



What are the key questions for audit of child protection systems and decision-making?

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‘A renewed focus on quality assurance processes and practices and on practice evaluation can help build a culture of local performance’

Key messages

- Safeguarding services demonstrate their public accountability through Performance Indicators. These indicators will be most accurate when they are supported and complemented by the service’s internal attitudes, behaviours and processes for ensuring quality.
- On their own, Performance Indicators cannot provide the organisation with the knowledge it needs about the quality of its practice and decision-making. Following the outcome of Lord Laming’s *The protection of children in England: a progress report* (2009), many children’s services departments plan to adapt their local performance systems with the aim of capturing some measure of the quality of safeguarding practice.
- A renewed focus on quality assurance processes and practices and on ‘practice evaluation’ can provide methods to help build a culture of local performance.

- A variety of audit tools exist for different audiences, targeted at different organisations and tiers of management within organisations. There is also a need to 'surface' and share the working practices that people have developed in this area.
- Directors of children's services would benefit from incorporating into local auditing practices a process aimed at identifying which organisational factors support good practice and which inadvertently make poor practice more likely. This needs the direct involvement of those at the front line, whether practitioners, team managers or people who use services.

Key topics and some example questions

Managing for quality

- Are different layers of management suitably skilled in managerial quality assurance (QA) models and practices?
- Is there any peer review or support in place for managers at different tiers, in their QA function?
- Are people throughout the organisation clear about demarcations between different tiers of management and accompanying QA accountabilities?
- How could the organisation use performance targets to improve the quality of work?
- Do you know whether staff think they get consistent and appropriate messages about organisational priorities?

Learning within and from individual cases

- How does everyone's voice get heard and their expertise used regardless of their status?
- Is there a shared culture where it is acceptable and even desirable to query contributions to individual assessments of children and families?
- Is there clarity about who is responsible for drawing together collective learning from individual cases?

A knowledge-based approach to work with children and families

- Do staff have adequate time to identify research relevant to their current cases? Is there encouragement and praise for doing so and does the organisation require workers to use this approach?
- Are staff familiar with different patterns of human reasoning that can bias their thinking and reasoning?
- Is the assessment and plan for a child and their family kept under continual review?
- Do managers have adequate time and support to lead practice, such as reading and reflecting on case files, with the knowledge to analyse the quality of work and decision-making? Has the organisation defined appropriate levels of quality assurance responsibility and activity for its various managers?

Supervision

- Does supervision provide practitioners with supportive challenge to their thinking and reasoning in relation to particular cases?
- Are supervisors helped to develop and sustain their supervision practice?
- Does the organisation provide clear expectations about levels of competence, appraisal and supervision?

What can your data tell you?

- Is the data your local authority collects answering your questions?
 - Do you use the aggregated data to plan and commission services?
 - Are any agencies failing to make referrals and, if so, do you know the reason? How would the data reveal this?



ICT systems

- Do staff find that the existing information and communications technology (ICT) systems make it easy to record, retrieve and print relevant data?
- Are there aspects of the ICT system that militate against the recording of data and/or analysis that would assist in decision-making and case planning?
- Are there any additional functions that it would be useful for the ICT system to be able to do?

Making the most of resources

- Do staff know when and how to access additional resources e.g. funding for specialist assessments?
- Is there any reserve capacity in the multi-agency networks formed around each child and family to deal with unexpected circumstances? What does this mean?
- How do you ensure good internal and cross-agency support to front-line staff when conducting S47 enquiries?
- Have staff developed dysfunctional short-cuts or 'work-arounds' as a way of managing work pressures?

Introduction

This briefing aims to help directors of children's services (DCSs) in thinking about how best to test and demonstrate the quality of practice in their area, building on the best available knowledge about focus and method. It will contribute to their informed accountability, helping ensure that their service operates sound decision-making at all levels of the organisation. The briefing is based on a combination of the research literature available and on current and developing practice.

'Assuring the quality of both professional practice and organisational processes and structures depends on robust internal and cross-agency audit and quality assurance systems'

What the issue is

Robust assessment and decision-making in safeguarding services, in respect of individual families and children, depends on good internal and cross-agency practice that draws appropriately on the most up-to-date knowledge base. This good practice depends in turn on adequate organisational processes and structures. Assuring the quality of both professional practice and organisational processes

and structures depends on robust internal and cross-agency audit and quality assurance systems. These systems need to consider evidence-based practices, human behaviours and organisational support, and the interactions between them. Such local auditing practices contribute to confident accountability as well as informing external requirements such as national Performance Indicators and inspections.

