Cheshire East Local
Safeguarding Children Board

LSCB Neglect Partnership Audit

May 2018

Contents

Executive Summary

This audit was undertaken to assess the quality of our support to children and young people where the concern is Neglect in order to improve outcomes and practice in this area. Neglect was previously audited in May 2017.

Six cases were audited which covered a range of ages and levels of need. Each agency audited their own agency's involvement based on evidence in their case records against a common audit tool. They all made a judgement on the quality of partnership working. Agencies then discussed their findings and the audit process in a multi-agency meeting.

The audit findings are summarised below in terms of our strengths and areas for improvement.

What are we worried about?	What's going well?	What do we need to do?
• There was no evidence of GCP being used routinely to assess change. • Referrals to Adults Learning Difficulties Team were not required in any of the sample so it was not possible to consider if this area of work has improved. • There were examples of not all relevant agencies being invited to relevant meetings, informed of the concerns and of referrals being made that the receiving agency were not aware of i.e. Housing, early Help, North West Ambulance Service and a GP. • Voice of the child was not evident in all the cases, including a child with communication difficulties. • Parental engagement was not assessed. • There were opportunities to consider neglect but agencies "treated" the symptoms rather than using screening tools to look at the source of the concern. • An example of an agency considering that Step Down was too early but no evidence of this having been challenged. • When a mother declines the Family Nurse Partnership service there is not a notification process to alert other services.	• Neglect audit 59% of case neglect was recognised at the earlier opportunity. • Agencies considered that they were effectively working together. • The use of GCP and the Neglect Screening tool was more evident than in the previous audit with 38% of cases having one. • 67% of audits found that the assessment identified what was working well in the family. • 84% of audits the child's lived experience being reflected in the assessment. • 87% of the cases the work undertaken resulted in improved outcomes for the child i.e. school attendance, health and future secured. • Evidence of wide multiagency attendance at Strategy meetings. • Example of a referral of Neglect concerns from a member of the public. • Examples of agencies reflecting on their practice and acting to improve it i.e. Barnardo's and accessing relevant information. • SCIES have developed a pack to support communication with children with communication difficulties.	• Ensure that parental capacity and ability to sustain change are assessed at the outset. • Review the process of promoting the Family nurse Partnership and actions to take where it is declined. • Seek assurance that the work that Cheshire Local Authorities and CCGs have initiated with North West Ambulance Service to improve the referral process is completed. • Information sharing between child and adult services needs to be improved. • Continue to increase the use of the GCP as both an assessment and reviewing tool. • Seek assurance that the work to improve the referral of Adults to the Learning difficulties Team has had a positive impact. • Publicises the SCIES pack for communication with children with communication difficulties.

Context

The Local Safeguarding Children Board (LSCB) agreed that a multi-agency audit should be undertaken to assess the quality of our services to inform and drive improvements to our services to improve outcomes for our children and young people. This audit is the second neglect audit and seeks to explore whether the recommendations from the first audit have had an impact on practice and outcomes for children.

Audit Methodology

The audit tool has been further developed and strengthened by incorporating the Signs of Safety approach to practice. It has been adapted for specific use with Neglect cases (see appendix 1).

Six cases were selected randomly from those cases open to Children's Social Care in the last 6 months where Neglect was a concern.

Partner agencies were asked to check their records to see if the child/ young person or parents were known to them, and if so to complete the audit tool, exploring the quality of their work and its impact on the child/ young person. The Safeguarding Children in Education (SCIES) team liaised with schools and offered support in completing the tool. Auditors were asked to consider only the last six months of their agency's involvement.

A multi-agency meeting was held to explore the audit information and to identify what's going well? What are we worried about? And what do we need to do? Feedback on the audit process was also sought during this meeting and is detailed below.

