



# MULTI AGENCY CHILDREN'S SAFEGUARDING AUDIT PACK

## GUIDANCE ON USING THE AUDIT TOOLS



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### 1. WHEN CAN THE AUDIT TOOLS BE USED?

Each of the audit tools is designed to be used by any of the partner agencies involved in individual work with the child or family on a single agency basis to audit a selection of case records in a specific category of work (Child Protection, Child In Need, Early Intervention and Children In Care). The tools can be used for self-audit or peer review. However, the intention is primarily for the tools to be used for audits conducted on a multi-agency basis by all agencies working with children in a local area.

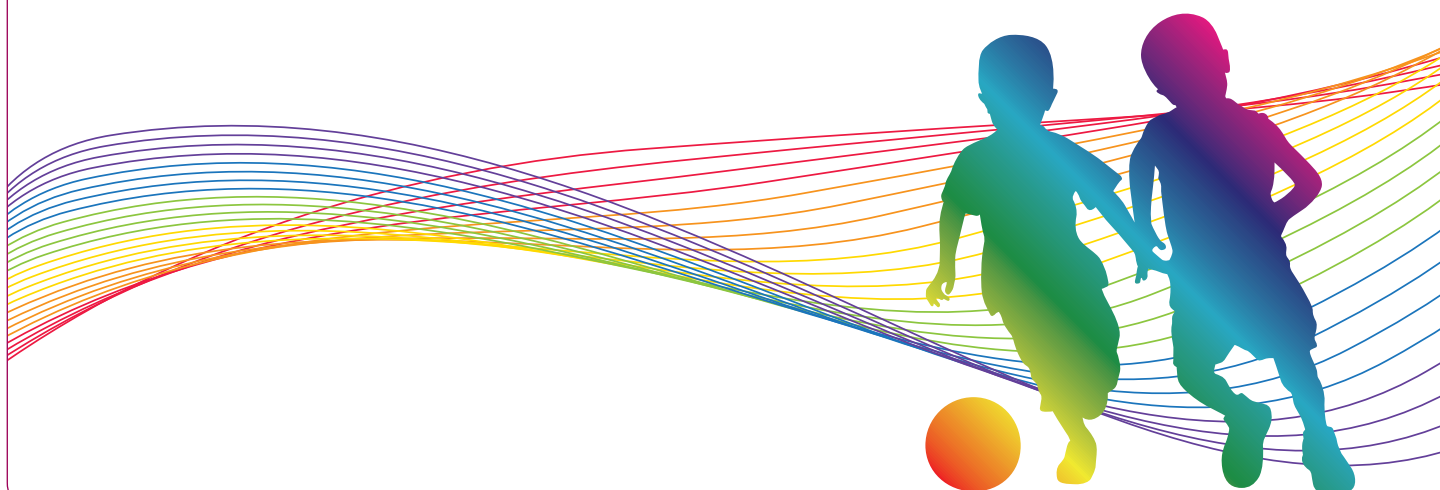
**Depending upon the features of the case, such agencies will include:**

- Children's social care.
- Health practitioners (general and specialist).
- Child and Adolescent Mental Health Services.
- School and other education professionals such as education welfare.
- Police – Child Abuse Investigation Teams and others.
- Children's Centres and other early years providers or commissioners.
- Voluntary sector providers working with the child or family.
- Adult services partners including mental health services, drug and alcohol services, learning disability services.

Once the cases have been selected, the agencies and practitioners actually involved in working with each individual child or family as a 'team around a child', core group or other network can be identified and audits carried out accordingly.

The audit tools have been designed to provide both a quantitative and a qualitative analysis. Each area of work, such as Assessment, will be graded separately by the auditor. This will allow comparative, evidenced judgements to be made between the various agencies working together on a particular case. In addition, it will enable the overview report writer to identify which areas of work are working well and which need attention, on both a single and a multi-agency basis.

