

Safeguarding through audit

A guide to auditing case review recommendations



Welcome



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01 Introduction

How to use this pack

Introduction

The purpose of this pack is to help local safeguarding children boards (LSCBs) to audit the recommendations of serious case reviews (SCRs).

It is an updated version of a pack that was first published by the NSPCC in 2004. At that point LSCBs were not in existence and both Sinclair and Bullock (2002) and the first joint chief inspectors' report (2002) commented on the lack of follow-up activity by area child protection committees (ACPCs) once SCRs were completed.

A more recent biennial review of SCRs (Rose and Barnes, 2008) found that some LSCBs had audited SCR recommendations, either developing their own mechanisms for doing this or using version one of this pack. There is an explicit requirement on LSCBs to do this in Working Together to Safeguard Children (2006):

“Reviews are of little value unless lessons are learned from them (and) the LSCB should put in place a means of auditing action against recommendations and intended outcomes.”

Using this pack is one means by which LSCBs can meet this stipulation and ensure that the significant resources invested in SCRs lead to improvements in the ways organisations tackle safeguarding.

For some LSCBs the requirement to audit recommendations may be a daunting one. It is potentially a huge task and the guidance does not suggest how it might be approached. Of course, many LSCBs are undertaking auditing to, for example, ensure compliance with section 11 of the Children Act 2004 (HM Government, 2007), but for those that are not this pack provides a suggested framework for beginning the task. We hope that some of the ideas in the pack will also be useful for those LSCBs which already have experience of audit.

Whilst the aim of this pack is to help LSCBs audit recommendations arising from SCRs, it may also have broader applications. It is our view that the factors associated with child deaths or serious injuries are not usually

dissimilar to factors present in other safeguarding cases. Whilst there are some cases that raise very individual issues, in most instances the context in which some children die whilst others are injured or remain safe is not significantly different. A number of individual factors may combine to produce the worst outcome, but those factors will be present in many other cases. Thus, the SCR provides a snapshot of inter-agency practice issues which will be applicable to other cases. By taking the findings from SCRs as the starting point for an examination of inter-agency safeguarding practice, LSCBs will have a relatively small, manageable number of issues on which to focus, but can be confident that they are relevant to a much broader group of children.

The pack is not an evaluation tool. It focuses on whether agencies are carrying out their work according to policies, procedures and standards set by the LSCB, to which member agencies have signed up. It does not provide the means to examine outcomes for children and families, which is a different and far more complex activity. However, the recommendations from SCRs arise from a detailed examination of inter-agency practice, and link to policies, procedures and standards which are based on established best practice. It is therefore reasonable to take the view that robust action to implement the learning from SCRs will improve outcomes for the children and families for whom LSCB member agencies have responsibility.

How to use this pack

The principle governing the pack design and content is that it provides a starting point for LSCBs to audit their own practice, recognising that members have many demands upon their time. We have tried to make the pack as easy to use as possible, but audit is a complex activity and it may take time to feel familiar with the process.

The pack will take you through a number of stages, beginning with the preparatory work necessary for carrying out successful audits. The need for adequate preparation cannot be over-emphasised and, as part of preparation, significant attention is paid to how SCR recommendations are framed. This is because the methodology suggested here relies upon recommendations as the framework within which audit takes place. It is therefore heavily dependent upon the quality of recommendations for its success. The links between recommendations, constructing action plans, and auditing are highlighted.

We have structured the audit process by:

- using the SMART (Specific, Measurable, Achievable, Realistic, Timely) approach to assess recommendations, since this is a well recognised method of testing the extent to which any plan provides a strong framework for action and evaluation. Some LSCB members will be very familiar with the SMART approach, but others will be less so. The pack therefore explains how to apply a SMART analysis in some detail
- developing a system for categorising recommendations into one of three types. The pack outlines how to categorise recommendations and provides examples of each type
- describing how to gather the information you will need in order to test whether the recommendations from SCRs have been implemented
- suggesting how auditors can report to the LSCB.

An exemplar shows how the audit process would be approached in practice, and an example of a reporting format is provided. Finally, the pack offers contact information if your LSCB would like help with any aspect of the audit process, and asks for your feedback so that we can improve the pack in the future.



Preparing to audit



The audit process outlined in this pack requires the active commitment of LSCB member agencies. As LSCBs are now increasingly familiar with auditing practice, we will assume that you have the necessary sign up from member agencies to the audit of their practice, and that the LSCB itself, through the chair, is equally committed to auditing inter-agency working together. It is as well to confirm this commitment periodically, especially when membership changes as, without it, the audit process can become stuck due to a lack of data.

Having ensured that member agencies are clear about their roles and responsibilities in relation to the audit of SCR recommendations, there are some other planning issues to consider:

What method of audit should your LSCB use?

This pack suggests one way of auditing practice against SCR recommendations. The system suggested here requires an inter-agency approach which should provide a rounded picture of progress against recommended actions. You may want to canvas other LSCBs and organisations about how they audit before deciding on the best system for your LSCB. Ultimately, your choice may be influenced by the resources at

your disposal. However, whilst there is no point setting up an audit process that is impossible to resource, it is equally unprofitable to create a process that will not deliver a useful product.