Learning for Multi-Agency Audits

There were a number of points highlighted for learning from this process:

What are we worried about?	What's going well?	What do we need to do?
• There were only two GP audit submissions. However one child's GP was outside of the CCG area and it was difficult to identify one child initially due to differing child's basic details. • One school did not submit an audit and another school sent their audit in after the cut-off date (it was still considered). • Children's Social Care did not submit an audit for one case. • The audit meeting considered it a challenge to consider a case only over the previous 6 months if there is considerable history predating that. • The room used for the audit meeting had poor acoustics making hearing contributions difficult for all.	• Pen picture of cases provided in the meeting by different agencies. • It was the consensus of the audit meeting that the audit template is fit for purpose. • Signs of Safety approach welcomed.	• Raise the level and quality of contribution by GPs with the named GP. • LSCB Business Team to identify an agency, based on Audit submissions, to present a brief case study for each audit case and brief that agency. • Book a different room more conducive to discussion. • Focus of the audit should remain on the previous 6 months as the purpose is to audit current practice. • SCIES have been made aware of the non-submission by a school.

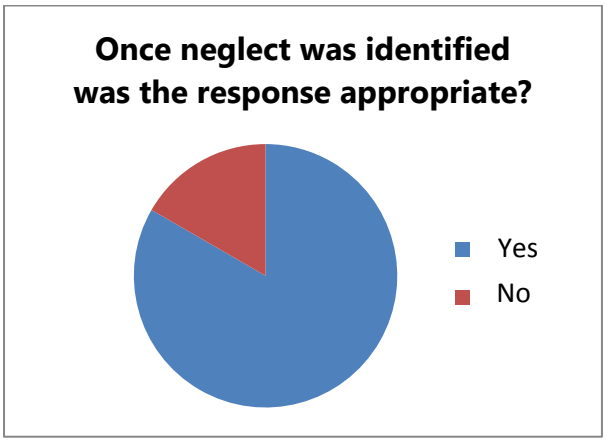
Findings from the Audits

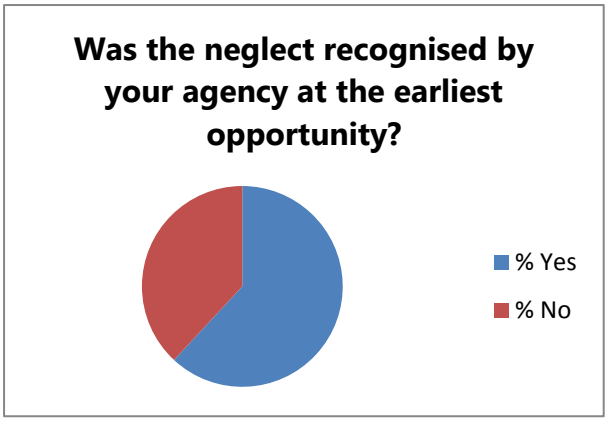
The Agency Audits identified that for the 59% of case neglect was recognised at the earliest opportunity.

In 38% of the audits the Graded Care Profile or Neglect Screening Tool was used.

67% of audits found that the assessment identified what was working well in the family.

The audits found that in 83% of cases once Neglect was identified then the response was appropriate.



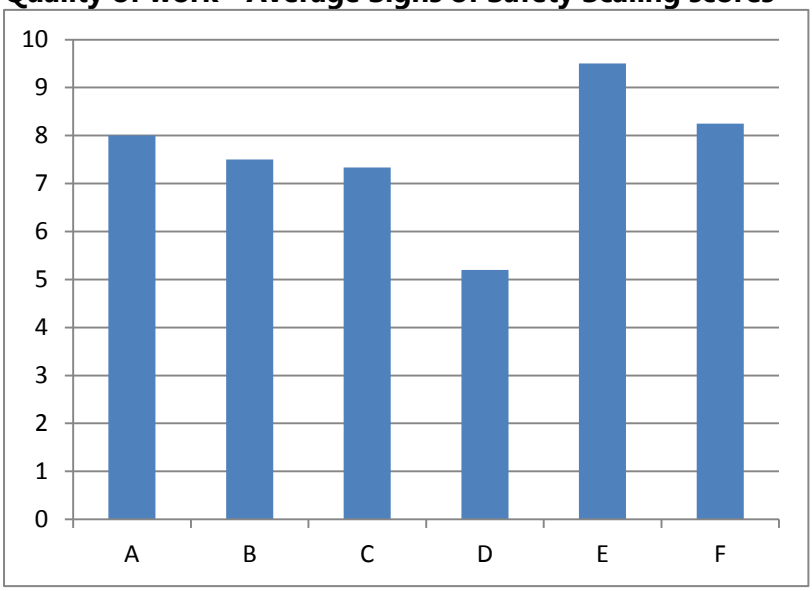


This response included in 84% of audits the child's lived experience being reflected in the assessment.

