

This good practice example has been withdrawn as it is older than three years and may no longer reflect current policy.

Improving the quality of practice through case audit: Halton Borough Council

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Brief description

This example illustrates how case audit is a powerful driver in improving the quality of front line practice and the management of services for children and families. Recommendations from audit are carefully tracked and outcomes are reported to senior managers and the Halton Safeguarding Children Board.

Overview – the provider’s message

‘We believe that robust audits are an integral part of our quality assurance systems. Audit of practice days has evolved over time and offers front line staff an opportunity to reflect in a safe environment while knowing each practitioner is accountable for their practice. Audits are now much more focused on analysing quality. We are able to bring to life the experiences of children, young people and their families, and assess the difference our practice is making.’

Paula St.Aubyn, Divisional Manager, Safeguarding, Quality and Review



The good practice in detail

Ofsted’s survey report, ‘[High expectations, high support and high challenge](#)’ highlighted that social workers see audit and scrutiny as crucially important in supporting them to improve outcomes for children and young people. Halton Borough Council’s quarterly ‘audit of practice days’ illustrates how case audit is a powerful driver for improving the quality of front line practice and management. A team of auditors, drawn from a cross section of front line staff and senior managers, meets for two days to analyse a random selection of children’s cases. The process is sharply focused on learning and includes meetings with social workers and families as well as analysis of recording. Recommendations from the audit are carefully

tracked and outcomes are reported to senior managers and the Halton Safeguarding Children Board.

The audit

The audits are carefully planned. Four dates are set over a calendar year; administrative and IT support are allocated and audit teams are agreed well in advance. Five weeks before audit, a quality assurance officer randomly selects cases and workers are required to ensure that their recording is up to date and confirm their attendance.

Cases are selected across all areas of work, including family support, child in need, child protection, looked after children and care leavers. Audits always include a number of initial contacts received from partner agencies. The random selection may be supplemented by audit of specific issues arising from inspections, local or national serious case reviews and research or emerging practice issues. A recent audit included children in need experiencing domestic abuse. Another audit tested the impact of changes in arrangements for strategy meetings that precede child protection investigations.

All staff have the opportunity to join an audit team, including front line field, residential staff and managers, and senior managers. Front line staff highly value working alongside senior managers. They describe how it builds mutual respect and trust as 'everybody's equal' and 'I don't feel intimidated'.

The days are structured carefully to gain maximum benefit from the allocated time. Auditors are carefully selected to reflect a balance of experience and expertise. The senior manager for quality assurance takes overall leadership of the process. She ensures that the context and focus are understood clearly and that the boundaries of confidentiality and the process to be followed are clear. Laptops are used to access



electronic records. During the morning, pairs of auditors, working to a structured pro forma, to reach and record judgements about the quality of practice over the previous six months. They also agree areas to explore with the social worker during the afternoon meetings and, where relevant, fostering and residential staff.

The [audit process](#) has evolved to focus on the child's 'lived experience' along with the quality and impact of practice.

For example, auditors are asked to consider how far the analysis and conclusion of assessments are reflected in any agreed actions and whether there is evidence of positive educational outcomes for children. Auditors make clear evaluative statements about the quality of practice but they do not give numerical grades.

Discussions with staff help auditors understand more fully the reasons why a particular approach or decision was taken. The conversations alert staff to the importance of comprehensive recording as they realise that they have not always reflected all aspects of their work in the case record. Auditors then finalise their written analysis and recommendations which are quality assured by the lead manager. The day ends with a discussion of strengths and weaknesses across the sample. At the end of the two days, recommendations about organisational practice, systems or policies are formulated.

Where poor practice is identified the lead manager is responsible for ensuring that a clear recommendation and timescale for what must be done is immediately conveyed to the relevant senior manager.

Managers pay careful attention to ensuring that recommendations are implemented effectively. Individual line managers receive recommendations and are required to confirm completion in writing. When this is not forthcoming, it is followed up assiduously. The lead manager completes a report and action plan that summarises the findings and provides evidence of the impact of previous audits. This is considered by senior social care managers, the Children's Trust Board and the Halton Safeguarding Children Board (HSCB). Audrey Williamson, as independent chair of the board, stresses that the audit process, 'offers reassurance about the quality of safeguarding work while providing a clear process to track improvement'. The board oversees the implementation of recommendations.

Involving families in case auditing

A recent development is the recognition that a local priority to improve the use of feedback from children and their parents/carers should also be a key element of case auditing. A set of core questions has been produced and auditors now meet with children and parents following the audit of practice days and incorporate their views into individual audit reports.

The benefits for frontline staff

Being an auditor is an important learning experience for front line staff which improves their professional confidence and competence. One describes how she is able to 'separate herself [from colleagues and friends] and wear the auditor's hat'; and how the ground rule of 'talk child and their experience not practitioner' assists with this. Participating in audit creates a greater sense of collective accountability for the quality of practice. Discussions with other auditors challenges personal assumptions and staff incorporate the positive practice they identify into their own work. One person summed the experience up as offering, 'two days of personal supervision and reflection'. Staff also have the opportunity to share their learning and exercise their accountability more widely when they formally present audit findings to whole-service performance review days and their teams.

The process is welcomed as a constructive professional dialogue from a 'no blame' perspective that is focused on learning. Staff describe conversations with auditors as small 'light bulb moments' where they realise, for example, that their work is leading to the beginnings of positive change in parenting. The care taken to formally recognise good work through letters to staff is also motivating.

Using audit to monitor and improve

Audit of practice days are resource intensive but the benefits outweigh the costs in staff time. Through the shared ownership of performance management and the trust and mutual respect that develop between front line staff and senior managers, the organisational culture is strengthened. Senior managers' deeper understanding of daily front line practice that they gain through the process is an added bonus.

The sharp focus on quality of the work and the child's experience leads to the identification of collective areas for practice development. For example, child in need and child protection plans now include SMART targets that state how children will be safer and explain to parents why change is needed. Audit findings are translated into action plans that could include the development of focused training programmes or workshops. The impact is tested through subsequent audit and re-audit. Organisational systems and processes are improved, such as the development of a pathway to ensure that children's centres contribute to the support of

all young children in need, and the initiation of a review of the role and function of family support workers.

The effectiveness of the audit process is kept under critical review. Over time, this has led to a move away from a primary focus on compliance with requirements as more data were reported directly to senior managers and the HSCB. Learning from experience has also led to a review of the nature of preparation and training that auditors receive and the use of random spot checks to supplement the audit of practice days.

Provider background

[Halton Borough Council](#) is a small unitary authority located between Cheshire and Merseyside. It includes two main towns, Runcorn and Widnes, on either side of the Mersey estuary. Halton is ranked as 109th out of 149 local authorities in terms of the Income Deprivation Affecting Children Index and the council estimates that around 50% of children are living in poverty. Children's services, whose work is reviewed through audit of practice days, comprises: two child in need and child protection teams; a permanence team; a young people's team including care leavers; a fostering team; and an adoption team.

Are you thinking of putting these ideas into practice; or already doing something similar that could help other providers; or just interested? We'd welcome your views and ideas. Get in touch [here](#).

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