How are you going to organise the audit process?

We suggest that an audit subgroup is the most appropriate way to organise audits, and a standing group has the advantage of developing a consistent approach and of integrating audit into the work of the LSCB, perhaps by auditing more broadly than SCR recommendations. An alternative is to convene an audit group on a needs basis, say six to nine months after the SCR recommendations have been adopted. This system may suit

those LSCBs which undertake few SCRs, and which limit their auditing activity to SCR recommendations. It does not, however, provide the same opportunities for continuous improvement and the development of expertise as a standing group.

If your LSCB has a standing SCR subgroup, you could ask this group to also take on the audit function. This would have the advantage of linking the analysis of practice from the SCR, the review recommendations, and the auditing process in a very direct way. In practice, however, your SCR subgroup may be unable to take on these extra duties, particularly if your LSCB conducts a lot of reviews. It may also be preferable to establish a separate subgroup if the LSCB chooses to adopt a wider audit brief.



Where should you start?

If your LSCB is not already carrying out audits, you will need to agree a benchmark from which to begin. For example, are you going to audit recommendations from past SCRs (of which there may be a considerable number), and if so, how far should you go back? One approach would be to collate recommendations from previous SCRs for a given period to agree where themes emerge, and where there are recommendations of particular importance. These could be your starting point for audit.

However, you will also need to consider whether the recommendations from past SCRs are SMART enough to audit (see pages 10 and 11). If they are not, you could put a significant amount of time and effort into something that is not actually achievable. Effective auditing depends upon good quality recommendations. You may find that only some recommendations from past SCRs are amenable to audit, in which case the pragmatic approach might be to only audit these.

You could decide to begin auditing with your current or next SCR, and to focus in the meantime on establishing the audit process, and on making sure the recommendations from the review are framed with the audit process in mind. This is probably the most realistic option for those LSCBs which conduct a lot of SCRs.

Will auditing be confined to SCR recommendations?

Working Together advises that LSCBs should establish a culture of audit and review to ensure that tragedies are not the only reason that inter-agency work is reviewed. You may decide to adopt a broader approach to audit than is offered by SCR recommendations. For example, you could audit against selected elements of the inter-agency child protection procedures. This may be a good option for those LSCBs which conduct few SCRs.

03 SMART recommendations

SMART recommendations

Effective audit is dependent on good quality recommendations. As a general rule, try to avoid making a lot of recommendations and, in accordance with Working Together, focus on those which will really make a difference to single or inter-agency practice and which clearly relate to the main conclusions of the SCR.

Recommendations also need to be SMART otherwise they are unlikely to be implemented, and will probably prove impossible to audit. It is therefore worth spending some time framing and negotiating recommendations as part of the SCR process. Inevitably, by the time the LSCB gets to consider recommendations, the overriding need may be to get the SCR completed and signed off. LSCB member agencies will also want to correct deficits and improve practice. As a result they may be over-optimistic about what can be achieved.

Asking the questions “have our recommendations focussed on the essential issues arising from the review?” and “how will we audit implementation of these recommendations?” is a useful final test before recommendations are signed off.

An example of a SMART recommendation would be: The assistant director of children’s social care should ensure with immediate effect that all social workers receive supervision in accordance with departmental policy.

This recommendation is:

Specific

Specific recommendations set out exactly what should be done and are usually limited to a single action. Multiple recommendations can be difficult to audit; for example it is quite common to see a recommendation such as: the assistant director children’s social care should reissue the departmental supervision policy and ensure that all social workers receive supervision in accordance with its requirements. This example requires two different types of action, and separate audit processes.

It is preferable to address the recommendation to someone, and this should be to the level where compliance can be ensured, even though that person may not actually be doing the work. The example locates responsibility for the action with the individual who has the authority to ensure compliance. Clearly, the assistant director will not be carrying out the supervision her/himself, but will be requiring that it is carried out through the line management structure. The term ensure is used because the assistant director has the necessary authority; otherwise another term should be used.

An example of a non-specific recommendation would be: doctors should receive child protection training. The questions that would arise at implementation and audit stage are: who is going to make this happen, which doctors should participate, and what constitutes child protection training?



Measurable

A measurable recommendation will describe the result which is to be achieved, answering questions such as how much, how many or how well? The recommendation in the example is measurable through sampling, since the workforce is likely to be too large to audit the supervision received by every social worker. Sampling is a bone fide method of gathering evidence for an audit; somewhere between 10 and 30 per cent would be a reasonable sample from which to draw conclusions. A bigger sample does not necessarily equate to better information.

Realistic

Realistic recommendations take into account not only what can be achieved in theory, but also what is possible in the real world. Once a recommendation has been accepted, the LSCB is entitled to assume that it can be implemented. In the example, if the children's social care supervision policy sets unrealistic standards, then the policy should be revised.

An example of an unrealistic recommendation might be: the assistant director children's social care should ensure that all referrals for family support receive a response within 24 hours. This recommendation might be achievable, it is measurable, but it is very unlikely to be implemented because it is unrealistic.