82% of audits found risks were clearly understood and 84% of times that the decision making was clear. 94% of audits also found that the planning process focused on making positive changes for the child.

Auditors considered that in 87% of the cases the work undertaken resulted in improved outcomes for the child.

Quality of work - Average Signs of Safety Scaling scores



Auditors were invited to apply a signs of safety scale of 0 to 10, where 10 means the quality of the work overall is outstanding and 0 means that the quality of the work overall is inadequate.

Each case was also considered against the Ofsted scaling and all were judged as Good.

Previous Neglect Audit

Neglect was previously audit in March 2017. The auditors for this audit in 2018 were asked to consider the 2017 areas for improvement when completing this audit

	March 2017 Audit	May 2018 Audit
Areas of improvement relating to the quality of practice within the wider system:		
1	CiN and CAF Meeting minutes, clarity is required regarding the following; Who records the minutes, distributes the minutes and receives the minutes.	The 2018 audit did not identify this as an issue.
2	Communication between agencies of the organising of CiN meetings sometimes lacked consistency.	The audit meeting considered that in the sample cases that communications between partners was effective.
3	Child Services and Adults Social Care requirement for a joined up approach.	In two of the cases, concerns were still raised that there needed to be a more joined up approach between children's and adult services both in the local authority and within the health service.
4	Referrals into the Learning Disability team.	The 2017 audit highlighted this as significant for a number of parents. The 2018 sample did not contain cases where this service was required by the parents. The Board should seek assurance that this issue has been addressed and that the changes are having a positive impact.
5	Provide schools and DSL's with a One Minute Guide (OMG) on how to escalate concerns for children who are CiN or CP with agencies inc. CSC.	None of the audits submitted identified a situation that required escalation. However during the meeting a case was identified where there was a difference of opinion on step down, but there was no evidence to indicate that differences of opinion had been debated within the case meetings.
Areas for improvement specific to work around Neglect:		
6	Quality of home conditions. Graded Care Profile Tool.	The audit evidenced an increase in the use of both the Graded Care Profile and the Neglect Screening tool with them being used in 38% of cases.
7	Police Recording.	This use of a "flag" on the police system was explored by the police; however the structure of their database does not allow this to be done. This situation was presented to the LSCB Executive and accepted.

Recommendations

Finding	Action	Lead	Date for completion	Outcome
Missed opportunities in joined up working between adults and children's services across different agencies including social care and health.	Improved communication between adult and children's services who share the same recording system.			
That some agencies find it difficult to evidence the voice of the child of those children who cannot communicate themselves due to learning difficulties.	SCiES team to promote their pack to health and social care.	SCiES		
Joint working with Disability services was raised in both 2017 and 2018 Neglect audits.	The Board should seek assurance that this issue has been addressed and that the changes are having a positive impact.			
Agencies not always looking at the source of a child's difficulties and managing this 'in house' by providing care/resources.	Reinforcement of training in relation to safeguarding and looking at the wider picture of the child.			
GP audits – lack of information being provided by GP's to the audit process.	GP's to become more involved in the audit process.			
North West Ambulance Service Referrals are not felt to include enough information and have not always been shared with the appropriate service.	LAS, CCGs and LSCBs to continue to address this issue.			
GCP and the Neglect screening tool was more evident in this audit, however they were not utilised in all cases and the GCP was not routinely used to review progress.	Improve the use of GCP2 to evidence the scale of neglect.			
The impact of parental capacity to sustain change was identified in a number of cases but not routinely assessed.	Integrate this in to initial assessments to inform intervention planning.			

Appendix A: Pen Pictures of the Children and Summaries

Case A

9 year old child, with Learning Difficulties/Communication Difficulties. The school referred the case into the Integrated Front Door with concerns over the child's appearance; health also raised concerns about the child not accessing medical treatment. At the time of the audit on a Child Protection Plan.

