Ealing Children's Services – Summary of Ofsted Improvement Plan 2019/20

A. Introduction

During their Inspection of Local Authority Children's Services (ILAC) in November 2019, Ofsted made recommendations and highlighted several areas that require improvement. The improvement plan below details our response to these recommendations with the goal of strengthening individual service areas and social work practice and ensuring robust management oversight throughout the system. The improvement plan will act as the primary driver of changes to be made and will be complemented by and align with detailed action plans for each service area.

B. Ofsted Recommendations

The priorities for improvement identified in the Ofsted report are:

1) Social work capacity and allocation of cases
2) The quality and timeliness of responses to referrals, including strategy discussions and child protection enquiries
3) The quality and consistency of management oversight and challenge by independent reviewing officers (IROs)
4) Sufficiency of accommodation including the range of accommodation options for care leavers
5) The quality and accuracy of performance reporting and quality assurance activities
6) The quality of responses to children and young people who are at risk of being homeless and children on the edge of care

The voice of children and their families is essential to ensure that we understand and are responsive to their views and therefore is added as an additional priority:

7) The voice of children and families

This plan is designed around these key improvement priorities and outlines what needs to be done, by when, and what the changes will be. It will support delivery of our aspirations to provide excellent services leading to improved outcomes for children and their families.

C. Governance

The Director of Children and Families will lead on the delivery of the plan and update as appropriate. Progress against the objectives will be monitored at the twice monthly improvement board chaired by the Executive Director of Children's, Adults and Public Health and will be reported up to the Senior Leadership Team, the Chief Executive and Leader Quarterly Safeguarding meeting and to the Leader and relevant Portfolio holders on a monthly basis at the Budget & Improvement meeting. Additional scrutiny will be sought through the Scrutiny Panel Process in 20/21. Ealing Safeguarding Children Partnership will be engaged as active partners in contributing to the development and implementation of the Plan.

D. RAG Key

RAG	B	G	A	R
KEY	**Action completed**	**Good evidence of progress against plan / actions on track**	**Limited evidence of progress / action unlikely to meet timescale, but plan in place.**	**No evidence of progress / action will not be delivered in timescale/ multiple actions outstanding.**

Recommendation 1: Increase social work capacity and ensure appropriate and timely allocation of cases

1.1 We will clarify practice expectations and implement standardised, consistent practice across the service. This will be done by revising the CIN processes, implementing team-based training and development and through reinforcement in weekly performance clinics.

	Outcome	Timescale	RAG
1.1.1	Staff demonstrate clear understanding of revised 'Timescales & Standards' guidelines. Evidenced by Mock Inspection that supports that staff demonstrates understanding of new guidelines and 70% of case files audited demonstrate improved timescales and use of practice tools.	April 2020 Oct 2020 (tbc)	
	• CIN Practice Guidance is now in place. • CIN Report launched on 18.05.20. Managers will now need to commence use of this to understand performance of the teams. • Weekly audits are being conducted across all service areas to track practice. • Mock inspection tentatively rescheduled to October 2020 due to COVID pandemic.		G
1.1.2	Social workers demonstrate consistent use of relevant practice tools to assess risk for children and families and evidence the impact on outcomes. Evidenced by 70% of case fields audited demonstrate improved timescales and use of practice tools.	June 2020	
	• First CIN panel took place 6 July and will take place every three weeks to reduce throughput in teams and delay in competition of work. • CIN Scrutiny Panel finalised. • CIN Scrutiny tracker created to support CIN panel which will take place on a monthly basis from June. • CIN Practice Guidance and Procedures launched in May. • Weekly audits are being conducted across all service areas to track practice, shows improvement but more to do, particularly across MAST Teams. • Training and development programme underway for DTM and TM in MAST.		G

1.2 We will ensure robust management oversight of timescales across service areas through supervision, weekly performance clinics and use of accurate performance data.