However, the case of Baby Peter has brought concern about both quality and accountability in safeguarding and child protection work to the fore. It is timely, therefore, to ask: are we asking the right questions in the right ways? What can practice or developments, including in other sectors, tell us about the characteristics of effective audit systems in social care and, specifically, safeguarding?

Quality assurance processes

Against the recent reassessment of the role of performance, there is increased focus on what Ofsted, in the Haringey joint area review (JAR) report, calls 'qualitative audit activity' (para. 40). By this they refer to practice for 'evaluating the quality of frontline practice (para. 40) or 'the quality of services at the front door' (Local Government Association 2009).

Specifically, increased significance is being given to the practice of local auditing, and particularly multi-agency audits (including case file audit), as a key means of ascertaining and evaluating the realities of safeguarding practitioners' day-to-day work, and of questioning and challenging the underlying issues about the quality of front-line practice. The following examples serve as a brief illustration. Reference is made to the need to establish rigorous procedures for auditing and monitoring of case files in the Haringey JAR recommendations. They play a key role also in Ofsted's new inspection arrangements under Comprehensive Area Assessment (CAA), including their annual unannounced visits. The latter will focus their activities 'on analysing and discussing case files so as to assess the quality of practice'. The documentation they will require to see includes 'the latest audits and action plans relating to contact, referral and assessment arrangements'. In Laming's report (Laming 2009), Case Study C of

multi-agency working highlights the place of multi-agency audits, stating:

‘The value of interagency audit has been particularly important in driving change and creating a culture of continuous improvement.’

(Laming 2009: p40)

Current practice and tools

Children’s social care has a strong history of ‘practice evaluation’ which has many aspects of qualitative audit. It is important to find out whether this has informed the development of a framework and criteria for auditing the quality of direct work with children and families. Such practices are well developed to serve the needs of individuals and managers or supervisors, but it is not clear whether they have been adapted to include organisational or inter-agency dimensions.

There does not seem to be a lot of literature about practice in the area of local auditing. It becomes especially important, therefore, to highlight and share the working practices that people have developed in this area. A selection of approaches and tools are described below; these are targeted at different organisations and tiers of management within organisations.

Section 11 audit tools

Section 11 of the Children Act 2004 is accompanied by *Statutory guidance on making arrangements to safeguard and promote the welfare under Section 11 of the Children Act 2004* for local authorities and all organisations providing

direct services to children. DCSF has encouraged local safeguarding children boards (LSCBs) to develop Section 11 audit tools to ascertain compliance with these duties.

Suffolk LSCB, for example, has developed a ‘generic standards’ audit tool, designed to facilitate ‘self-auditing’ by organisations and teams within the local

authority and safeguarding children board (SCB) partners (Suffolk Safeguarding Children Board 2004). It identifies generic standards that derive from Section 11 responsibilities, and which apply in broad terms to the local authority and all SCB partner agencies. These cover:

- responsibility and accountability: senior officers, councillors and members of boards of partner organisations
- staff: general responsibilities
- involving children, young people and families
- safety and accessibility
- training and professional development
- recruitment, vetting procedures, and allegations against staff
- inter-agency working
- working with children and young people
- professional practice
- anti-discriminatory practice
- safe working (keeping staff safe).

‘It is especially important to highlight and share the working practices that people have developed’

Audit tools for local safeguarding children boards (LSCBs)

LSCB Challenge and improvement tool

This resource, published by the Department for Children, Schools and Families, focuses on effective governance as a starting point to establish effective relationships, clear accountability and transparency of operation and purpose. See www.dcsf.gov.uk/everychildmatters/resources-and-practice/IG00332/

Welsh LSCB Self-assessment and improvement tool

This self-assessment and improvement tool was developed by Tony Morrison and Jan Horwath. It is designed to be used to evaluate progress, strengths and weaknesses in areas that are judged to be crucial for achieving effective cooperation at strategic and practice levels in order to both safeguard and achieve better outcomes for children. These elements include:

- a shared strategic vision
- effective governance arrangements
- systems, structures and capacity.

Using this tool, LSCB members rate their performance in each of these domains in relation to LSCBs' statutory duties (HM Government 2006) and then propose actions to address areas of weakness.

