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| **Dewsbury and District Hospital****Halifax Road****Dewsbury****WF13 4HS** | **Pontefract Hospital****Friarwood Lane****Pontefract****WF8 4PL** | **Pinderfields Hospital****Aberford Road****Wakefield****WF1 4DG**  |

###### Version 1

**Multi-Agency Pregnancy Liaison and Assessment Group (MAPLAG) Audit**

**Safeguarding Team**

**Audit Lead: Angela South**

**Audit Sponsor:**

**Clinical Audit Facilitator:**

**Report Date: July 2021**

**Report By: Angela South**

**Audit No: 1 Contents**

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# Introduction

Effective sharing of information between practitioners and local agencies is essential for early identification of need, assessment and service provision. Safeguarding Practice reviews have highlighted that missing opportunities to record, share and understand the significance of information in a timely manner can have severe consequences for the safety and welfare of children.

Sharing information increases the capacity of practitioners to take actions to keep children safe. Practitioners should be proactive in sharing information.

**Working Together to Safeguard**

**Children 2018**

Multiple agencies recognise that pregnant women with complex health and social needs do not always access the services they require for both themselves and their unborn baby. Local agencies in Wakefield recognise that early intervention is essential if children and young people are to be safeguarded effectively. There is a need to shift the focus from protecting children from harm to preventing abuse and neglect in line with the findings of the Munro Review.

Within Wakefield, key agencies discussed the need to work collaboratively within the MAPLAG process to provide effective holistic health care and safety planning to safeguard and protect individuals, vulnerable pregnant women and their children and unborn baby.

It was thought that this process would enable relevant agencies to work together, share information at the MAPLAG meeting and provide a collaborative consistent plan of advice, support and care to the pregnant women. The first MAPLAG Meeting was held on 21/01/2019 to discuss the format of the future meetings and the first meeting where cases were discussed was 08/03/2019.

This Audit seeks to retrospectively assess the outcomes of the cases heard in the second year of MAPLAG Meetings. The Audit covers cases discussed from 21/04/2020 to 05/03/2021.

# Evidence Base/Standards

This MAPLAG Process is a multi-agency process utilised in Wakefield supported by the Safeguarding Effectiveness Group of the Wakefield Safeguarding Children Partnership (formally WDSCB).

# Aims and Objectives

Aim:

To examine the use of the process and effectiveness of the work of the MAPLAG one year on after its development.

Objectives:

To determine if MAPLAG is identifying specific risk factors in high risk vulnerable families with complex needs in pregnancy

To evidence a collaborative co-ordinated approach to safeguarding and appropriate support provided within the action plan

To evidence a consistent approach by all professionals towards effective inter-agency communication and information sharing.

# Methodology

Sample

The sample has included all of the women referred into MAPLAG from 21/04/2020 to 05/03/2021.

There were a total of 117 cases identified in the Audit period and all cases were reviewed using a 5 question proforma (see appendix 1).

Audit type:

All cases were audited by reviewing the safeguarding records, Maternity electronic records and the notes and agendas of the MAPLAG Meetings.

Process:

The data was obtained by the use of the data collection tool (Appendix 1), retrospectively from the above records.

Following completion of the audit the information will be collated, analysed and emerging themes and trends will be identified. A report will be produced and shared with members of the MAPLAG, the Trust Safeguarding Group, Wakefield Safeguarding Effectiveness Group and Midwifery Team Leaders.

Data analysis

Given the small audit sample a data analysis tool was not utilised.

Report writing done by Angela South, Safeguarding Named Midwife

# Results

The results are as follows:

|  |  |
| --- | --- |
| Question | Result |
| 1. Has a criteria topic been identified
 | Yes in all 117 cases |
| 1. Who made the referral
 | 76 by Social Worker43 by Midwife( 8 cases were referred by both Social Worker and Midwife)4 by 0-19 service1 by FNP1 by SWANs |
| 3. Was there additional support provided  | Yes 107 casesDeclined in 10 cases |
| 4. Was there a referral to Children’s Social Care | Yes in all 115 casesNo in 2 cases (1 homeless, 1 early help) |
| 5. Was the baby removed or home on a plan | Removed 21 casesHome 90 casesNo continuing pregnancy 2 casesParenting assessment placement 2 casesMoved out of area 2 cases |

# Conclusions

Of the 117 cases audited:

* 100% of the cases met the criteria for referral.
* 62% of the referrals were made by Social Workers, 35% of the referrals were made by Midwives and 3% of the referrals were made by other services
* 90% of cases had additional support provided, 8% declined and 2% did not have a continuing pregnancy.
* 98% of the cases were referred to Social Care and 2% were not referred.
* 18% of babies were removed from parents care, 77% went home with parents, 2% did not have a continuing pregnancy and the final 3% consisted of 2 cases to a parenting assessment unit, 2 cases moved out of area prior to delivery

Areas of Good Practice

# Professional understood the MAPLAG Referral process and felt able to make a referral

Additional support was made available as part of a collaborative effective information sharing and working together process, to support these vulnerable women and their families.

Initially the meetings were set on a 6 weekly basis, with a view to moving to a monthly basis if the need arose. Despite the challenges around the continuance of the process, in a virtual environment, due to Covid restrictions, the rate of referral has remained constant and manageable, with no indication at this time that monthly meetings are required.

Areas for Improvement

At the commencement of this process of MAPLAG meetings the referrals were slow to arrive and were late in the woman’s pregnancy, giving limited time to work with the families. However as professionals began to understand the new process referral numbers began to increase and were made earlier in the pregnancies. Whilst the referrals are continuing to be made, it is evident that following an in house discussion in one agency there was a flurry of referrals. This indicates that agencies need to refresh practitioner’s knowledge on a regular basis to encourage referrals.

**Presentation**

This audit will be presented to the members of the MAPLAG, Wakefield Safeguarding Effectiveness Group and the Trust Safeguarding Group. In addition it will be shared with the Midwifery Service via the Midwifery Team Leaders.

# Action Plan

|  |  |  |
| --- | --- | --- |
| **Task** | **Person Responsible** | **Date to be completed** |
| Continue to monitor referrals and case numbers(move to monthly meetings if indicated) | Angela South | Ongoing |
| Record all notified cases on database | Janet Swaine | Ongoing |

**Key Learning Points**

* The MAPLAG process is embedded into practice however the process must be shared/introduced to new staff via supervision and training to encourage its continued and further use.
* Agency attendance and contribution has continued to be phenomenal. The information sharing and collaborative working has enhanced the reduction of risk and enabled safeguarding of these vulnerable babies and their families.

**Risks Identified as a Result of the Audit**

* No risks have been identified as a result of this audit

**Document Control**

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Appendix 1

**MAPLAG Audit Proforma**

**Case Number**

**Booked –**

**Delivered –**

**Questions**

1. **Has a criteria topic been identified**
2. **Who made the referral**
3. **Was there additional support provided**
4. **Was there a referral to Children’s Social Care**
5. **Was the baby removed or home on a plan**