	Outcome	Timescale	RAG
1.2.1	Referrals into Ealing and timelines for allocations are within statutory and internal timelines. Evidenced by mock inspection, audit activity (65% April and 90% May) and minutes from weekly performance clinics.	June 2020 Oct 2020	
	• CWD – Improving – daily checking of Power IB report by duty manager working. July target 96%. • Supervision in SAFE is performing at 90% for bi-monthly supervision and 50% for monthly (temporary timescales put in place during C-19 lockdown). • SAFE Current health check completed w/c 6th July audited this compliance. Although not a vast majority of SAFE cases looked at (21 allocated to auditors), feedback from the audit outcomes received to date evidence timely management oversight. There has been a review of supervisions on file for both CIN and CP cases for May. • Overall performance 96% cases supervised in May – CWD. • All cases allocated within timeframe. • Performance clinics continue at two weekly intervals – 100$ allocations – Leaving Care. • Mock Inspection tentatively planned for October 20 – delayed by COVID19		G

1.3 We will revise the structure of the EDT team and consider the implications of revised model in partnership with Hounslow.

	Outcome	Timescale	RAG
1.3.1	The new EDT structure will ensure sufficient capacity and the ability to always offer direct work where needed. Evidenced by audit activity and weekly EDT business reporting demonstrating appropriate social work capacity. Target of all children at safeguarding risk are seen as priority 1.	April 2020	
	• Regular monitoring confirms that this action has been completed.		B
1.3.2	The new EDT structure will ensure sufficient capacity and the ability to always offer direct work where needed. Evidenced by audit activity and weekly EDT business reporting demonstrating appropriate social work capacity. Target of 80% of EDT audits rated as good.	April 2020	
	• Ongoing monitoring shows improvement but not yet consistently enough to change to blue.		G

1.3.3	Agree any service & resource changes for Hounslow EDT service. Agree any service & resource changes for Hounslow EDT service. Evidenced by audit activity and weekly EDT business reporting demonstrating appropriate social work capacity.	April 2020	
	• Ongoing monitoring shows improvement but not yet consistently enough to change to blue.		G

1.4 With a focus on the balance between social workers and family support workers, we will ensure that teams' skill mix is appropriate to ensure that all cases are allocated to the correct type of practitioner.

	Outcome	Timescale	RAG
1.4.1	The balance and skill mix within teams is appropriate and supports effective safeguarding and lower caseloads. Evidenced by FSW role reduced by 12 posts, SW role increased by 12 posts, Mosaic caseload an allocations report. Target that all MAST teams have new structure in place according to phased timescale and a realistic target for caseloads be determined using throughput model.	April 2020 Feb 2020 April 2020 April 2020	
	• Adolescent, Greenford and Acton are working to the new structure of 11 FSW per team. • Central still have two pods with 2 per team. • Recruitment underway to recruit permanent social workers • Additional social work capacity is in place to support the reduction of caseloads and the improvement in assessment timescales – currently at 75.56% in May 2020, with a year to date performance of 68%. • FSWs are no longer holding statutory work – guidance has been created and circulated to teams.		G

1.5 We will ensure that consistent group case and 1:1 supervision is embedded in practice and monitored through supervision audit activity, weekly performance clinics and management development training. This will consistently support quality of practice.

	Outcome	Timescale	RAG
1.5.1	1:1 supervision takes place consistently and case records reflect evidence of effective management oversight. Evidenced by workers receiving 1:1 supervision monthly as evidenced in performance clinics audit activity and staff forums and recording on files is of the required standard.	Feb 2020 MAST April 2020	
	• CWD - Not yet met. Overall improvements since April are embedding in practice. Proposal to move to bi-monthly supervision for stable CIN cases in line with CIN visits policy. Continue with weekly reporting in performance clinic. Overall performance 94%.		G

	• Connect and Fostering - New weekly CLA report captures supervision, although initially only gsv and not 1:1 supervision, despite being on file. Working with performance team to capture both. Tracker that is kept by PSO's and submitted to HF on a monthly basis that captures gsv. • SAFE - Supervision data is provided to the SAFE managers on monthly basis. Performance meetings led by TM's are held weekly with managers; Service manager is sent 2 weekly performance summaries per team. • Audit activity shows: CWD 96% cases supervised May MAST April – 60%, May 35% Connect and LCT 100% Overall 70% - ongoing area of focus.		

1.6 We will use accurate up to date data to assess thresholds and allocations in the system by means of the implementation of a robust throughput model.