The tool, which includes 25 items in five areas, is summarised in the table below from a report from the Vale of Glamorgan LSCB on the review of safeguarding arrangements in local authorities in Wales (Vale of Glamorgan LSCB, 2009). A worked example can be found in the report from the Vale of Glamorgan LSCB on review of safeguarding arrangements in local authorities in Wales (Vale of Glamorgan LSCB 2009).

Welsh LSCB Self-assessment and improvement tool

Strategic focus	Governance	Capacity	Outputs	Outcomes
1 Statement of purpose	6 Constitution	14 Chairing	17 Consulting children/young people	24 Assessment, planning, intervention and review multi-disciplinary working
2 Clear on safeguarding roles	7 Membership	15 Funding	18 Learning strategy	25 Children safer
3 Child-focused outcomes	8 Member responsibilities	16 Work/sub groups	19 Safe recruitment	
4 Strategic plan (3 yrs)	9 Agency responsibilities		20 Management of staff	
5 Independent identity	10 Robust Section 11 audit		21 Public awareness	
	11 Safeguarding policies, protocols		22 Communication strategy	
	12 Performance management		23 Serious case review (SCR) process	
	13 Business planning			

Social care governance audit framework

This framework adapts the more familiar clinical governance notion to social work and social care. It requires whole-agency participation and offers a model for examining day-to-day practice at all levels of the organisation. It brings together what people do with what they know or need to find out, and it connects the work of individuals and teams with the leadership and development of the whole service. This framework has been tried and tested in all Northern Ireland trusts (Social Care Institute for Excellence 2007), including within child protection services. It is currently being applied and further developed by Somerset County Council.

‘One strand of this evaluation programme involves looking at how effectively organisations are embedding safeguarding practices and integrated working into the delivery of services’

Sheffield safeguarding evaluation programme

Sheffield Safeguarding Children Board has developed a safeguarding evaluation programme. One strand of this evaluation programme involves looking at how effectively organisations are embedding safeguarding practices and integrated working into

the delivery of services within service districts. The evaluation programme looks at the effectiveness of integrated working and also seeks to find out whether professionals feel confident and supported when working with children and young people.

This approach is explicitly designed to build a cumulative picture rather than just one-off snapshots. Work has, for example, enabled similar questionnaires to be used in different parts of safeguarding work.

To obtain as broad a picture as possible about safeguarding policies, procedures and working practices, a variety of measures are used for the evaluation. These include:

- Self-audit – via a self-audit tool, developed to capture information on safeguarding practices among local organisations, covering safeguarding policies and procedures, information-sharing, recording incidents of concern, recruitment of staff and volunteers, training and safer employment.
- Questionnaire for professionals, volunteers and members of the public – via a questionnaire which organisations are asked to circulate among staff and volunteers. The questionnaires are anonymous and ask staff, volunteers and members of the public about their experiences of safeguarding, early intervention and integrated working, and whether or not they feel confident responding to issues of concern and what they perceive to be local priorities.
- Case file review – via a sample of cases being reviewed by the safeguarding children board for evidence of good practice in safeguarding and early intervention.
- Consultation with people who use services – via asking parents and carers if they are prepared to talk to someone from the safeguarding children board about their experience of the services they received. The aim of this part of the evaluation is to ensure that the views of people using services are included.

See www.safeguardingsheffieldchildren.org.uk/welcome/safeguarding-children-board/research-and-evaluation

Lessons from other fields in identifying factors that impact on quality

Concern with improving performance standards in other sectors has led to a number of key approaches to the issue. These tend to be framed in terms not only of quality but also of the inter-linking issues of safety and reliability. Three groupings are:

- systems models for accident or incident investigation and the related concept of 'safety culture' (see for example Reason 1997)
- 'mindfulness' and the organisational support of other characteristics of 'high reliability organisations' (HROs) (see for example Joyner and Lardner 2009; Weick *et al* 1999)
- Management models such as Toyota Production System's 'lean thinking organisations' and Total Quality Management (TQM) (see for example Liker and Hoseus 2007; Aspden *et al* 2004: Appendix F Part II; Seddon 2008).

There are two key characteristics that these different approaches have in common:

- The first is the way in which they understand determinants of standards or quality of performance. Rather than assuming that it is totally in the hands of individual workers to choose between good and less good or problematic practice, all three approaches work on the basis that staff are influenced by myriad systemic factors that shape the nature of the tasks they face. Any dichotomy between individual and system is deemed unhelpful toward understanding or improving standards. Instead, people are seen as inherently part of the system and the appropriate focus is, therefore, on the interactions of people and other aspects of the system.