Judgement on the Quality of the Work: **Good**

What are we worried about?	What's going well?	What do we need to do?
• Family moved from a different area – this has meant that there is a lack of history. • Further investigation shows that father is a sex offender in a different local authority and the risk was not known to this local authority. • Child has communication difficulties due to his special educational needs – school had become used to 'making allowances for the family' and 'managing symptoms' rather than looking at the source of the concerns. • Mother appears to have learning difficulties but does not meet the criteria for diagnoses. Worker did not cross reference with child's records despite them being on the same system. • Parental capacity to parent effectively. • GP submitted a report – however this was illegible.	• School liaised with health and they made a referral to integrated front door. • Referral was completed in a timely manner with a C&F assessment being undertaken within 24 hours. • A strategy discussion was attended by all professionals. • Evidence of agencies working together to share information has identified what life is like for the child. • School completed a neglect screening tool. • School have reflected on their actions in this case and have changed their practice as a result. • The assessment gives an account of what life was like for the child.	• Specialist and adult services need to be aware of the bigger picture of the family when working with adults and children. • Consider how to communicate with and access help for children with disabilities/communication needs. SCiES have a pack they have created in order to support this. This information should be publicised with Health and Social Care – The pack is on the SCiES website. • Joined up working between agencies and the disabilities team is needed. • Continued assessment of parental capacity.

Case B

16 year old young person. Living with mother and 6 siblings, long history of involvement with Children's Social Care with lack of sustainment, by the mother, despite provision of support packages. At the time of the audit on a Child Protection Plan.

Judgement on the Quality of the Work: **Good**

What are we worried about?	What's going well?	What do we need to do?
• Long history of involvement with agencies at different levels of support being given. • Overcrowding in the family home appears to be an issue –	• This case was appropriately escalated to Child Protection in a timely manner. • Graded Care Profile has been used and has identified areas	• Continue to support in order that ability to change by the mother is sustained. • Close monitoring of the case due to the history that pre-

housing not involved in the CP plan. • Concerns over mother's ability to sustain change despite prolonged involvement – this has led to chronic neglect. • Mother does not buy in to support and has not attended meetings or been available at home visits. • Concerns that this young person will become a Young Carer for her younger siblings. • Early Help services feel that this case is too early to 'step down'. • Mother has strong bond with young person and siblings – this is a concern in that sometimes agencies feel that the children are protecting their mother from services. • Voice of the child not clear in records.	of work. • FACT 22 and Social Care offering support. • Good collaboration between agencies is evidenced. • School have a good relationship with the young person, offering 1:1 support and the school nurse being involved. • Evidence that the young person has started to make changes in a positive way – especially from school. • School nurse is planned to liaise with the higher education provider. • Young Person has strong bond with mother and siblings.	precedes this audit. This knowledge to be used to support decision making about sustainability and not allow the neglect to continue. • School nurse to share information and liaise with higher education provider in order for this young person to sustain changes. • Question – were concerns put forward by all agencies, when the decision was made in CP conference to Step Down from CP plan to CIN?

Case C

2 year old child. Case referred to Children's Social Care via the Fire Service. Previously a member of the public working in a charity shop, who was concerned over the poor presentation of the child had referred in with similar concerns of neglect and child was at Child in Need. At the time of the audit on a Child Protection Plan.

Judgement on the Quality of the Work: **Good**

What are we worried about?	What's going well?	What do we need to do?
• Lack of clarity about who made the referral – some agencies felt charity shop worker and LL evidences this referral came from the fire service after having been referred in by anonymous referral previously. • Midwifery identified concerns early on with interactions with the family. • Lack of engagement by the mother has led her to refuse services such as Family Nurse Partnership. • Early Help not included in the support. • Neglect screening tools have not been used.	• General Public have identified that the child looks neglected and have been able to ring the case through and voicing these concerns (albeit anonymously) – this could indicate positive impact of Neglect Campaign in Cheshire East in 2017/2018. • Health records identified a change in the child's demeanour/presentation by evidencing the voice of the child – this led to support. • Joint visit by the police and social care to the family home.	• Historical information indicates mother refused Family Nurse Partnership support but was not considered for a referral for Early Help. Better communication needed to ensure that this help is offered and raised. • Consideration to be given on how to promote Family Nurse Partnership to young mothers. • Support from Family Nurse Partnership can only be given for a 2nd child if the mother accepted previous support – consideration to be given to what support can be offered. • Neglect identified early on

		without use of Neglect Specific Screening Tools - should these be used?