	Outcome	Timescale	RAG
1.6.1	Service areas effectively utilise throughput model to monitor demand and inform decision-making. Volume and demand in the social care system are managed effectively. Evidenced by audit activity, supervision and dip sampling Mosaic reports. Target that all services are utilising the throughput model to inform decision-making and monitor demand.	April 2020	
	• CWD – Planned work in October with AL/JC. • Work is now allocated in a timely manner, and caseloads are beginning to reduce - average is now 16 across the service. Further work needs to be done to ensure interventions with families are timely and assessments are completed within 45 days.		G

1.7 We will review the structure and social work practice in ECIRS to improve the team's effectiveness and efficiency.

	Outcome	Timescale	RAG
1.7.1	Timelines for making contact with families are in line with need as reflected by RAG ratings. Evidenced by rating Mosaic reports with a target of 90% of cases showing that contact was made in line with RAG ratings.	April 2020	
	• Weekly monitoring ongoing. Some challenges with MOSAIC reporting. Current figures show that 95% of Red RAG cases are responded to within 24hrs.		G

1.7.2	MASH partnership involves partners in health, the police and the Ealing Safeguarding Partnership. Evidenced by MASH partners meeting daily in MASH hub and audit activity demonstrating effective joint decision-making is recorded in case files. Target - 100 MASH hub cases clearly demonstrating joint MASH partnership decision making.	Mar 2020	
	• Third MASH strategic group held on 1 June. Focus of meeting was on governance, ToR agreed and work is being completed on information sharing agreement. Frequency of meetings will be bi-monthly with monthly meetings scheduled for the Operational MASH group. Some delay due to COVID, but work now progressing and auditing of MASH cases being undertaken in June and July 2020.		**G**

1.7.3	Management oversight is clear with documented evidence and rationale for decision making and safety planning in all service areas including the MASH partnership. Evidenced by audit activity showing evidence of oversight recorded in the child and family enquiry and the case file, performance reports show a decrease in referrals to MAST and a decrease in the percentage of NFAs in assessments. This will be further supported by the creation of a DA hub. Target of 100% case records audited show management oversight.	From Jan 2020 progress by May 2020	
	• As at March, currently 89% of ECIRS case records audited show management oversight. • Audit activity over April and May showed an improvement in the recording of management oversight on cases but not yet consistently across MAST • Auditors noted in 90% of cases audited that children and young people were safe and well. • Pandemic lockdown saw a reduced number of referrals in April and early May. Numbers are now beginning to return to pre-COVID levels.		**G**
1.7.4	Domestic Abuse Hub is created with additional resources to provide a more dynamic, timely and specialised response to domestic abuse at the front door. Evidenced by families being provided targeted response at earlier stage. Target to show that audits demonstrate increased understanding of domestic abuse at the front door.	April 2020	
	• DA Hub - 24 applied for FSW role - these are now being shortlisted. No applications for senior social worker - this will need to go out again. • Delayed due to COVID19 • Recruitment underway for SW, FSW and AW. Shortlisting and interviewing before end June. • 24 applied for FSW role – these are now being shortlisted. No applications for Senior Social Worker – will need to be re-advertised.		**A**

1.8 We will review Private Fostering practice to ensure the service is sufficiently robust.

	Outcome	Timescale	RAG
1.8.1	Increased awareness and identification and referrals of Private Fostering arrangements by professionals and families in the borough. Evidenced by audit activity, action plan in place and monitored at six-weekly steering group meetings and Improvement Board. The annual report on private fostering services to be shared with ECSP. Target is to increase the number of private fostering arrangements in the borough.	Sep 2020	
	• The private fostering plan has been updated showing significant progress. It has also now been updated with a COVID 19 category as it is possible private fostering placements may be made during this time. This has been disseminated via the multi-agency network, ECIRS and ECSP.		G
1.8.2	Staff demonstrate clear understanding of obtaining parental consent for private fostering arrangements.	Dec 2019	
	• Completed. All staff have attended training session		B

Recommendation 2: Improve the quality and timeliness of responses to referrals,strategy discussions and child protection enquiries

2.1 Ensure full compliance, quality of practice and timescales across service areas by embedding robust management oversight and recording of decisions by means of weekly performance clinics and team-specific training and development.