- Secondly, they are much alike in the way they conceptualise the role of front-line staff (be they pilots or production staff) in creating quality, safety and reliability. The more traditional, centralised command and control system is 'characterised by a downward diffusion of work orders and an upward reporting of work status' (Johnston 2001). In these models, in contrast, it becomes imperative, in the words of Toyota, to 'turn workers into problem-solvers' – see Figure 1. This is epitomised in Toyota's 'quality circles', where groups of workers meet to discuss the quality of production and identify likely workplace improvements, which they present back to management.

Implicit in this is an organisational interest not only in whether good quality products and outcomes have been produced but also in finding out *how* these have been achieved. They are seen as inextricably linked; it is not possible to improve one without understanding the other. The emphasis is on learning and on gaining an increasingly better understanding.

Figure 1. Mindfulness in high-reliability organisations: pocket card from Woodside Energy, Australia.

What is a high-reliability organisation (HRO)?

An HRO is one where people are:

- wary of success
- worried about success breeding complacency
- alert to warning signs – identify, debate and conscientiously act on them
- empowered to challenge if a culture of denial is being displayed
- aware a significant failure or disaster is never far away!

Conflicting goals naturally create a culture of denial

Challenge your colleagues if any of the following denial behaviour is shown:

- it can't happen here
- a tendency to dismiss intermittent warning signals
- assumption that the situation is normal
- it is safe until proven dangerous (onus of proof).

Working in a high-reliability organisation (HRO)

Mindful approach

Worried about complacency?

- procedures must be followed, but never stop checking
- keep analysing alternatives.

Stay alert to warning signs:

- abnormal process conditions
- intermittent changes in plant status
- out-of-sight problems
- the feeling of operating blind
- making decisions on single-point information.

Be empowered:

- STOP, make SAFE, report the warning sign to supervision
- ensure the warning sign is entered into the reporting system
- appoint a devil's advocate
- participate in the assessment with the relevant experts to PROVE IT SAFE.

Prior to an accident there are always warning signs which, if they are responded to, will avert the accident.

Figure 1 reproduces a pocket card from Woodside Energy, Australia. This is one of the tools used in their 'mindful' approach to operations. Reproduced in *Mindfulness: realising the benefits* (Joyner and Lardner 2009). Used with permission.

The active engagement of staff presumed as necessary in these models is premised on the notion that it is increasingly difficult to predict with absolute certainty how procedures or processes will manifest when they leave the drawing board and are acted out in the real world. This is due to the non-linear dynamics involved:

'People can never know in detail what will happen in the future. The world is dynamic and complex and we have to learn to read and adapt to the environment as we go. When an engineer first sets up the process she has an image of how the process will operate, what the conditions will be, and what people will do. Once the process is in operation the real world does its best to confound all the great thinking of the engineer. The process is bound to fail in many unexpected ways. We can learn from past failures of the system and the engineer can try to develop the next one better but there will be new, unexpected failures. We cannot anticipate the world as fast as it can confound us.'

(Liker and Hoseus 2007: p155).

This heightens the need for feedback mechanisms about emergent problems from practitioners up through organisational hierarchies, in order to permit learning and modifications to be made as necessary. This is increasingly pertinent to multi-agency safeguarding work, where so many agencies with varying working practices and priorities are interacting. Interactions lower down the system will be unexpected and senior management or designers cannot predict all that may occur.

'It is increasingly difficult to predict how processes will manifest when they leave the drawing board and are acted out in the real world'

These developments draw our attention to an extra dimension that directors of children's services would benefit from incorporating into local auditing practices. This is an emphasis on audit as a learning exercise: on learning what good practice looks like in actual cases and on learning how it has been achieved – what supports it and what makes it more difficult to attain. This will require talking to practitioners, and children and family members, as well as reviewing written records. This is because formal documentation is not able to explain *why* people act in the way they do and what factors influence them for good or for ill. It is difficult for records to illuminate the potentially subtle differences in perspective that can influence how agencies and individuals work together, or for them to suggest changes that might lead to necessary improvements.

The key questions set out at the start of this briefing draw on this approach, understanding the factors that interact and influence front-line safeguarding work (derived from Fish *et al* 2008).