Audits of records of casework can be effectively supplemented by obtaining the views of the children concerned in the cases and their families. A participation worker could speak to each of the children involved in the audit about the service they feel they have received and the impact it has had on their lives. Their views should be fed into the meeting where the completed file audits are being discussed. As well as offering a different and more vibrant perspective to the audits of casework which can influence the lessons to be learned; hearing directly from the children concerned will reflect Ofsted inspection methods in the full inspections of safeguarding and looked after children.



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### 2. TERMS OF REFERENCE AND CASE SELECTION

The priorities and general programme for the types of cases to be audited will be identified by the Local Safeguarding Children Board (LSCB). The running of an audit will generally be the responsibility of the sub-group of the LSCB charged with a quality assurance or monitoring and evaluation role.

There should be clear terms of reference for each audit, which contains the purpose of the audit. The terms of reference should include an outcomes focus, which will reflect Ofsted methodology in forthcoming inspections. The brief may be wide, for example to establish a baseline assessment of performance in a particular category of case; or more narrowly focussed, for example, to assess the effectiveness of core group working in child protection cases. Clarity about the purpose of the audit will assist in identifying how to select cases for audit. In conducting audits of children in need, it may be helpful to identify cases according to a particular area of concern, e.g. children at risk of exclusion from school; or by level of need, e.g. S.17\* cases which are allocated to a social worker.

#### HOW TO IDENTIFY SCOPE OF AUDIT?

##### PRACTICE EXAMPLE:

###### Identification of concerns and issues:

- Recent SCR in full first identified poor planning at pre-birth assessment stage and poor information-sharing between midwife and health visitor.
- Other known examples of poor communication between adult mental health services and children's social care.
- Need to assess effectiveness of family support on safeguarding children as this has not been properly evaluated.

###### Decision about scope of audit:

- Audit of children aged under two who are currently subject to a child protection plan or who have been subject to a CP plan within the past year.

###### Rationale:

This will include children in the following categories:

- Pre-birth assessment stage.
- Under two year olds currently being supported and monitored through a child protection plan.
- Under two year olds whose protection plan has ceased due to care proceedings.
- Under two year olds whose protection plan has ceased due to improvements in family functioning.

###### Such an audit can potentially test the following aspects of working (which can be narrowed down if preferred):

- The timeliness and effectiveness of planning and decision-making within pre-birth assessments.
- The focus on risk and whether this is driving planning and decision-making.
- Effectiveness of planning for permanence for young children.
- Effectiveness of working together between children's services and services for adults, such as mental health, learning disability, drug and alcohol services.
- Effectiveness of information-sharing and core group working.
- Effectiveness of support services provided for children of this age and parents, including their contribution to the assessment of risk and whether support services may be artificially propping up a family.

Having identified the scope of the audit, terms of reference can be drawn up which incorporate the above objectives and which should emphasise the need to judge the impact agencies are having on improving outcomes for children aged under two.

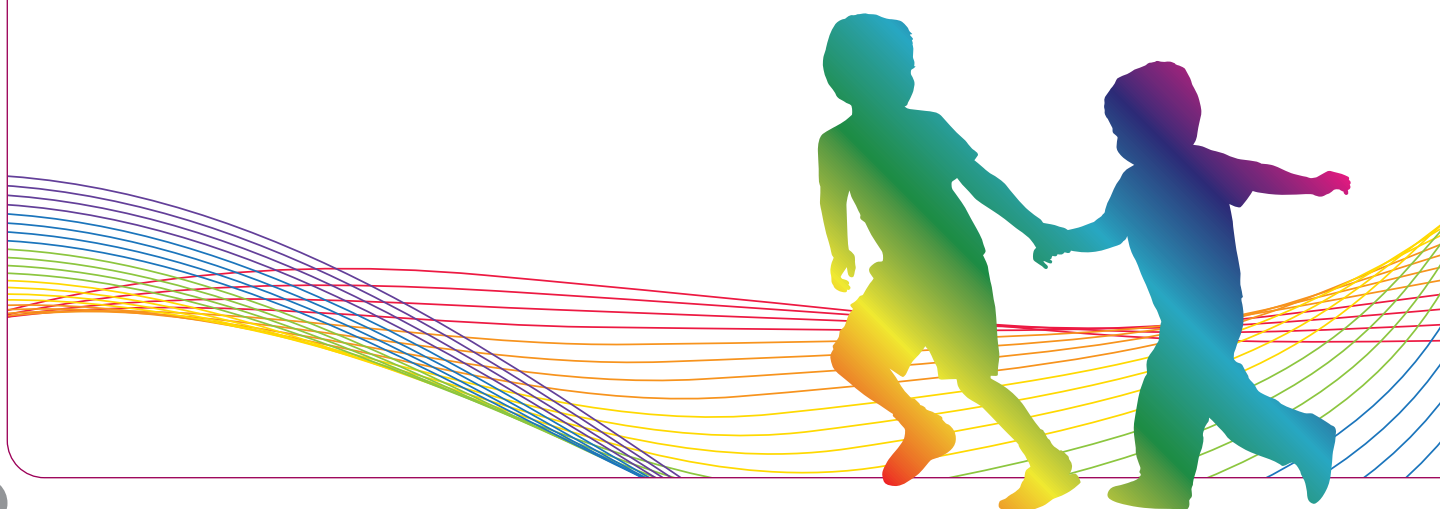
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### 2. TERMS OF REFERENCE AND CASE SELECTION cont'd

