1. **Introduction**

This report provides an overview of Bedford Borough Safeguarding Children Board’s (BBSCB) peer audit undertaken in January / February 2015. The focus of the audit was children who were the subject of repeat child protection (CP) plans under the category of neglect.

A dip sample of 3 sibling groups was selected. All cases selected had at least 3 agencies involved. Sibling groups were chosen in order to obtain a range of ages, from 4 months to 16 years. In addition the sample reflected different cultural backgrounds and included children with disabilities.

The following sections detail the audit process, key themes and recommendations.

In addition to this report, individual feedback sheets from the audit panel were sent to the professionals involved. These detail any recommendations in relation to the children with whom they were working.

2. **Audit Process**

In order to drive the work and identify professionals who should be complete the audit in each agency, the BBSCB Learning and Improvement Standing Group established a multi-agency audit panel. This comprised:

- Helen Hughes – Designated Nurse
A new multi-agency peer audit tool was devised (Appendix I). This was completed by all front line practitioners and managers involved in each case, across all agencies. The audits were then shared with members of the audit panel and on 11th February 2015 an audit review day was held. This included the panel group members as well as some of the practitioners and managers involved in each of the cases, (See Appendix II: Programme for the day). The day was facilitated by an independent consultant, (the author of this report).

3. Key Themes

Perhaps not surprisingly, there were a number of common characteristics amongst the cases, these included:

- **Adverse Childhood Experiences** (formerly known as the “toxic trio”) - the mothers in particular, in these cases suffered from mental health and substance misuse issues.
- **Domestic Abuse** was a common feature of the cases.
- The families had been known to services for many years (in one case, for 12 years) and there had been a number of previous plans and interventions.
- Families had experienced a number of changes in social workers.

**Strengths**

The audit identified a number of strengths and areas of good practice. These included:

- All agency managers completing the audit felt that the practice of their own agency had been good or outstanding.
There was clear evidence of strong partnership engagement at core groups, with all professionals working closely together, supporting one another and keeping in regular contact.

A number of professionals commented that recently allocated experienced social workers had resulted in a clear focus and advances in moving plans forward. These had resulted in improved outcomes for many of the children.

There was evidence of good community support for families through early help and from faith organisations in particular.

For two of the families, professionals felt that plans were robust.

There was evidence of strong relationships between professionals and families.

There was good evidence of father inclusive practice. In one case in particular the workers were praised for changing meetings to accommodate the father and working with the family in the evenings and weekends so that the father could be part of the work and decisions made. In this particular case, the involvement of the father had been significant in progressing the plan.

Areas for Improvement

The audits demonstrated that the voice of the child/young people was not clear or evident in the cases audited. That children and young people were not seen frequently enough by the professionals involved, or were not asked about their views and feelings. The practitioners focused too much on the needs of the parents, especially on vulnerable parents, and overlooked the implications for the child. Agencies did not interpret their findings well enough to protect the child.

Practitioners should:

- use direct observation of babies and young children by a range of people and make sense of these observations in relation to risk factors
- see children and young people in places that meet their needs – for example, in places that are familiar to them
see children and young people away from their carers
ensure that the assessment of the needs of disabled children identifies and includes needs relating to protection.
be alert to how acute awareness of the needs of parents can mask children's needs
ensure that actions take account of children and young people's views.

A number of other areas for improvement were identified. These included:

- A need to understand the previous history and greater use of chronologies in informing assessments and plans.
- There was a need to ensure that plans were SMARTer (Specific, Measurable, Attainable, Relevant and Timely). It is also important that plans relate to all siblings. In some cases, plans did not include outcomes for all siblings and a number of significant issues were felt to have been excluded from plans.
- Core group minutes were not evident – there were delays in sending minutes out to key professionals. Furthermore in discussions with professionals, there was uncertainty about the procedures surrounding core groups.
- Early years providers reported that it was sometimes difficult for them to address issues with families (whose children often just stopped attending). There was no statutory requirement for them to report this and so vital information held by early years providers could often be lost or the provider might not be aware of its significance.
- All cases included discussions about how information from specialist health professionals was drawn together. There is no consistent approach across Bedford. Health assessments are often siloed and information is not always co-ordinated and fed back to those representing health at core groups and CP conferences.
- The need for a "neglect" assessment tool (such as ‘the Graded Care Profile’), supported by further training around neglect for professionals, was identified a number of times.
4. Feedback on the Template and Process

The panel felt that the audit day, through discussions with workers, had enhanced the information obtained in the audit template. It helped to provide more qualitative information and establish an up to date picture of the work, plans and reasons for decisions.

