# C:\Users\juliecholerton\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.Word\SAB_logo_rgb.jpg Multi-agency Audit Report: Transitions and Trauma Brighton & Hove Safeguarding Adults Board Quality Assurance Subgroup March 2023

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This report sets out the findings of the multi-agency audit conducted between September 2022

and March 2023 and makes recommendations for actions and learning for all agencies.

# Background

* 1. One of the key functions of the Brighton and Hove Safeguarding Adults Board (BHSAB) is to seek assurance of the effectiveness of safeguarding activity. On behalf of the BHSAB the Quality Assurance Subgroup (QA) is responsible for the co-ordination and management of the Quality Assurance Framework, including undertaking multi-agency audits. The QA subgroup aims to complete two themed audits per year.
  2. This themed audit was undertaken in response to one of the recommendations made by the Independent Reviewers as part of the Thematic Learning Review, a discretionary Safeguarding Adults Review undertaken by the BHSAB. This recommendation stated, **‘As part of their future audit programme the SAB consider a review of the transitional approach taken across safeguarding between Children’s and Adults services, for example focusing on the identification of trauma and support offered to mothers whose children are taken into care**’.
  3. The QA subgroup commenced the Transitions and Trauma audit in September 2022. The purpose of the audit was to:
* To further understanding the transition between children’s pathway services to adult pathway to services.
* Seek to understand the increasing impact of trauma for women who have children taken into care and the needs for partner agencies in adult safeguarding to incorporate this within interventions. For the purposes of this audit the definition of Trauma will be as used in the Thematic Review.
* Identify areas of good practice and areas of improvement in response to working with women who have compound Trauma which impact on their responses to support.
* Develop opportunities to share learning and training across the workforce within this area of need.
  1. The audit group comprised of representatives from:
* Brighton & Hove City Council, Health and Social Care (BHCC HASC)
* NHS Sussex
* Brighton & Hove City Council, Housing
* Sussex Partnership NHS Foundation Trust (SPFT)
* University Hospitals Sussex NHS Foundation Trust (UHS)
* Oasis Project
* Brighton & Hove City Council, Community Safety (+ VAWG)
* Probation Service

# Methodology

* 1. An audit tool was circulated to the audit group in October 2022. This included a questionnaire, with space for a brief summary of a case example, questions grouped by theme, and space for recommendations.
  2. The audit tool was structured as follows:
* **Part A** Case Summary
* **Part B** Trauma
* **Part C** Transitions
* **Part D** Recommendations
  1. **Part A** Case Summary
* Please provide a brief summary of a case example or examples from your service, or a service you commission, where a woman or person who identifies as a woman, is known to have had a child taken into care. (Please highlight if this adult was previously a looked after child.)
* Was this individual identified as having multiple and intersectional needs and if so what were these in relation to (homelessness, substance misuse, mental health, domestic abuse, offending behaviour)? Please identify any other professionals and agencies you are aware she was receiving support from.  
  1. **Part B** Trauma
* Was Trauma identified in this case and if so what was this felt to be in relation to?
* How was the trauma identified and by which agency?
* Was any support provided in direct response to the identification of trauma or was practice adapted in this case to accommodate this? Please give examples.
* Does your agency offer training to staff in relation to the identification of trauma?  
  1. **Part C** Transitions
* Was there any communication between adults and children’s pathway services in relation to the transitional element identified in this case?
* How did communication and any sharing of information impact on the planning interventions, or outcomes in this case?
* Were any specialist services that support women who have had children removed involved in this case at any point or are you aware of this being considered?  
  1. **Part D** Recommendations
* What do you think would help cases like this?  
  1. In total 12 partner services/agencies were contacted to take part. Responses were received through the return of completed forms between November 2022 and February 2023. The table below indicates the agencies invited to complete the audit and their responses:

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| **Agency** | **Audit Tool** |
| BHCC HASC | Return provided x 2 |
| NHS Sussex | Return provided by Primary Care |
| SPFT | Return provided |
| UHS | Return provided |
| Oasis Project | Return provided by Looking Forward |

* 1. Agencies were invited to complete the tool either individually or as part of a group or team discussion. Some of the returns were completed as part of a group or team discussion, and represented a collective view. There was also some variation in the level of detail and completion across returns.
  2. An audit meeting was scheduled for February 2023, with audit group agencies invited to attend. In advance of this meeting, BHSAB colleagues collated the returns received and produced an initial summary to lead discussion.
  3. Due to reduced capacity this meeting was rescheduled, and the following agency representatives attended the rearranged audit meeting on 22nd March 2023:
* **Guy Jackson – BHSAB, Business Manager**
* **Alexandra Barnard – BHSAB, Administrator**
* **Tom Bennett – BHCC Community Safety, Coordinator for Exploitation and Serious Violence Reduction**
* **Katherine Taylor-Birnie – BHCC HASC, Safeguarding Adults Lead**
* **Richard Christou – NHS Sussex, Designated Nurse**
* **Liam Sargent – SPFT, Named Professional for Adult Safeguarding**
* **Lydia Radford – SPFT, Deputy Named Professional for Adult Safeguarding**
* **Anne Clark – BHCC Community Safety, Domestic Abuse and VAWG Commissioner**
* **Laura Ward – Oasis Project, Chief Executive**
* **Francesca Carpenter – Oasis Project, Head of Client Services**
* **Debbie Knight – Probation, Head of Brighton & East Sussex**
* **Emma Gilbert – BHCC Housing, Tenancy Services Operations Manager**

# Audit Tool Findings

### Part A: Case Summary

* 1. The identified cases included a range of situations in which there had been a multi-agency approach involving a number of agencies.
  2. In the majority of cases, the women had historical involvement with at least one or more agencies, some as previously looked after children. Most of the returns showed that both adults and children’s teams were supporting these women. However, one case included little if any contact with services prior to a child protection plan being put in place.
  3. In half of cases, the women had received or were awaiting assessment for a learning disability. In almost all cases, the women had identified mental health needs.
  4. In all cases multiple and compound needs were identified by services. In two thirds of cases, records identify concerns around domestic abuse and substance use. In half of cases, the women were experiencing homelessness and there were also incidents of offending behaviour.

### Part B: Trauma

* 1. In a majority of cases (4/6) returns indicated that trauma was not clearly identified. There was some record that practitioners were aware of, or considering, previous or potential trauma. Where trauma was (partially) identified, on occasion this was through practitioners liaising with the individual.
  2. In all but one case, colleagues did not see evidence of adapted practice or support provided in direct response to identification of trauma. The return from Oasis Project was completed by Looking Forward, who have accreditation for trauma-informed practice.
  3. Half of agencies offer training to staff around the identification of trauma. Oasis Project / Looking Forward outlined training offered at induction, on an ongoing basis, and individually based on personal development needs. Knowledge of trauma is recognised in the recruitment process, and within supervision.

### Part C: Transitions

* 1. In two thirds of cases, respondents did not find evidence of communication between adults and children’s pathways services in relation to the transitional element of cases. Looking Forward received a referral for ongoing support from Children’s Social Care colleagues, where their intervention with the individual was reducing. This continued communication and understanding of each organisation’s respective services was felt to have enabled practitioners to better assist women in such cases.
  2. In two thirds of cases (4/6), the level or quality of communication and information sharing was felt to have had a negative impact on case outcomes. Two cases identified some positive impacts, including where communication or information sharing had enabled proactive or planned support.
  3. In most cases (4/6), respondents did not find evidence of the involvement of specialist services that support women who have had children removed. In the other two cases, there was evidence of support from Looking Forward as well as from a Mother & Baby Unit.

### Part D: Respondent recommendations

* 1. Respondents were asked what they felt would help in cases like these. A large number of suggestions were made, which can broadly be grouped into some areas of focus; information sharing and recording, processes, expertise, culture, appropriate identification of care and support needs, and service provision.
  2. A fuller summary of the individual recommendations made can be seen in the appendix.

# Summary of Audit Group Meeting

* 1. Agencies comprising the audit group were invited to attend the audit meeting (§2.10) to discuss and agree the findings. Colleagues reflected that working to identify and review a case for audit had taken a considerable amount of time. But it was felt that reviewing a longer period of an individual’s records, especially in liaison with children’s colleagues, had given a particularly detailed understanding of the individuals’ journeys and the challenges colleagues faced.
  2. There was consensus that the audit highlighted the need for a more systematic approach to identifying trauma, across organisations and at all ‘layers’ of services. Trauma was felt to be challenging to define and training and support differs across organisations. The potential for a multi-agency trauma-informed framework or approach was discussed.
  3. Colleagues felt that the audit fairly reflected issues with communication and multi-agency working within transitional safeguarding. Examples of good communicative practice were noted, and members reflected on the positive impact of good relationships between practitioners in children’s and adults’ services. However, it was identified that this was often the result of individual relationships or networking, rather than ensured by policy or process.
  4. Relatedly, when there were formal processes undertaken (i.e. child protection plan), well-attended multi-agency meetings were associated with more rigorous processes and improved multi-agency practice.
  5. Members noted that there was a lack of transitions focused teams / organisations, and a lack of related specialist services. Members also questioned whether existing services were accessible and ‘acceptable’ to parents. The potential to undertake co-production was raised.
  6. The returns underlined where trauma is identified, this may be ‘lost’ amongst other more clearly defined needs (for example substance use, abuse and neglect). The lack of low-level services or processes, and early intervention as part of a preventative approach, were felt to be particular issues. Colleagues also recognised the impact of the broader context of limited and reducing resource.
  7. Good transitional safeguarding practice was enabled by ongoing communication and involvement with Children’s services, and between children’s and adults’ teams within organisations. Involvement of Health (including GPs) and Housing colleagues, who are often involved throughout an individual’s lifespan, was identified as an area for development. Colleagues discussed the potential for formal transitional processes or shared frameworks.

# Recommendations

* 1. **In recognising the limited awareness and use of specialist services to support mothers whose children are taken into care, particularly across adult services, the Looking Forward service and any accompanying pathways and eligibility criteria are disseminated across the system as well as through the BHSAB. Existing resources, such as any directories or maps of relevant structures, pathways, and services already in place to also be made more widely available through the BHSAB. This will assist in identifying the various services that are available, how these can be accessed, and as a result promote early referrals, increased use, and support improved practice outcomes.**
  2. **A local multi-agency trauma-informed framework or Protocol is developed. This would support the definition and identification of trauma, recognition of the impact it can have, awareness of different approaches or models used, as well as broad principles and key steps that should be considered by professionals and agencies. It would also align with other work being undertaken in relation to standardising trauma-informed approaches.**
  3. **There is consideration given to the development of a local Transitions framework or Protocol. This would promote engagement and planning at an earlier stage, establish formal processes or guidance between Children and Adult services internally and from a multi-agency perspective, improved information sharing and ongoing communication, as well as developing a more holistic approach with the routine involvement of agencies such as Housing and GP Practices.**
  4. **This report should be published by the BHSAB as well as being disseminated internally by agencies involved in the audit to ensure the learning is effectively shared.**

### Appendix: Grouped and collated responses: “What do you think would help cases like this?”

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| *Information Sharing / Recording* | * Good local sector knowledge and awareness of specialist services and needs / experiences of women with multiple and compound needs, alongside experience of child separation and impact on mental health. * Primary Care should consider adding an alert on patients notes when they are aware a child has been taken into care, irrespective of whether formal CSC documentation has been received. * CSC should ensure Primary Care receive safeguarding reports (i.e. ICPC & RCPC reports) which should include a clear explanation of process, expected timescales and outcomes from the lead agencies. * SABs/SCPs to consider collating information on agencies that are available to support patients that have had such an experience, and to share this list with Primary Care. * Information sharing following children's safeguarding meeting, particularly where children are removed, and likelihood of returning to parent (enabling risk assessment and better therapeutic intervention) * Information sharing around diagnoses. * Access to historical and cross directorate notes, and commitment by agencies to looking back over chronologies to aid understanding before engaging. |
| *Process / Practice* | * Early referral to specialist services following permanent separation (opportunity to establish a relationship at time of potential ‘cliff edge’). * Primary Care Practitioners to consider referring to services rather than signposting to services on a case-by-case basis. * Early referral to ASC / LDLT / SCDS i.e. during pregnancy rather than at the point of birth. * Dedicated advocacy for parent(s). * Early assessment (at point of distress), and behavioural approaches informed by psychologist. * Trauma informed documentation within the system that requires a focus on trauma informed, on planning and taking account of impact of trauma. * Shared approach to transitional safeguarding planning, to better support and engage young people experiencing harm or risk of abuse and neglect that may continue into adulthood. * Shared approach and investment in social work practice is needed, shared guidance on trauma informed and transitional safeguarding casework, and a shared framework as to this. |
| *Expertise / Training* | * A psychologically trauma informed approach to engaging (multi agency adopted guidance on approaching conversations, tips for practice). * Training for adult social workers on the impact of child removal and ‘how’ we can be trauma informed around this. * Training around substance misuse as a way of coping or blocking out traumatic experiences. * Training on use of language, particularly around engaging with people. * Access by social workers to psychology for individuals experiencing / surviving (past) trauma. * Reflective practice; multi agency access / provision. |
| *Culture* | * Enabling adults to ‘share their trauma’ without prejudice. * Move away from ‘passive parenting’, concepts of grounding / withdrawing for “bad behaviour”, focus on “boundaries”. * Positive parenting with therapeutic support and psychologically minded approach for family. * An informed approach, taking disabilities and obvious distress fully into account. * Increased curiosity / awareness of difficulties in childhood, where currently normalised. |
| *Appropriate Identification of Care & Support Needs* | * Increased professional curiosity by mental health practitioners about children not present during visits. * Mental health assessments reflecting personal / family history and highlight trauma history. * Early diagnosis of learning disabilities, and appropriate response. Avoiding framings of ‘bad behaviour’. Enabling safer attachments, able to keep self safe and distinguish between exploitation and relationships. * Acceptance of multiple needs, and risk of further safeguarding risks emerging. |
| *Service Provision* | * Local investment from commissioning into specialist services, such as Looking Forward. * ICB to continue to offer and promote Trauma Informed Care (TIC) Awareness Training to Primary Care practitioners. * Provision / pathways for individuals without formal trauma diagnoses. * Consistent psychological support, enabling young people to understand abusive relationships and look after themselves. * Services created for people with learning disabilities (compassionate and informed care). * More resources within the local authority with focus on transitions. * A transitional safeguarding agreed approach in the local authority. * Scoping and quality assurance on transitions areas and the effectiveness of case work and planning on this area. * Co production from service users with regard to action planning, increasing accessibility, boost engagement (“is a more trauma informed approach what people want to see?”). |