Conducting an audit for a baseline assessment lays a useful foundation for further, more specific audits which can drill down into identified areas of concern. Audits of this baseline type should not include too many cases. Experience from inspections and other quality assurance activity has demonstrated that audits of a small number of cases will successfully identify questions to be asked and themes to be pursued. A multi-agency audit of say ten child protection cases will be sufficient to establish such a baseline. Similarly, it is helpful if the case work time frame is limited so that the auditors look at the most recent year or 18 months of case work. Conducting full audits across a range of agencies will already be a time-intensive activity, and it is not necessary to increase the numbers on baseline audits and therefore add to the time taken. Further audits of more specific areas (e.g. staying with the example of core group effectiveness) will not involve completion of the audit tool in full, so a wider sample of cases can be audited within the same time allocation.

Cases should be selected to cover the range of work in a particular category of case. For example, a child protection sample for a baseline assessment should include different categories of abuse or neglect and a mix of gender and age groups. Different ethnicities should be represented in proportion to their representation in the area or in accordance with proportions of children subject to a child protection plan. Another factor may be to select across the range of social work teams, health visitor bases or different schools involved with the cases selected. Of course, it is not an exact science, especially when selecting only ten cases. For a baseline assessment, it is important that the cases identified have not been pre-judged by the selector as representing either good or poor performance. It may be helpful for the cases to be selected by a neutral and knowledgeable person, such as a lead administrator for child protection. The cases selected should represent a random, stratified sample.

Management information can provide helpful guidance on case selection. For example, if planning an audit of children in care who experience more than three placements in one year, management information may indicate where placements are least stable, by age group, types of placement, distance of placement etc. so that the audit can focus on the most concerning areas. It will also show total numbers of children affected, which will assist in decisions about selecting a percentage of the total for audit.



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### 3. COORDINATION OF THE AUDIT

Consideration should be given to the need for some external overview of the audit, in order to bring objective challenge to the process and to ensure that it is focused on good learning outcomes for every single agency participating in the audits. It should also promote effective partnership working and good outcomes for children and their families. Alternatively, if an internal coordinator is selected, that person should be recognised as someone with a multi-agency overview, for example, the chair of the LSCB Quality sub-group.

#### The role of the coordinator is:

- To chair an initial meeting of the auditor group, ensuring that each auditor/agency understands the terms of reference of the audit; how to use the audit tool and the timescales for completion of the audits.
- Following the completion of the audits, the coordinator should review each of the audits from different agencies relating to each of the cases audited in order to identify inconsistencies, gaps or questions to be asked about any of the individual audits and to begin to identify emerging themes from the audits as a whole.
- The coordinator should then chair a follow-up meeting with the auditors to clarify any inconsistencies and to draw out the emerging themes and debate them. This meeting is an important part of the learning process, as auditors exchange issues and learning points as a group; begin to take ownership of the emerging issues; develop ideas about more effective ways of working and start to take the emerging issues back to their own agencies. Debate about some of the inconsistencies across different agency audits may result in a change in the overall gradings, as a fuller picture of the case emerges.
- The coordinator should also use the meeting to gain feedback about what worked well and not so well in conducting the audit, in order to make any amendments for further audits.
- Individual audits should then be passed to the practitioner concerned and their manager so that they receive detailed feedback about their work (clearly, if any safeguarding concerns were identified, this should have been taken up with the manager immediately).
- The coordinator should complete an overview report. The purpose of the overview report is to:
  - Highlight in a quantifiable way which aspects of practice and management are working well and which are causing concern, through analysis of the grades given at the end of each section within the audit.
  - Evidence the key issues with examples which provide a qualitative analysis of the issues which led to the grades.
  - Identify learning from good practice, not only from concerns. Learning lessons from good practice may be more effective than learning lessons from concerns.
  - Draw together themes and make recommendations.
  - Provide overall judgements on the quality of the work.
- The overview report is then presented to the LSCB or similar steering group to enable the LSCB to have a clear picture of performance in front-line practice.
- The LSCB quality sub-group will have the responsibility for devising an action plan with Specific Measurable Agreed Realistic Timely (SMART) objectives, and overseeing its implementation.

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### 4. AUDITOR ROLE

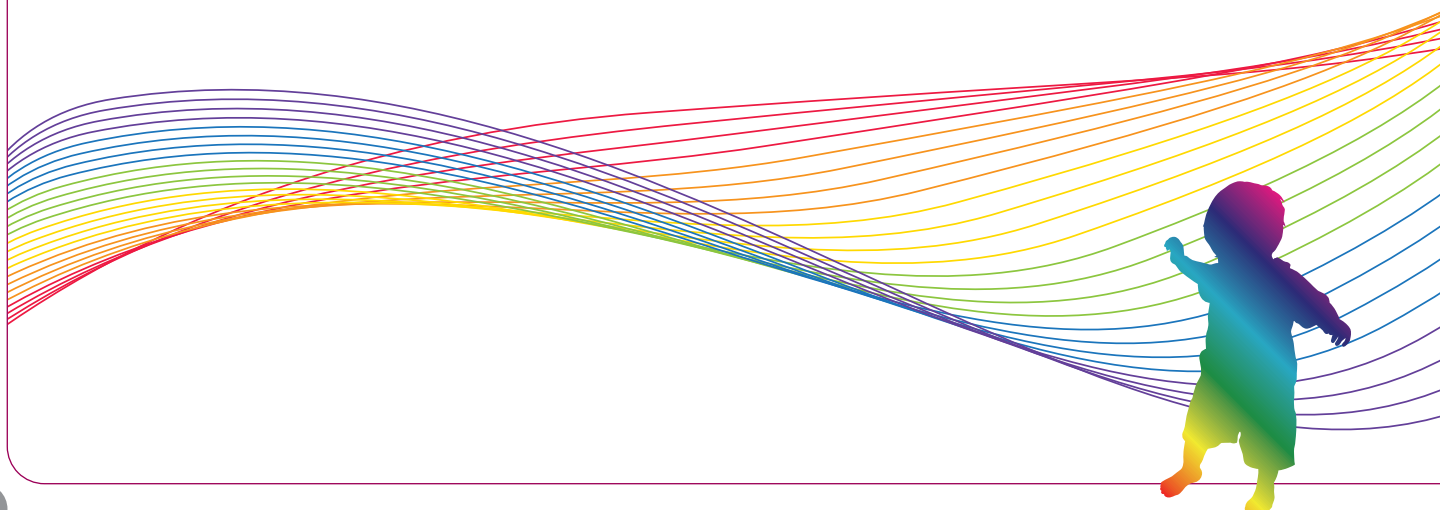
Representatives on the LSCB quality sub-group should be in a position to lead on the audit activity within their own agency. Membership of the sub-group may need to be reviewed to enable this to happen. When the audit is to be carried out, it will be helpful for there to be at least two auditors from each agency so that consistency of judgement and inclusion of key areas of work can be discussed and agreed. Auditors will develop confidence and improve their skill base as they continue to carry out further audits. It will however be important on each audit to have a mix of auditors, some with considerable experience and others new to the role. It is both a good development opportunity for front-line supervisory staff to be involved in audits and also enables learning and awareness of wider themes to directly and immediately be taken back into teams and have a positive impact on front-line practice. Auditors across agencies will learn from each other and will themselves need to develop into an effective multi-agency group. New auditors can be added to the audit teams on a rolling basis.