Case D

12 year old child. Referred to Children's Social Care by the paediatrician due to Toxic Trio being identified within the family and the impact of this on the child. At the time of the audit on a CIN plan.

Judgement on the Quality of the Work: **Good**

What are we worried about?	What's going well?	What do we need to do?
• North West Ambulance Service made a referral that went to Adults Social Care – not enough information on this referral. • North West Ambulance Service referral did not go to health services. • Difficulty due to both parents presenting as victim and perpetrators of domestic abuse. • Cheshire East Domestic Abuse Hub referred to Barnardo's but this was for the mother and the children were not referred as they were not on their system. Barnardo's have limited system information. • GP sent in a report and there were only historical concerns – they have advised that they are not aware that the child is on a CIN plan. • Toxic Trio is identified in this case as being a significant factor – especially the alcohol issue. • School have not sent in a report on this case. • Children's Social Care have advised that parent has been referred to Webster Stratton – Early Help have no notification of this.	• Concerns identified early on. • Assessment tools used for Neglect identification (Graded Care Profile). • Joint working between Early Help and Childrens Social Care – this supported by joint assessment visit. • Robust CIN plan is in place in order to support. • Positive impact of support has evidenced changes being made for the welfare of the child. • Direct work is being undertaken with the child and the child is aware of why support is being given. • Toxic Trio Identified. • As a result of this case Barnardo's have reflected on their support and now have put in measures to ensure that they have access to appropriate information in a timely manner.	• Integrated Front Door are currently looking at North West Ambulance Service referrals, trying to get these improved – ongoing. • Consideration to be given about IT systems meaning that Child and Adult Social Care systems are not always joined up. • More liaison is needed between Adult Social Care and Childrens Social Care. • More dissemination of information to GP's is needed. • Clarification needs to be given as Early Help are not aware of a Webster Stratton referral being made or if 1:1 parenting work is needed.

Case E

5 month old child. Referred into Children's Social Care by midwifery service as they were aware of the history of the mother. Evidence of Toxic Trio within the mother's life still being present. At the time of the audit the child was a Looked After Child.

Judgement on the Quality of the Work: **Good**

What are we worried about?	What's going well?	What do we need to do?
• There appears to be more information in health records than has been shared. • Toxic Trio still being evident in the mother's life.	• Early referral by midwifery service due them having a good knowledge of the history of the mother. • Early Strategy meeting held • Due to the early referral – the child is now legally secure with foster parents in a safe place and having their needs met. • Excellent communications between services and the mother with information being shared at all times – future expectations of the mother have been made clear. • Child is still having contact with the mother.	• Although Neglect was identified at an early stage – the Graded Care Profile was not used as it was felt it was not needed – consideration to using the tool to evidence Neglect?

Case F

6 year old child. Originally referred to Children's Social Care by police via a Vulnerable Person's Assessment to the Integrated Front Door. Following a Domestic Incident in the home, further questions were raised about the care of the child. Child also not accessing health care. At the time of the audit under a CIN plan.

Judgement on the Quality of the Work: **Good**

What are we worried about?	What's going well?	What do we need to do?
• No audit received from Children's Social Care. • Child originally referred in Jan 2017 and movement between levels of need and involvement have made this case difficult to follow on Liquid Logic. • Mother has since had another baby with another partner who is due to be adopted – concerns about the impact of this on the siblings. • Concerns over child now living with step-mother and father, in that step-mother is only very young (21) and her ability to parent effectively.	• Neglect Tool and Graded Care Profile used. • Police referred to Integrated front door after concern with mother's partner being identified – strategy meeting held. • In-depth parenting sessions have been provided. • Child's voice is evident • Housing have been included in moving forwards in this case – home environment is improved. • Learning mentor in school is provided and is offering support 1:1. Child is happy in school and making progress. • Good communication between father and services. • Child's general health has improved. • Good communication between agencies. • Signs of Safety has been used to good effect.	• 8 sessions of support work is recommended re: father and step mother's parental capacity. • Support to continue to ensure child is happy and needs are being met.