The role of performance indicators

The current debate about Performance Indicators (PIs) needs to be considered in an account of audit practice and function. In *The protection of children in England* (Laming 2009), Lord Laming noted that in order to get a reliable picture of current safeguarding practice in any area it was insufficient to rely

‘This heightens the need for feedback mechanisms about emergent problems’

on current performance indicators. These, local authorities had suggested to him, ‘focus on processes and timescales’ and not on quality, and so do not ‘drive positive improvements’ and secure better outcomes’ for children and young people (para. 2.3): ‘the performance indicators currently in use for the safeguarding of children are inadequate for this task’. Following the publication of the report, many children’s services departments plan to adapt their local performance systems with the aim of capturing some measure of the quality of safeguarding practice.

The debate mirrors critiques by academics (such as Tilbury 2004). These have tended to highlight the common and problematic ‘tendency to equate quality and accountability with documentation’ (Tsui and Cheung, 2004) (Burton and van den Broek 2008: p1). It has noted the destructive potential that follows, of ‘creating a simplistic description of practice and focusing on achieving service outputs with little attention to user outcomes’ (Munro 2004: p1):

‘The research provides various examples of the negative impact on practice, such as ‘professional notions of accountability... being subsumed by bureaucratic accountabilities.’

(Burton and van den Broek 2008: p11)

In a recent example, across five local authority areas ‘workers consistently claimed that it was easy to lose sight of the primary activities of supporting families and safeguarding children, to the second-order activities of performance and audit’ (Broadhurst *et al* 2009: p8). This is epitomised in the competing priorities of ‘“putting (data) in” and “going out” to see families’ (Peckover *et al* 2008: p391).

However, others from the policy and practice field have highlighted that rather than being fundamentally flawed, Performance Indicators have a specific function of publicly demonstrated accountability. The sector-led response by the Association of Directors of Children’s Services (ADCS), London Councils, the Society of Local Authority Chief Executives (SOLACE), IDeA and the Local Government Association (LGA) to Laming’s report (Laming 2009) noted that: ‘Effective inspection and regulation are important, but also have limitations’ (Local Government Association, 2009). Ofsted, in judging the performance management arrangements in the JAR of Haringey (Ofsted 2009) as ‘insufficiently robust’, explained: ‘The reliance on national and local performance indicators is *too great*’ (para. 40, emphasis added). They indicated that what is required is to ‘use Performance Indicators to question and challenge underlying issues about the quality of frontline practice’ (para. 40). This supports the approach that Performance Indicators are a necessary measure of the quality of decision-making and organisational supports but cannot stand in isolation. They are complemented and proven by the organisation’s internally generated audits of service.

As Performance Indicators will continue to play a key role in performance management, it is important that efforts are made to maximise their usefulness. To this end, DCSs need to ask:

- Can I be confident that my PIs are reliable or has the pressure to meet targets inadvertently created perverse incentives, such that staff are encouraged to develop dysfunctional 'work-arounds'? Has it become common, for example, to count initial or core assessments as 'complete' when they may be of insufficient quality or incomplete (Broadhurst *et al* 2009: p15).
- Do we build the opportunity for well-reasoned judgement when missing indicator measures, so that staff are able to make appropriate and agreed exceptions in individual cases, for example, the extra time that is needed to work with a child with communication impairments when doing an initial assessment? (Broadhurst *et al* 2009).



If you are satisfied that your PIs are trustworthy, are you making them tell a story about what is happening in teams? How is this narrative getting through to staff?

If, for example, you have a high rate of children who are the subject of a child protection plan more than once, has your organisation the means to consider what this might say about the service and whether you should change some of what you do? In other words, is your organisation understanding that data helps you to ask intelligent and pertinent questions rather than just providing a complete picture?

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This briefing is one of three considering the quality assurance aspects of safeguarding services:

Briefing 1: *Effective interventions where there are concerns about, or evidence of, a child suffering significant harm – considers the questions we should ask about and for the families we work with.*

Briefing 2: *What are the key questions for audit of child protection systems and decision-making?*

Briefing 3: *The oversight and review of cases in the light of changing circumstances and new information: how do people respond to new (and challenging) information?*

Briefings 2 and 3 consider the questions we should ask of the services we work in.

Centre for Excellence and Outcomes in Children and Young People's Services (C4EO)

Funded by the DCSF, C4EO has been established to help transform outcomes for children, young people and their families. It will do this by identifying and coordinating local, regional and national evidence of 'what works' to create a single and comprehensive picture of effective practice. To find out more and to look at our resources, please visit www.c4eo.org.uk