Auditors who are to take part in the multi-agency audits should generally have experience of auditing case records through their own line management role. However, when taking part in the multi-agency audit, they should audit cases within their own agency but where they do not have line management responsibility or other involvement with the case. This will enable a combination of objective challenges and a good knowledge of key responsibilities and standards required from the agency concerned. It may be difficult for school staff to fulfil these requirements and consideration should be given to a related professional, e.g. education welfare, conducting an audit of school records about a child. The lead auditor from the LSCB sub-group should ensure that all auditors from their own agency understand the key principles of the audit, including a focus on outcomes and how to use the audit tools. The first meeting chaired by the coordinator will check the auditors' understanding of the terms of reference of the audit and the use of the audit tools.

Either all auditors or the lead auditor from each agency should take part in the follow-up meeting chaired by the coordinator, in order to clarify issues and identify learning points, as described above.

### 5. FEEDBACK AND DISSEMINATION OF LESSONS

Practice will be improved through the auditor giving immediate feedback from the audit, by sending a copy of the audit to the practitioner and their manager, rather than awaiting the overview report for lessons to be disseminated. It will be vital for the auditor to raise concerns immediately with the practitioner concerned and their manager if the child is not being adequately safeguarded through the work undertaken. It is also important for practitioners to receive feedback through audit, to gain some validation about the course of work they are pursuing or to receive praise and to respond to constructive criticism about the work on the individual case while they are currently undertaking the work and not in retrospect. This immediate feedback makes the audit live and meaningful on an individual case basis as well as through identifying wider themes.



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Feedback about areas of practice which have been highlighted through the audit, whether these involve partnership working or are applicable to the role of a single agency can also be given to groups of workers through team meetings and other informal groupings, as part of a continuous learning and development process. It will also be important to hold more in-depth discussions with specialist workers who may particularly need to understand the implications of audit findings, such as child protection conference chairs or independent reviewing officers.

Careful consideration needs to be given to recommendations and action plans arising from the recommendations, to ensure that the learning is embedded and changes can be made. Experience from Serious Case Reviews unfortunately demonstrates that the same issues arise many times, so an effective monitoring of the action plan and an evaluation of the difference made is crucial. Recommendations will be on different levels, individual agencies will no doubt wish to take action on failings within their own agency practice. Recommendations within the overview report should be few in number and are likely to be about major areas of concern or partnership working. Recommendations about learning from good practice should be included. If the audit sample is small, further investigation may need to take place to test the validity of a particular concern before recommending a specific course of action.

The outcomes of the audit, including issues arising from the overview report and the action plan should also be disseminated to all front-line staff. This will create ownership and understanding of any changes to policy and practice arising from the action plan.

### 6. CONTINUING THE LEARNING IMPROVEMENT CYCLE

The LSCB will have overall responsibility for identifying priority areas for audit and for receiving the overview report and ensuring action is taken on the lessons learned. However, the quality sub-group of the LSCB will have primary responsibility for identifying the issues and the lessons to be learned and implement and oversee the action plan arising from the audit. There will therefore be a continuous cycle of planning a new audit, while assessing the impact of the implementation of the action plan and using the new audit to identify whether required improvements have been made. Audit work will take its place as part of a continuous programme of quality improvement across agencies.

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- \* S17 – Section 17 of the Children Act 1989 places a duty on Local Authorities to provide a range of services in order to:
- Safeguard and promote the welfare of children within their area who are in need and
  - So far as is consistent with that duty, to promote the upbringing of such children by their families by providing a range and level of services appropriate to those children's needs



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