Appendix B: Neglect Audit May 2017

Areas of improvement relating to the quality of practice within the wider system:
CiN and CAF Meeting minutes, clarity is required regarding the following;, • Who records the minutes • Who distributes the minutes • And who receives the minutes.
Communication between agencies of the organising of CiN meetings sometimes lacked consistency. The majority of agencies felt that sometimes attendance to meetings would be improved if communication was improved.
Child Services and Adults Social Care requirement for a joined up approach. All agencies felt that although both children and adult services may be offering the correct support there was still a requirement for better links and coordination between the services.
Referrals into the Learning Disability team. Referrals were made to the Learning Disability team for parent's cognitive assessments to take place; however the assessments never took place. A clear pathway for this type of assessment is required covering the referral process, service thresholds and which agency is commissioned to undertake the assessments.
Provide schools and DSL's with a One Minute Guide (OMG) on how to escalate concerns for children who are CiN or CP with agencies inc CSC. Education disagreed with actions in a number of the cases, they didn't consider a plan to be SMART enough, their views were fully taken into account or they considered that a parent couldn't follow the guidance they were being given. However, these were not addressed at the time and it may be due to not understanding how to do this.
Areas for improvement specific to work around Neglect:
Quality of home conditions. The majority of agencies agreed that there were inconsistencies in defining if the home conditions were of the right standard. This is an opinion based process and different professionals have different opinions on what good home conditions look like.
Graded Care Profile Tool. The graded care profile tool was used in 2 of the five cases audited, and all the agencies agreed that when it was used it was a helpful tool.
Police Recording. Police involvement was documented and it was agreed that the correct actions were taken however neglect was not identified on their system even though detailed recording indicated neglect.

Appendix C: Audit Guidance and Tool

Multi-agency Audit on Neglect

Guidance Notes:

1. The audit should review **how the work considered the child**. This also applies to those services whose core work is with adults.

2. Please do not include identifiable data in the report – **please use initials instead of names** for the child/ young person. Please make it clear what the relationships between people are – for example please use 'dad', 'step brother', 'Health Visitor' instead of PK. **Please give the unique ID at the beginning of the form for the child/ young person – this is given on the case list.**

3. You should complete a **separate audit form for each child** in the audit and this should be from **your agency perspective** and from the details held in your agency's records.

4. You should look back at the **last 6 months of your agency involvement.** For example, if you have had no involvement for the last 3 months, please consider the involvement starting 9 months ago.

5. **Please give detail against each point**. We will have a multi-agency meeting following the audit to agree a judgement on the quality of our work as a partnership for each case, so we need to understand what informed your judgement on your agency's work. **In line with Cheshire East's implementation of Signs of Safety model**, please complete the appropriate boxes throughout the form - 'what **is working well?' and 'what are we worried about?' and 'what needs to happen? (For example can be any actions that you have identified)'.**

6. **If you have answered 'not applicable' please explain why.**

7. The audit asks you to make an **overall judgement** about the quality of the work of your agency for each section – please use the Ofsted grading criteria below:
   - **Outstanding** – practice that is significantly above the standards for their own and multi-agency working
   - **Good** – practice that consistently meets the standards for their own and multi-agency working
   - **Requires improvement** – practice that is inconsistent in meeting the standards for their own and multi-agency working
   - **Inadequate** – practice that fails to meet the standards for their own and multi-agency working

We would like to **recognise and celebrate good practice** and what is working well; there is a space for this to be identified at the end of the form, this includes any work from your own or another agency.

Thank you for taking part in this audit. Please return the completed **anonymised** forms to LSCBeast@cheshireeast.gov.uk. Please note this email address is not secure to external agencies, if you need to send us any confidential information please contact us at LSCB@cheshireeast.gcsx.gov.uk

Case no (UIN)	
Agency completing the audit:	
Audit completed by: (name and title)	

Quality of the Recognition:

No.	Question	Response (Yes/No)	Comments on Quality of Work		
			What went well?	What are we worried about?	What needs to happen? (Any actions)
R1	Was the neglect recognised by your agency at the earliest opportunity? (If yes, how was this recognised?)				
R2	Were any practice tools used? E.G. 'Graded Care Profile' or 'Neglect Screening Tool' (If so, whom by and what was the outcome identified for the child at this stage?)				