This was the first peer audit undertaken and it was recognised that the timing had been poor because a number of agencies had been involved in a whole range of other audits and reviews, (both single agency and audits being undertaken by the other 2 LSCBs in Bedfordshire). This had put pressure on a number of key managers.

Further learning included:

- Selecting sibling groups meant that discussions had been lengthy and had necessitated considerable time from a wider range of professionals.
- Most front line staff reported finding the template easy to use. Some asked for further guidance around ratings.
- There is a need to review the template for schools use because schools do not have a line management structure and so completion of the second section was often absent.
- Some front line practitioners found it difficult to make judgements and so simply provided facts.
- Staff commented on how the day had enabled them to reflect on their practice. This often meant that discussions were protracted. (See recommendations below)
- It would have been helpful to have had copies of the CP plans with the audits. Future audits which are focused on specific processes, might wish to have copies of key documents.

5. Recommendations

a. One of the cases involved Photographs being taken. This triggered discussions about whether professionals should take photographs to support their work. Whilst organisations such as the Police have clear powers to take photographs, other agencies do not have clear policies. For this reason it is recommended that all BBSCB member organisations consider their position on the use of photographs and develop appropriate policies and procedures for their use.
b. Whilst thresholds for services are currently being reviewed, practitioners would benefit from further guidance about current thresholds.

c. Further awareness raising is required around Information sharing and the joint protocol in Bedford.

d. Core group procedures should be revised and re-issued (including clarity about minute takers and distribution of minutes).

e. The BBSCB should consider receiving regular data about who attends core groups and which agency they represent.

f. The BBSCB to lead on further work around the exploration of neglect. This should include a review of the BBSCB guidance on neglect. It was felt by the panel that this work could take place through a Pan-Bedfordshire Task and Finish group.

g. There is a need to review how specialist health assessments are commissioned and coordinated.

h. Bedford should explore the use of medical examinations in neglect cases in order to ensure medical opinion and consistency.

i. All agencies should consider opportunities given for Reflective Practice.

j. Professionals should be encouraged to exercise professional curiosity.

k. Future multi-agency audits would benefit from brief training and more detailed guidance being given to those expected to complete the template.

l. It was noted that besides this audit, BBSCB has obtained learning through Serious Case Reviews (SCRs) and a recent Learning Event. It was therefore felt, by the panel that this learning could be brought together into a “Lessons Learnt” paper to be produced by BBSCB and disseminated to all staff across the BBSCB partner agencies.

This report has been agreed by all members of the audit panel at a meeting held on 4th March 2015 and will be presented to the LISG for formal sign off on 30th April 2015.

Natalie Trentham
Independent Consultant
05/03/15
Appendix I

Bedford Borough Safeguarding Children Board

Multi-Agency Audit Tool

Introduction to the Audit Tool

Attached is a multi-agency audit template, which is designed to be completed by front line practitioners and managers in different agencies, who are working with the same child or family. This audit is designed to monitor outcomes and practice in order to help all of those taking part, to identify good practice and areas for improvement.

This Audit

It has been agreed that this audit will focus on children who have been the subject of two or more child protection plans, under the category of “neglect”.

3 cases have been selected for audit. These children represent a cross section of the children on CP plans and all have at least 3 agencies involved with them.
The cases are:
1. C/M 7 children - Ages from 5 to 15 years.
2. Q 4 children – Ethnicity mixed White & Asian, a case originally on a CP plan to Bedford which transferred out to another LA and then was received back in two years later on a CP plan. All children 5 years or under.
3. B/W 3 children – All under 5 years

Partners are asked to check their agency records and complete the audit tool based on their own agency’s involvement.

Practitioners working directly with the child or family are required to audit agency’s practice (including their own practice), by completing the case details and sections 1 and 2 of the audit.

A manager of the team or service is then asked to complete sections 3 and 4.

The completed audits must be submitted to Sally Stocker by January 26th 2015 to sally.stocker@bedford.gov.uk

The findings of the paper audit will be drawn together in a multi-agency audit day, which will be held on 11th February 2015 (details to follow). There will be dedicated time slots for all 3 cases to enable a multi-agency discussion. It is intended that this event will provide an opportunity for us to reflect on our practice and identify both strengths and key learning for the future. The day will include all agencies and staff who have been involved with the child or family, as well as multi-agency members of Bedford Borough Safeguarding Board’s Learning and Improvement Standing Group. The event will be chaired by an independent consultant, Natalie Trentham, who will draw together the findings into an overview report for the BBSCB.
Audit Template for Completion

Case Details *(To be completed by front line practitioner)*

<table>
<thead>
<tr>
<th>Audit Title</th>
<th>Children with 2 or more CP Plans under the category of ‘neglect’</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child’s Initials</td>
<td></td>
</tr>
<tr>
<td>Siblings Initials</td>
<td></td>
</tr>
<tr>
<td>Gender of child</td>
<td></td>
</tr>
<tr>
<td>Age of child</td>
<td></td>
</tr>
<tr>
<td>Ethnicity &amp; language of child</td>
<td></td>
</tr>
<tr>
<td>Religion of child</td>
<td></td>
</tr>
<tr>
<td>Agency/Team</td>
<td></td>
</tr>
<tr>
<td>-------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>Name of Auditor completing Sections 1 to 3</td>
<td></td>
</tr>
<tr>
<td>Date of Audit</td>
<td></td>
</tr>
<tr>
<td>Manager completing Sections 4 &amp; 5</td>
<td></td>
</tr>
<tr>
<td>Date your agency became involved</td>
<td></td>
</tr>
</tbody>
</table>
Auditors are requested to grade each section according to the following scale:

Outstanding = 1        Good = 2      Requires Improvement = 3      Inadequate = 4

Section 1: Assessment and Planning (To be completed by front line practitioner)

<table>
<thead>
<tr>
<th>Auditors comments</th>
<th>Evidence source (What is on the file to support this?)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1 What triggered your current involvement?</td>
<td></td>
</tr>
<tr>
<td>1.2 What did your assessment find?</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>1.3 How did you identify religious, language and cultural needs?</td>
<td></td>
</tr>
<tr>
<td>1.4 Describe what joint working you undertook with other agencies?</td>
<td></td>
</tr>
<tr>
<td>1.5 How was risk identified? What was the impact of risk on the child?</td>
<td></td>
</tr>
</tbody>
</table>
1.6 How was the voice of the child evident?

1.7 Please summarise your agency’s progress in achieving the current plan.

1.8 How were the identified outcomes for this child met in the plan?

1.9 How was the voice of the father evident?

1.10 What were the views of the parents/carers?
| Judgement: How would you rate your agency’s assessment and planning for this child? |  |
Section 2: Outcomes for the Child *(To be completed by front line practitioner)*

<table>
<thead>
<tr>
<th>2.1 What difference did the intervention make to the child?</th>
<th>Auditors comments</th>
<th>Evidence Source <em>(what is on the file to support this?)</em></th>
</tr>
</thead>
<tbody>
<tr>
<td>2.2 What worked well?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.3 What did not work well?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.4 Is there anything that should have been done differently?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.5 What can we learn from this case?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Judgement: How would you rate your agency’s response to the outcomes for the child?
**Section 3: Workforce and Management** *(to be completed by the Team / Service Manager)*

<table>
<thead>
<tr>
<th>Auditors comments</th>
<th>Evidence Source <em>(what is on the file to support this?)</em></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>3.1</strong> What is the evidence of clinical supervision or management oversight of this work?</td>
<td></td>
</tr>
<tr>
<td><strong>3.2</strong> What is the evidence that agreed actions have been followed through?</td>
<td></td>
</tr>
<tr>
<td><strong>3.3</strong> Were there any workforce or other issues that impacted on the child? E.g. changes in workers, allocation delays.</td>
<td></td>
</tr>
<tr>
<td><strong>3.4</strong> Is there any evidence that</td>
<td></td>
</tr>
<tr>
<td>access to resources affected the work or the outcome for this child?</td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>If so what?</td>
<td></td>
</tr>
</tbody>
</table>

Judgement: How would you rate your agency's response to the workforce and management of the case?

<table>
<thead>
<tr>
<th>Section 4: Auditors Comments (to be completed by the Team / Service Manager)</th>
<th></th>
</tr>
</thead>
</table>

4.1 What is your overall rating of your agencies involvement? 

Why?

4.2 Any other comments and or observations pertaining to the case?
<table>
<thead>
<tr>
<th>4.3 What recommendations would you like to make to the BBSCB?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Judgement: This is a pilot. Please include any comments about the audit template/process.</td>
</tr>
</tbody>
</table>
Appendix II

Audit Day Programme

11th February 2015

Lakeview Village Hall Brooklands Avenue, Wixams Bedford MK42 6AB

9.00am -10.30am  Audit Panel Group discussion:
• Confirmation of process and programme
• Reading late information
• Missing Information
• Key questions for each case
• Emerging cross cutting issues

10.30 – 12pm  Presentation and Discussion of Audits: B/W (3 children)

12.00 -12.30pm  Lunch Break

12.30pm – 2.30pm  Presentation and Discussion of Audits: C/M (7 children)

2.30pm – 2.45pm  Break

2.45pm –4.15pm  Presentation and Discussion of Audit: Q (4 children)

4.15pm – 5.00pm  Panel group discussion, summary of Actions, Next Steps & Learning