An example of a recommendation which would be impossible to measure would be: hospital records for babies and children must contain all relevant information. Firstly, how do you know what is considered relevant information? Secondly, it could not be known from looking at records whether all relevant information was present. You would know this only with hindsight, once a deficit had been identified.

Achievable

Testing whether a recommendation is achievable involves asking two principal questions. Firstly: can this be done, is it possible? And secondly: can the individual to whom the recommendation is addressed achieve the required outcome? The example recommendation is achievable. There is already a departmental policy which sets out the expectations for the supervision of social workers, and all managers should be working to the policy. The assistant director is the line manager with responsibility for ensuring that the policy is followed.

Timely

Recommendations rarely include timescales, although they may recommend that something happens with immediate effect. This does not mean that recommendations should be open ended. Setting timescales should be part of action planning, and sometimes it is only at this stage that problems with the achievable and realistic elements of the SMART analysis become apparent. The example recommendation can be implemented immediately, because it is already a departmental requirement. Other recommendations will take time to implement because they require developmental work or inter-agency negotiations. It is easy to be optimistic about the amount of time needed to implement recommendations, especially where they involve large organisations or significant changes to practice.

If you find that your LSCB is consistently making the same or similar recommendations from SCRs, it is useful to pause and do a SMART analysis. It may be that there is a continuing failure of single- or inter-agency practice, or it may be that a recommendation will never be fully implemented because one or more of the SMART criteria is not met.

An example of a recommendation which is not achievable would be: the senior nurse child protection should ensure that a protocol for sharing information between health visitors and GPs is developed and implemented. Apart from being a multiple recommendation, this example requires the senior nurse child protection to ensure something for which she does not have the authority. She line manages neither the health visitors nor the GPs.

04 Linking recommendations, action planning and audit

Linking recommendations, action planning and audit



Action plans provide a framework for the implementation of SCR recommendations, and many LSCBs will construct these as a matter of course. Without an action plan, you are leaving the whole process of implementing recommendations to the discretion of individual member agencies, including the timescales for achieving identified improvements in practice.

A good action plan will include:

- the outcome (what is the recommendation intending to achieve)
- SMART recommendations
- confirmation that the recommendation has been agreed at the appropriate level in the receiving organisation
- the precise actions to be taken in order to implement the recommendation
- who is responsible for ensuring that each action happens
- the timescale for each action
- whether the actions have been taken.

Recommendations, action plans and auditing can be viewed as three discrete processes. However, our experience is that a number of LSCBs are explicitly linking the three. For instance, some LSCBs require the SCR overview report author to incorporate recommendations within a template which:

- kick-starts the planning process by drafting (for LSCB approval and further work) what actions are required to meet the recommendation, who is responsible for making sure the actions are carried out etc.
- facilitates auditing in that the information needed to audit is already identified within the template.

The benefits of such a model are self-evident. It is probably more economic and certainly more integrated. Those who devise recommendations are encouraged to make them more SMART and discouraged from making recommendations which are unlikely to be implemented. The LSCB subsequently has a crucial role to play within this model by, for example, elaborating the draft plan and using its authority to ensure actions are carried out.

Whether or not this model is adopted LSCBs should build the essential elements of the auditing process into action planning by determining the evidence needed for the audit at the time the action plan is drawn up. Integrating audit into action planning

provides a good test of whether recommendations are SMART, and gives the audit process the stamp of the LSCB's authority.

To illustrate how you might integrate recommendations, action planning and audit we will look at the sample recommendation: the assistant chief constable should ensure that all police officers receive training on the links between domestic violence and child abuse. We use a template adapted from one devised by Kent Safeguarding Children Board.



This is a difficult recommendation to implement because there will be a very large staff group to consider. In general, we would avoid recommendations with such a broad scope as this one. However, it can be achieved with sufficient determination, and it can be audited.

Outcome	Recommendation	Actions	By whom?	By when?	Actions taken	Information for audit
Police officers acquire knowledge of the risks to children associated with domestic violence.	The assistant chief constable should ensure that all police officers receive training on the links between domestic violence and child abuse.	<ol style="list-style-type: none"> 1. Determine number of courses and arrange. 2. Issue instruction re: mandatory attendance. 3. Deliver and evaluate course. 4. Report on attendance. 5. Set up rolling programme for new recruits. 	<p>Head of police training</p> <p>Superintendents</p> <p>Head of police training</p> <p>Head of police training</p> <p>Head of police training</p>	<p>Three months</p> <p>one month</p> <p>six months</p> <p>one month</p> <p>ongoing</p>		<p>Head of police training unit to provide written summary of number of officers attending training against total in post.</p> <p>Reasons for any variance to be given. Arrangements for any officers who have not attended.</p> <p>Arrangements for future new recruits.</p>

It is essential for effective action planning that recommendations are addressed to someone with the authority to ensure compliance. Once the recommendation is agreed, you can identify the actions necessary to implement the recommendation, who

will be responsible for taking them and within what timescale. The key to integrating audit into this process is to agree with the responsible person at the point the action plan is prepared what information will be provided for the audit.

05 Types of recommendations

Types of recommendations

As part of the preparation for auditing, we find that categorising recommendations into three types helps with thinking through the process. From examining a number of SCR action plans, we believe that all recommendations can be allocated to one of the three categories for audit purposes.

However, categorising recommendations is not essential for effective audit, and there is no need to do it if you do not find it helpful. We offer a word of caution though. If you are not going to categorise recommendations, you still need to clearly understand and identify their essential elements. For example, there is a key difference between providing a training course and developing a skill. One does not necessarily equate to the other.

To illustrate the differences between the types of recommendations, we will look at a similar issue from the point of view of three different recommendations.

Type 1 – Resources recommendations

Sample recommendation

A training course should be developed for police officers on the links between domestic violence and child abuse.

Resources recommendations are tangible. They require the production of something - usually a policy, procedure or protocol, or perhaps an information database. In terms of follow-up, they are easy to audit as the required document or other material either has or has not been produced.





Type 2 – Professional action recommendations

Sample recommendation

All police officers should receive training on the links between domestic violence and child abuse.

Professional action recommendations require someone to do something rather than produce something. They often arise when a policy or procedure has not been followed, and frequently focus on training. The example recommendation is challenging because it requires all police officers to receive training. The recommendation is achievable, but in making it you would want to be sure it was realistic. It might be more realistic to recommend that all new police officers should receive training on the links between child protection and domestic violence.

Some professional action recommendations are fairly straightforward. For example, a SCR may find that social workers are not always producing written reports for child protection reviews, and may recommend that social workers must provide a written report for every child protection review. Auditing this level of recommendation is relatively easy through a simple sampling or reporting process. Many professional action recommendations will, however, be more complex than this. For instance, a recommendation that GPs should inform the health visitor of each attendance at the surgery of a child on the child protection register presents more of a challenge in terms of both implementation and audit methodology.

Type 3 – Professional knowledge and skills recommendation

Sample recommendation

All police officers should have an understanding of the links between domestic violence and child abuse.

These are recommendations that require individuals to acquire or improve their professional knowledge and/or skills. They are not the same as recommendations that require professionals to attend training, since training may or may not result in new or improved skills. They are the most challenging recommendations to implement and to audit, and we suggest they are made sparingly. They are, however, arguably the recommendations that will make the most difference for children.

06 The audit path

The audit path

In order to see the overall process of an audit, we have summarised the main steps you will need to take each time:

Decide on the lead auditor

Someone should be nominated to lead the audit. If you have an audit subgroup, the lead auditor will usually be a member of that group. Alternatively, you could ask a member of the LSCB to lead the audit, or, in certain circumstances, an independent person, for example the chair of the SCR.

Agree who else will be involved

It is not necessary to have a large number of people undertaking the audit. The role of the auditors is limited to planning the audit, receiving and analysing information, and reporting to the LSCB. The lead auditor plus two others should be sufficient. One of the benefits of an audit subgroup is that you will have a pool of people to draw from to undertake individual audits. In the absence of a subgroup you will

be looking afresh each time for an audit group, and people will have less opportunity to become familiar with the audit task and to develop a skill base.

Decide the audit scope

Ideally, every SCR will have a small number of SMART recommendations, in which case you should aim to audit them all. However, if there are a great many recommendations, the LSCB may feel that not all of them need to be audited, or that it is not practical to audit them all. This may be particularly true if your LSCB is auditing past SCR recommendations, where the “essential” and SMART tests have not been applied. Auditing a sample of recommendations will provide useful information, and it is better to do what is manageable than attempt something which will overwhelm the resources of the audit group. This decision can be made at the time the action plan is constructed.

Group the recommendations

When it is clear which recommendations are to be audited, the group should consider categorising them according to type (see section 5).

Agree the arrangements for gathering evidence

The LSCB should have already agreed what information is needed for the audit as part of action planning. If this has not been done it is essential to do it now so that it is clear who is responsible for producing what information by when. If difficulties emerge at this stage we suggest that these are referred to the chair of the LSCB to resolve before proceeding any further with the audit.

Produce an audit calendar

For each recommendation, you should note when the information is due to be reported so that you have a picture of the audit path for individual recommendations and for the overall audit.

Plan audit group meeting

Once you can see when information is due to be returned, you can decide when the audit group should meet to review the material and complete the audit summary report.