Judgement on the Quality of Recognition:

Judgement	Comment on this judgement		
	What went well?	What are we worried about?	What needs to happen? (Any actions)
Please delete to leave one judgement: Outstanding Good Requires Improvement Inadequate			

Quality of the Assessment:

No.	Question	Response (Yes/No)	Comments on Quality of Work		
			What went well?	What are we worried about?	What needs to happen? (Any actions)
A1	Once neglect was identified was the response appropriate? (What was the response? Was history used to inform the assessment?)				
A2	Was the impact of the child's lived experience reflected in the assessment?				
A3	Did the assessment identify what was working well in the family? (strengths and resilience)				
A4	Was information appropriately shared?				
A5	Was decision making clear?				
A6	Were the risks clearly understood?				
A7	Were the children consulted/ involved in the assessment and were their views and wishes clear?				

Judgement on the Quality of the Assessment:

Judgement	Comments on this Judgement		
	What went well?	What are we worried about?	What needs to happen? (Any actions)
Please delete to leave one judgement: Outstanding Good Requires Improvement Inadequate			

Quality of the Planning and Intervention:

No.	Question	Response (Yes/No)	Comments on Quality of Work		
			What went well?	What are we worried about?	What needs to happen? (Any actions)
P1	Did planning focus on making positive change for the child?				
P2	Was the child consulted/involved in the plan? Are the child's views and wishes clear and was the plan explicit about what would be better in terms of outcomes for the child by the actions agreed?				
P3	How was planning measured to ensure making positive changes for the child? Identify use of specific tool and evidence of voice of the child and changes to lived experience.				
P4	Were there clear and appropriate timescales for achieving the changes and were contingency plans set out in the plan?				

Judgement on the Quality of the Planning and Intervention:

Judgement	Comments on this Judgement		
	What went well?	What are we worried about?	What needs to happen? (Any actions)
Please delete to leave one judgement: Outstanding Good			

Requires Improvement Inadequate			

Quality of Co-operation:

No.	Question	Response (Yes/No)	Comments on Quality of Work		
			What went well?	What are we worried about?	What needs to happen? (Any actions)
C1	Was multi-agency working effective?				
C2	Was there evidence that the family were meaningfully involved?				
C3	Were the family clear about what the concerns were, what needed to happen next and how support would be given?				
C4	Were the family's needs taken into consideration alongside agencies expectations, in that agencies focussed on key priorities in order that the family were not overwhelmed with expectations?				

Judgement on the Co-operation: *Please consider the evidence of management oversight, challenge support and direction at referral, assessment and throughout the plan*

Judgement	Comments on this Judgement		
	What went well?	What are we worried about?	What needs to happen? (Any actions)
Please delete to leave one judgement: Outstanding Good			

Requires Improvement Inadequate			

Impact:

No.	Question	Response (Yes/No)	Comments on Quality of Work		
			What went well?	What are we worried about?	What needs to happen? (Any actions)
I1	Did the work result in improved outcomes for the child?				
I2	Where there elements of good practice?				
I3	Where there any learning points?				

Judgement on the Quality of the Impact:

Judgement	Comments on this Judgement		
	What went well?	What are we worried about?	What needs to happen? (Any actions)
Please delete to leave one judgement: Outstanding Good Requires Improvement Inadequate			

Judgement on the Quality of the Work Overall for your Agency:

Judgement	Comments on Quality of Work		
	What went well?	What are we worried about?	What needs to happen? (Any actions)

Please delete to leave one judgement: Outstanding Good Requires Improvement Inadequate			

On a scale of 0 to 10, where 10 means that the judgement on the quality of the work overall is outstanding and 0 means that the judgement of the quality of the work overall is inadequate, where would you rate the quality of the casework?

0 10

Please comment on your reasoning for this scoring:

Any areas of good practice identified – What worked well? (This could be in your own or another agency):

Any other comments: