PRE- BIRTH PROTOCOL MULTI-AGENCY AUDIT REPORT

As well as a response to findings from SCRs, the Gloucestershire Pre-Birth Protocol was developed to enhance multi-agency support to pregnant women and their partners. In particular, to provide early identification and intervention to minimise the negative impact to the unborn as described in the report The Best Start for Life.

Kanchan Jadeja

June 2021

Gloucestershire Safeguarding Children Partnership

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Introduction

This multi-agency audit was commissioned by the GSCP QiiP Group to assess the impact and use of the pre-birth Protocol implemented in 2019. The Pre-Birth Protocol was revised following the findings of two Serious Case Reviews (SCRs) which highlighted the need for more robust and multi-agency approach to pre-birth work and planning. As a policy priority, effective multi-agency pre-birth work is critical for safeguarding an unborn baby.

As well as a response to findings from SCRs, the Pre-Birth Protocol was developed to enhance multi-agency support to pregnant women and their partners. In particular, to provide early identification and intervention to minimise the negative impact to the unborn as described in the report The Best Start for Life.

This recent government report highlights the importance of the first 1001 critical days:

"*Today, the period from conception to age two is globally recognised as critical for building strong societies. We are fortunate that support for families in England is delivered by many committed midwives, health visitors, social workers and primary care practitioners, as well as thousands of committed volunteers. However, what is clear is that services are patchy, not joined up and often do not deliver what parents and carers need. This must change if we are to truly transform our society for the better"* (The Best Start for Life A Vision for the 1,001 Critical Days The Early Years Healthy Development Review Report Presented to Parliament by the Secretary of State for Health and Social Care by Command of Her Majesty March 2021 CP)

The protocol was developed by the then GSCB partnership to highlight the importance of the following:

- Early identification and to maximise community interventions so that the baby and family are supported in the community.
- Multi-agency working together at all aspects of the journey of the unborn including early help, Section 17, Section 47 and follow through to Initial Child Protection Plan and if the baby becomes a child in care.
- To minimise the need for legal proceedings and to consider family based interventions so that the baby remains within the family and community.
- Highlight the importance of Family Group Conferencing to identify support with the family and community.
- To include safe and multi-agency discharge from hospital for the baby by closely with parents and family members.

Methodology.

The GSCP has developed a multi-agency audit methodology which was previously used in the completion of the neglect audit. This methodology sets out a set of questions and identifies all agencies that are to take part in the audit. Once audits have been completed by single agency, a practitioner day is held to discuss the findings and to agree a set of findings and recommendations. Using this methodology, records were reviewed by dedicated auditors within their own agencies and a multi-agency practitioner discussion was held to bring together the themes and learning from the audit.

This Audit process was designed to provide comprehensive assessment about the understanding and implementation of the Pre-birth protocol across the partnership. The audit identified 20 unborns

and babies from Children's Social Care liquid logic system and a spreadsheet with questions was developed. It is important to note that this audit was carried out in the second year of the Covid 19 pandemic when children's safeguarding agencies were under pressure from the challenges posed by the pandemic. In addition, professionals were themselves impacted by increased workload and there was fatigue in the system due to the pandemic.

There were additional challenges for some agencies in accessing information for the audit. For example, health colleagues had difficulties because they have paper records and this made the process lengthy. In recognition of these pressures, the GSCP agreed that it was important to provide colleagues with more time to complete the audit and to modify the questions in line with their own recording processes. A more bespoke questionnaire with relevant questions was developed by a senior colleague in health, for health colleagues was developed to simplify the process and to accommodate their recording systems. There has been considerable time and effort from all agencies to ensure that the audit was completed and the findings provide learning both for work with pre-birth but also highlight some of the challenges faced by agencies in reviewing recording.

Agencies taking part in the audit were:

Children's Social Care (field teams, children protection service FDAC, legal services), Early Help (Children's Centres, Families First), Police, Health (midwifery, Health Visiting, G.P services). Not all of the 20 unborns and babies were known to all agencies. For example, none known to FDAC, fewer were known to police and only one unborn was open to Families first.

Findings.

- All unborns babies were identified as safe by all agencies.
- Understanding and use of the Pre-Birth Protocol varied hugely across different agencies.
    - It was not being used consistently across the partnership to inform work with unborns. All thresholds were relevant and appropriate.
    - Children's Social Care evidenced the use of the pre-birth assessment to inform practice and there were a number of good pre-birth assessments identified by the auditors.
- There is good evidence of working in partnership with parents, especially mothers and in most cases recorded. Robust efforts were made to engage fathers; this is a key feature of the protocol. This was a key finding by Children's Social Care and Health.
- Good engagement of Police in strategy meetings in respect of unborns and babies. Good working together between partners including children's social care and health (maternity, health visiting), police in strategy discussions.
- The audit found that the role of Police is not fully utilised by the partnership. For example, in discharge from hospital, in carrying out safe and well visits to the family after mother and baby leave hospital to go home.
- Within the Police service, a thorough contingency plan at the point of birth, or trigger plan on discharge requires further work, Police responses are by nature episodic, and however, there could be more multi-agency working. "*Police do not appear to have taken an active*

role in joint working." (Police auditor). There is learning here for Police and other agencies to ensure that they involve Police as a partner in implementing the pre-birth protocol.

- Police colleagues carried out work with pregnant mothers, but were not aware of the Pre-birth protocol.

- Responses from G.Ps were light in detail. However, these responses highlighted that G.Ps were aware of multiple vulnerabilities of parents and carers and were sighted to multi agency meetings within their surgeries relating to unborns and their siblings, although they did not always participate in these.

    - Effective safeguarding discussions are held at in-house monthly meetings with GP, midwife and health visitor. This is not always recorded and the learning from this audit is that the surgery "*we need to look at how we can do this better".*

- Team around the family is pivotal to discussions about supporting families and the involvement of midwifery in these meetings (which is soon to be implemented) will enhance work with babies and unborns.

- Children's centre colleagues developed an internal plan to progress further understanding and implementation of the Pre-birth protocol on completion of this audit.

- None of the responses highlighted whether a couple was in a same sex relationship. Improved understanding is required about supporting same sex parents across the partnership.

- Health Visitors reported good engagement with parents. In addition, there was good analysis in the health visitor records about the detail and the elements of visiting small babies. For example, handling the baby, behaviours and observation of mother and baby interaction etc.

- Most referrals to MASH about unborns were from maternity services. This is positive and highlights the importance of maternity colleagues using the pre-birth protocol

- In Children's Social Care view of partnership working, there was some evidence of over optimism relating to parental capacity to change. This led to later intervention and legal involvement at a later date. This was found to be the case by legal colleagues in his response to pre-birth audit.

- None of the unborns reviewed had FDAC involvement; however, feedback on practitioner day from the FDAC service manager suggests that further work is needed to improve partnership working and multi-agency assessment of need.

The Analysis

Awareness and Use of Pre-birth Protocol.

- Awareness and understanding of the Pre-birth protocol varied across the partnership. All cases reviewed by Children's Social Care evidenced knowledge and understanding of the pre-birth protocol. There was evidence of completing the pre-birth assessment and involvement of other agencies. The auditor had identified the assessments as good and comprehensive. This suggests that although there is overall knowledge of the protocol it is not consistently used by Children's Social Care.

- All threshold decision making by Children's Social Care in Child Protection Conferences and overall decision making in respect of unborns and babies were found to be appropriate. The Reviewing service used the protocol, but its use was found to be inconsistent. The significance and importance of using the protocol was highlighted by the auditor. Where the pre-birth assessment was not completed; there was a delay in intervention and engagement with parents.