Report to the LSCB

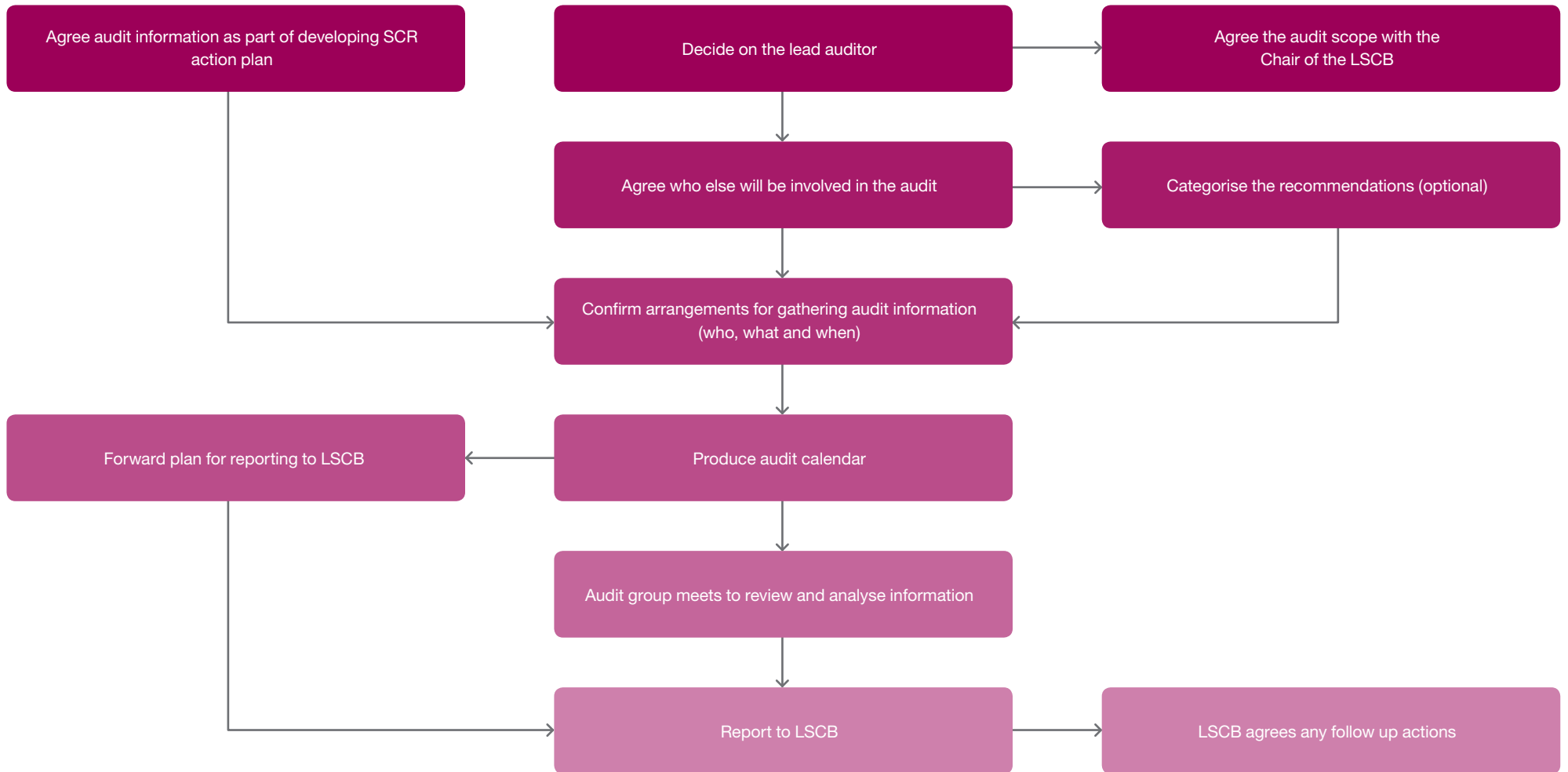
Forward plan for an item on the LSCB agenda.

Follow-up actions

We do not advocate an open ended approach to auditing. We suggest that where recommendations have not been implemented, have been implemented only in part or there is insufficient evidence of implementation, this is clearly referenced in the audit report so that the LSCB can agree the necessary follow up actions. It is tempting to embark on a programme of follow up audits but this can quickly overwhelm the resources available and will not necessarily achieve the desired result since the audit group can only report, not require.



The audit path



07 Gathering and reporting evidence

Deciding on the information

Who will gather the evidence

Agreeing timescales

Analysing the information

Reporting the audit findings

Gathering and reporting evidence

In this section of the pack we highlight some of the issues involved in effective evidence gathering, and use some sample recommendations to suggest how you can approach the task. It may make auditing recommendations sound onerous, in which case bear these things in mind:

- It is not the responsibility of auditors to chase agencies for evidence: agencies are responsible for supplying evidence and the LSCB has the authority to make this happen.
- Do not assume that it will be possible to audit all recommendations in detail. As you will see below auditing resources recommendations is much simpler than the other types. Where there are a lot of professional action or knowledge and skills recommendations you may need to be selective and you may need to use sampling.

We have divided evidence gathering into three stages:

- Deciding on the information you need.
- Determining who is going to get it.
- Agreeing timescales.

Deciding on the information

The key question for this stage of the evidence gathering process is: what information will tell us whether the recommendation has been implemented? You should be asking this question at the action planning stage.

We will look at this question from the standpoint of the three types of recommendation described earlier.

Using the example resources recommendation: children's social care and the police should develop a protocol for sharing information on and responding to incidents of domestic violence, we can see that deciding what information will show whether this type of recommendation has been implemented is straightforward. Either the protocol has been developed or it has not. You only need to decide whether the audit group wants to see the protocol, or if a self report will be sufficient.

For professional action and professional knowledge and skills recommendations, deciding on the information you need becomes more complex. This is especially so if the recommendation requires action by more than one agency.

Professional action recommendations might be addressed to a single agency, for example: the local authority should provide child protection awareness training for all newly employed teachers.

Or to more than one agency/ professional group, for example: all attendances of children at A&E departments should be notified to the general practitioner within three days. Confirmation that this information has been sent and received must be logged on the child's hospital and GP health record.

When deciding what information will tell you about implementation of these recommendations, you can:

- ask for a self report. This would mean simply asking the relevant agencies whether the specified actions have been taken. This is economic but you will not be in a position to know how the conclusions have been reached. If you make too many recommendations there is a danger of over reliance on self reports as the only practical way of auditing implementation
- ask for a self report plus supporting evidence. You can either leave it entirely in the hands of the agencies to decide what data they need, or you can discuss and agree this with them
- specify the data you want the agencies to provide. This approach has the advantage of ensuring that you receive the information needed to carry out the audit. It also provides consistency when a number of different people are involved in gathering information.



We suggest that whilst asking for a self report is a viable option for a resources recommendation, it does not provide a robust basis for auditing either single or inter-agency professional action recommendations. Auditors should be looking for a measure of objective evidence.

To illustrate this we will use the sample professional knowledge and skills recommendation: the chief probation officer should ensure that probation officers understand the potential links between substance misuse and risks to children.

For this type of recommendation, it is especially important to agree on the information for the audit at the action planning stage. In the sample recommendation, the probation service could require all supervisors to assess their staff for current competence in the identified skill area,

and arrange training and development for those not currently competent. Reporting the outcome of these activities would provide the information for the audit. If you wait until the audit is under way before considering what information is needed, you are likely to find that either the practicalities of implementing the recommendation have not been fully addressed, or that there is no mechanism for collecting data on the progress of implementation.

Who will gather the evidence?

For some recommendations, gathering and reporting the information will be done by the same person. This would be the case for most resources recommendations. Clearly, however, the more complex the information to be gathered, the more likely it is that several people will be involved. Again, as an illustration, we will use the sample recommendation: the

chief probation officer should ensure that probation officers understand the potential links between substance misuse and risks to children.

If we assume that the probation service will use supervision to review the current competence of existing staff, then clearly there will be a number of individual supervisors reporting their findings. The information will probably also go to more than one second line manager.

As an audit group, you only want one report, so you need to identify someone who can collate the information. Wherever possible, the person reporting to the audit group should be the LSCB representative for the agency to which the recommendation is addressed. This provides a strong link between the audit function of the LSCB and those required to gather the information.

For inter-agency recommendations, the decisions about who gathers and reports the information for the audit are likely to be more taxing. When considering who will gather the information for the audit, bear in mind that the nearer this person is to the work of the LSCB, the more likely you are to get good quality information within the specified timescale. At the end of this section of the pack, we have provided an exemplar which illustrates how the auditing of an inter-agency recommendation could be approached.



Agree timescales

Two timescales will need to be agreed with the person responsible for gathering and/or reporting the information for the audit. The first is the audit period itself, ie what will be the timeframe for information gathering. We can illustrate this by looking at the following sample professional action and professional knowledge and skills recommendations

The Education Service should provide child protection awareness training for all newly employed teachers.

When deciding on the timeframe for information gathering you need long enough to ensure that there will be sufficient evidence. However, if the timeframe is too long there is a danger

of making the task too onerous for the person gathering the information. Also, more information does not necessarily equate to better evidence. Here we are looking for a snapshot of activity over a reasonable period of time. Because this recommendation involves teachers, school terms provide an obvious framework for the audit. A reasonable timescale might be two school terms, so you would agree that the information for the audit would be gathered at the end of the second term.

All attendances of children at A&E departments should be notified to the GP within three days. Confirmation that this information has been sent and received must be logged on the child's hospital and GP health record.

For a recommendation such as this, a timeframe of a few weeks would be a reasonable audit period. There are likely to be a large number of attendances, so that a sampling approach will be necessary when you come to gather information. A long audit period would therefore serve no purpose. Alternatively, you could adopt the approach taken in the exemplar and use a fixed sample size rather than a timeframe.

The chief probation officer should ensure that probation officers understand the potential links between substance misuse and risks to children.

The audit period for professional knowledge and skills recommendations may be dictated by implementation arrangements. In this example,

we will assume that information is to be gained via the supervision process. The audit period therefore needs to allow enough time for all the relevant staff to be supervised. Be realistic about timescales. Professional knowledge and skills recommendations may take some time to implement. In this example, it is likely to be several months before information gathering for the audit can begin.

Once you have decided on the audit period, you will need to agree a timescale for gathering the information and reporting to the audit group. Where a recommendation has inter-dependent actions, the timescale for completing the audit needs to take this into account.