- Initial and Review Child Protection Conferences were identified as of critical importance for multi-agency working, sharing information and collaborating on a safety plan for the mother and baby. However, in one case, the decision not to place unborn on a child protection plan because father was in prison was misguided and did not take into account mother's vulnerability and history of abuse in relationships. This suggests that the high level threshold decision making is relevant but nuanced understanding and implementation of risk and likelihood of harm requires further work.

- Children's Social Care assessments included the use of Adverse Childhood Experiences (ACEs) and trauma informed practice in the pre-birth assessments. This was identified as good practice by the auditor.

- Where parents came from a BAME background, cultural nuances and the understanding of language required further attention. One agency reported that they were unsure whether the parent understood what was being said to them.

- The work carried out on child protection plans needs to be earlier than is currently the case, more rigorous in assessing risk, understanding the capacity to change and supporting parents to make the changes identified. The negative outcome of delay is that proceedings come later in the pregnancy or at birth which provide insufficient time to assess parental capacity and permanence for the baby. The positive intervention carried out in assessing work on pre-birth needs be underpinned by progressing plans for unborns and babies.

- The audit found that there are opportunities missed by children's centres in engaging with the wider partnership to support vulnerable parents. Early Help colleagues in community centres worked well with mothers to be and although professionals have worked hard to involve fathers, further work is required to meaningfully engage with fathers. A plan has been put in place to progress this further with Children's Centre staff.

- Where information from the pre-birth assessments is shared with Children's Centres and Family centres, the outcome for the unborn and work carried out with the families is more effective. Therefore, communication between social workers and Children's and Family Centres is crucial to achieve improved outcomes for unborns and babies. This is also the case for Families First work.

- There was only one of the twenty unborns reviewed by the families first auditor. She found that an earlier referral would enable the service to work alongside the social worker to support work with the family. This is echoed by Children's Social Care. Therefore, engagement with families first is a key element of progressing a plan by children's social care.

- The Pre-birth protocol has been shared across the partnership but there is poor awareness in midwives. However, there was evidence that the pre-birth work was clearly prioritised and referrals were made where safeguarding concerns were evidenced.

- Maternity Services, Health Visitors did not always directly refer to the pre-birth protocol and auditors reported that many were not always aware of the pre-birth protocol. In a case where there was a late presentation of a pregnancy, the GP, health visitor and maternity services worked well together to identify any risks and safeguarding the child.

- In health visiting services, relevant agency assessments were completed. There was good discharge from hospital practice with health visiting working well with other agencies.

- Good liaison was evidenced between maternity services and health visiting including good continuity of care. There was good multi agency working where in one case visiting was shared between Children's Social Care, midwives and health visiting. Enhanced midwifery care was provided when the mother was vulnerable including use of ACEs in some cases to assess vulnerability. Good engagement with parents and health visitors but, the question is whether there is evidence of professional curiosity and challenge when required with parents.

- Some agencies had very little knowledge and understanding or made use of the pre-birth protocol. For example, the police service, early help and the GP service. There was less awareness of the pre-birth protocol in these agencies. Whilst work with unborns and babies was appropriate, it did not include the principles of multi-agency working set out in the pre-birth protocol.

- The use of discharge template was positive at point of discharge evidenced by all agencies engaged in discharge planning. However, not all agencies were involved in discharge from hospital. Many partner agencies are not aware of discharge planning and this is an area of practice that requires multi-agency working in order to keep the baby safe in the community. In addition, opportunities are often missed for engagement with colleagues in other agencies. For example, police colleagues could have further awareness of risks when the baby is discharged from hospital. This is particularly important where there is a high prevalence or likelihood of domestic violence in the family, police involvement in discharge from hospital could provide additional safety for the baby.

- Police auditing found that there was good management of risk, their role is strategy discussions work was highlighted as good practice because it provided relevant information about risks to the unborn from parents. Police recording did not always include details about the impact of their involvement with the unborn. Records reflected impact on other children in the household and '*the pregnancy'.* This was identified as an area for improvement.

Management Oversight.

- Some records reviewed did not contain information about management oversight on work carried out with unborns and the use of the pre-birth protocol. In some agencies, for example police, health visiting, it was not possible for the auditor to assess management oversight because records for the baby did not contain management oversight records. There was an example of good group supervision to discuss safeguarding concerns relating to small babies.

- In agencies where it was possible to review management oversight this was found to be good, for example, good management oversight was reported in the early help community centres.

- Children's social care reported that there was good management oversight in pre-birth assessments and overall work with unborns. This was evidenced in progressing from Section 47 to ICPC and Child Protection Plans. Further work is needed to develop this so that it is consistent across work with all unborns.

Equality and Diversity.

- Further work is required to understand cultural dimension of pregnancy and child birth.
- Information gathered from partners should include details of same sex relationships.
- Although children's social care reported that work with fathers is good, further engagement with fathers and males across the partnership.

Action Plan

1. All agencies to promote the use of the pre-birth protocol, either by creating a champion, making use of internal communications mechanisms and/or in supervision sessions.

2. Information should be shared with Families First workers by Social Workers to improve collaborative working. Unless there is a reason not to do so, information should be shared.

3. There are good examples of plans from the unborn or baby's perspective. Across the partnership, the lived experience of unborns and babies to be included in case recording and case discussions.

4. G.Ps to be invited to and where possible participate or provide information at multi-agency meetings.

5. In house meetings between health visitors, maternity colleagues to be recorded on safeguarding records of unborns in GP surgeries.

6. G.P information on Children on Child in Need plans is not consistently and routinely updated. Where consent has been sought, this information should be shared with the G.P.

7. The record of communication between GPs and health visitors should be routinely completed and shared where possible, unless there is a reason not to.

8. The partnership to engage more effectively with Police where relevant and appropriate in discharge from hospital and to carry out safe and well visits.

9. The discharge from hospital should be a multi-agency process and consideration should be given to broaden involvement of other agencies. For children's social care a recorded in a drop box in liquid logic would enable the social worker to have easy access to the discharge template.

10. Police to review any actions required beyond strategy meetings consideration given to trigger plans at birth and following discharge from hospital, especially where chronic neglect, domestic violence and substance misuse has been identified as risk factors.

11. Social Workers must share information with Early Help Family Social Workers, to make better use of the service provided.

12. Maternity services to demonstrate the use of the protocol in the green form.

13. Information should be shared between social workers and children's and families centres.

14. A short briefing document covering the key points of the pre-birth protocol to be developed and circulated to the partnership.

Conclusion.

All agencies reported that when professionals worked together, this created better outcomes and plans. Strategy discussion meetings, ICPCs and other opportunities to share information were considered to be useful by all those who attended and responded. However, between meetings, there is less communication and this could be improved upon. At times this work takes place in isolation of the wider partnership working for the unborn, baby, mother and partner. There is work required to have an improved understanding and engagement with other agencies outside of safeguarding processes.

A positive outcome of carrying out this review is that it highlighted the need for agencies to review their understanding of the pre-birth protocol, their work with unborns and how they work with other agencies. All those who took part reflected this in their responses.

Across the partnership agencies could improve how they can exercise professional curiosity with pre-birth and small babies. All agencies reported that when professionals worked together, this created better outcomes and plans

Further, it was reported that where agencies have worked well together to highlight concerns and work with parents to provide support they needed, this is shared in the pre-birth implementation group but further opportunities at practitioner level are needed for professionals to review what works well. Equally, where there is less than adequate practice, opportunities could be created for agencies to have reflective discussion to improve practice. This audit has provided the partnership with an opportunity to consider both good practices, areas of improvement within their own agencies as well as a partnership. It is positive that the audit has energised colleagues to make changes:

"*The audits have ensured we have focus on the unborn child. Team managers have more enhanced and informed discussions with Family support workers – Case Discussions on unborn / parent seen is more key".(*Commissioning).

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