Analysing the information

Once you have received all the information in relation to a recommendation, the audit group will need to meet to analyse the material and reach a judgement on whether the recommendation has been implemented. Sometimes this will be self-evidently a yes or no response, but sometimes the information may tell you that the recommendation has only been partially implemented. In these circumstances, it will be important to understand why the implementation is incomplete, and what action is being taken to address this.

The LSCB should therefore set an expectation that, where the information gathered for an audit indicates that a recommendation has not been fully implemented, an explanation for this is provided to the audit group.

As an illustration, we can look at the information that might have been provided for the sample recommendation: the local authority should provide child protection awareness training for all newly employed teachers.

Recommendation	Information	Analysis
<p>The local authority should provide child protection awareness training for all newly employed teachers.</p>	<p>A total of 98 new teachers received child protection training during the autumn and spring terms out of a possible total of 107 (92 per cent).</p> <p>Sickness absence and availability for training* accounts for the variance. Teachers who did not attend training in the autumn and spring terms will do so during the summer term, together with new employees.</p> <p>Two training courses for new teachers will be delivered each term; this is estimated to be sufficient to cover all new employees.</p> <p>*This means that schools were unable to release teachers for scheduled attendance due, mainly, to staff shortages.</p>	<p>The recommendation from the case review has not been fully implemented. However, the percentage of new teachers receiving training is high at 92 per cent. The local authority has put arrangements in place to ensure that teachers who have not yet attended the training do so next term. There is forward planning for future new employees to receive training.</p>



If the recommendation has been implemented in full, you will obviously conclude that no further action is required, and this constitutes the signing off of the audit. In situations of partial or non-implementation the audit group will need to consider what should happen next. You could ask for a subsequent report. However, you may reasonably decide this is not a good use of your audit group's limited time. A better option may be to report the audit findings to a senior person in the relevant agency for further action. The LSCB should have a process for continuing to monitor the implementation of outstanding recommendations.

Reporting the audit findings

The audit group will need to find a format for reporting the findings of the audit to the LSCB. You should make this as succinct as possible, whilst ensuring that all the necessary information and issues are included. We have provided an example of a report format, and the type of information which might be included. LSCBs may want to adopt this format, or a variation of it. Ultimately, the reporting arrangements must reflect the needs of the individual LSCB.

The following pages contain an exemplar illustrating how we would approach the audit of an inter-agency professional action recommendation.

Exemplar

This exemplar shows how a recommendation might be audited. It is intended as an illustration of how this might be done. An audit group would need to consider local circumstances and balance the need to gather solid evidence against the need for economy. This example also shows how important it is to have the commitment of all agencies on the LSCB to the audit process.

Sample recommendation

The chief executive of the strategic health authority should ensure that all attendances of children at A&E departments are notified to the general practitioner within three days. Confirmation that this information has been sent and received must be logged on the child's hospital and GP health record.

This is a complex recommendation. There are a number of challenges, for example:

- There are two discrete but linked recommendations, involving both notification and confirmation.
- It involves discrete agencies/professionals, ie, A&E departments (of which there may be more than one) and GPs (of which there will certainly be many). Directing the recommendation to the chief executive of the strategic health authority recognises the specific role that the SHA has in relation to

managing Trusts' implementation of SCR action plans (Working Together to Safeguard Children 2.43).

- It is a professional action recommendation which cannot be audited by a simple yes/no response. Evidence will have to be gathered to establish whether (or to what extent) the recommendation has been implemented.

Gathering evidence

It is logical to start with the first part of the recommendation – notification – as confirmation is dependent on this being done properly.

A file audit should be used to establish whether notification has taken place. This will inevitably pose a number of questions eg how many files should be audited? Some of the potential issues are outlined in the table, together with an illustration of how they might be resolved.

Question	Proposal
How many hospitals to include (assuming there is more than one within the LSCB area)?	One or two – you could consider extending the audit to other hospitals if the initial findings cause concern but more doesn't necessarily mean better in terms of evidence.
Timeframe ie over what period of time are attendances to be audited?	This depends on volume – you need to generate sufficient data without creating unreasonable demands upon those gathering the information. In this instance you could dispense with a timescale and just go by volume, eg a sample from the last 50 attendances
How many records of attendances will provide a reasonable sample?	As a general guide, 20-30 per cent is a reasonable sample size where you have large numbers. In this instance, 15 attendances out of 50 should provide adequate evidence
Who is to gather the information?	To be discussed with a suitably senior clinician. Ideally a doctor with specific responsibilities for child protection would carry out this task. Otherwise, it could be administrative staff.



A similar process needs to be undertaken to establish whether the second part of the recommendation – confirmation by the GP – has been implemented. This will involve reviewing the GP files for the sample cases to check for recording of the hospital attendance. Accessing GP records is likely to prove more challenging than accessing hospital records, as GPs may not be directly represented on the LSCB. Nonetheless, the LSCB should have links with GPs via primary care trust representation on the Board, and through the designated professionals. Given that the data may be gathered

by different professionals within each practice (eg, practice manager, health visitor) one person should be responsible for collating the information and providing it to the audit group. Ideally this person should be a health representative to the LSCB.

In respect of both parts of the recommendation it is important to agree a timeframe ie, when the information will be reported back to the audit group. For a relatively complex recommendation such as this one, four to eight weeks would probably be needed to gather the information.

Analysing and reporting

The audit group will need to meet to review, analyse and report upon the data and draw conclusions. The table illustrates how the audit group might record this process.

Recommendation	The chief executive of the strategic health authority should ensure that all attendances of children at A&E departments are notified to the general practitioner within three days. Confirmation that this information has been sent and received must be logged on the child's hospital and GP health record.
Audit period	50 attendances to 30.06.08
Sample size	(i) 15 hospital records of 50 total attendances (30 per cent) (ii) 14 GP records reviewed (one GP would not agree to participate)
Data	(i) Of 15 hospital files five contained confirmation of attendance to the GP; of these three notifications took place within three days. (ii) Of 14 GP records eight files contained a note of A&E attendance (but only five of these were notified by A&E – one being by parent and the others by unidentified sources)
Analysis / conclusions	The recommendation has only been partially implemented. The level of notification by the hospital (33 per cent) is unsatisfactory. The results of the audit of GP files are more encouraging with eight of 14 (57 per cent) containing a note of attendance. It is a matter of concern that one GP refused to cooperate.

Audit summary report



Finally, we have included a suggestion for summarising the information gathered during the audit and reporting this to the LSCB.

Recommendation	Evidence sought	Evidence received	Comments	Further action
The assistant director children's social care and the assistant chief constable should develop a protocol for sharing information on, and responding to, incidents of domestic violence.	The LSCB police and social services representatives were asked to confirm that the protocol had been developed and adopted.	A copy of the protocol, endorsed by both agencies, has been forwarded to the audit group.	The recommendation was implemented within the agreed timescales.	None
The assistant director education should ensure that child protection awareness training is provided for all newly employed teachers.	The LSCB education representative was asked to confirm the total number of newly employed teachers for the autumn and spring terms, and the number of these attending child protection training.	A total of 98 new teachers received child protection training during the audit period out of a possible total of 107 new teacher employees (92 per cent). Two training courses for new teachers will be delivered each term; this is estimated to be sufficient to cover all new employees.	Good progress has been made towards implementing the recommendation and appropriate further action is planned. The LEA will ensure that the teachers who did not attend training in the autumn and spring terms do so during the summer term, together with new employees	The audit subgroup recommends that no further action by the LSCB is needed.



Recommendation	Evidence sought	Evidence received	Comments	Further action
<p>The chief executive of the strategic health authority should ensure that all attendances of children at A&E departments are notified to the GP within three days. The information must be logged on the child's GP health record.</p>	<p>Fifteen files from one A&E department were examined by the designated doctor. This represented 30 per cent of 50 attendances by children to 30.06.08. Checks were made of the GP records for the same children. It was only possible to audit fourteen GP records because one GP refused to participate.</p>	<p>Of the 15 hospital records audited, only five provided evidence that the GP had been notified of the child's attendance at the A&E department. Three out of the five indicated that notification had happened within three days; the timescale could not be established in the other cases.</p> <p>Of the 14 GP records audited, eight contained information that the child had attended the A&E department. Five of the notifications had come from the hospital, one from the parent and two from an unidentified source.</p>	<p>The SCR recommendation has not been fully implemented. The level of notification by the hospital (33%) is not satisfactory.</p> <p>The GP records show a more encouraging picture in that eight out of the 14 records examined contained a note of the child's attendance at the A&E department. It is a matter of concern that one GP refused to cooperate with the audit.</p>	<p>For discussion/agreement by the LSCB.</p>
<p>The chief probation officer should ensure that probation officers understand the potential links between substance misuse and risks to children.</p>	<p>The probation service was asked to confirm how many probation officers already have the required level of knowledge, and to state how identified deficits will be addressed.</p>	<p>Of the 68 probation officers in post during the audit period, 49 were considered to have the required level of knowledge. This was tested through supervision. The remaining 18 officers will receive training and/or study leave, and will be re-assessed in two months' time.</p> <p>The probation service has additionally confirmed that all new probation officers will attend the basic child protection training run by the LSCB, which includes input on the links between substance misuse and risks to children.</p>	<p>Good progress has been made towards implementing the recommendation and appropriate further action is planned.</p> <p>The decision to make attendance at the LSCB child protection training mandatory for new probation officers will address the needs of future staff.</p>	<p>The audit subgroup recommends that no further action by the LSCB is needed.</p>

Further help and advice and your feedback



If you would like to discuss any aspect of this pack please feel free to contact either:

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We are particularly interested to know who has used this pack and how helpful you found it. Please take a minute or two to email one of us to let us know.

This pack has been designed to help LSCBs conduct self-audits of recommendations from SCRs. However, we are aware that some LSCBs may lack the resources to conduct a self-audit. NSPCC Consultancy Services is available to:

advise and support LSCBs
in undertaking audits
OR
undertake this work on behalf
of LSCBs.

A fee will be charged for the
Consultancy service. For an informal
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Cruelty to children must stop. **FULL STOP.**