	Outcome	Timescale	RAG
2.1.1	Referrals into Ealing and timelines for completions of CFAs as well as visits to children are within statutory and internal timelines. Evidenced by audit activity. Target 85% (Apr) /90% (Oct) CFAs are completed within 45 days	April 2020 Oct 2020	
	• CWD – 95% achieved. • CFA performance improving. • CWD – 85% CFAs within 45 days – projected to meet target in July. • CIN – 68% CFA performance year to date		G
2.1.2	As 2.1.1 – Target 85% of visits to children are completed within 10 days (CP) or 20 days (CIN).	April 2020	
	• CWD – 85% CIN visits within timescale – currently 68%. CIN visits now being monitored and performance tracked. • CP performance improving (SS).		G
2.1.3	As 2.1.1 – Target 90% of visits to CLA are completed within timescales.	April 2020	

	• CWD - Still issues with up to date recording and data capture in the report (report is still picking up some CSDPA cases and only 139 of the 213 CIN). Continuing work to improve CIN visits frequency and recording to reflect policy. Currently CP 100%, LAC 95%, CIN 78%. • Connect and Fostering - Weekly report captures visits although data needs cleaning as some previous CLA are being captured within report. Visits currently at 91%. • CWD – LAC visits within timescale – currently 87%. • LAC visits 98.7% completed within timescale.		G
2.1.4	As 2.1 - Target 85% of visits to Care Leavers are completed within timescales.	April 2020	
	• 93% of visits on time. 20 plus moved to leaving care team in March 20 and already significant improvement in visits.		**G**

2.1.5	The balance and skill mix within teams is appropriate and supports effective safeguarding and lower caseloads. Evidenced by audit activity, Mosaic caseload allocations report. Target to demonstrate required skill mix is in place.	From Jan 2020	
	• Outcome met for all teams with regards to skill mix and the average caseload is currently 16. • Recruitment currently being undertaken by all services to reduce reliance on agency staff		**G**

2.2 We will improve the quality and timeliness of strategy discussions.

	Outcome	**Timescale**	**RAG**
2.2.1	Strategy discussions take place for all children at high safeguarding risk with effective involvement of partners, within established timelines and are appropriately recorded in the case files. Evidenced by audit activity. Target 100%.	April 2020	
	• CWD – Strategy discussions include multiagency partners – 100%. • Work has been done on the system to force compliance, (at least 2 partners present in discussion alongside social care) and this is now in place. • Extensive audit work has informed a training and development programme that is now being delivered to Team Managers and Deputy Team Managers in MAST. 2 workshops undertaken, and a further 4 before the end of July 20. Repeat auditing will continue alongside to test impact of training.		**G**

Recommendation 3: Improve the quality and consistency of management oversight and challenge by independent reviewing officers (IROs).

3.1 We will manage the performance of the existing externally commissioned IRO service by means of contract and performance monitoring meetings to ensure current performance improves whilst we undertake a full review of the longer-term provision of the service.

	Outcome	Timescale	RAG
3.1.1	A high quality and responsive and child- focussed IRO service is in place. Evidenced by C&F satisfaction on reviews. Target – review on effectiveness of IRO service completed and agreement on timescales for subsequent plan.	Sep 2020 April 2020	
	• A dedicated CPA/IRO Challenge Form has been created to chronicle and report on CPA/IRO escalations on Mosaic. • Issues Resolution Process (IRP) guidance has been produced which underpins the Mosaic workspace. • Ealing Care Planning and Review Standards has been produced. • New IRO escalation service went live in March 2020. Mosaic workflow has been adjusted to include IRO escalation. • The number of issues being raised has reduced, and where they are escalated they are resolved swiftly.		G

Recommendation 4: Increase sufficiency of accommodation, including a range of accommodation options for care leavers.

4.1 We will refocus the care leaver local offer to ensure clarity around our council tax exemption and review and refresh the accommodation offer.

	Outcome	Timescale	RAG
4.1.1	We will refocus the care leaver local offer to ensure clarity around our council tax exemption and review and refresh the accommodation offer. Evidenced by care leavers having a full awareness and understanding of their entitlement and receive a consistent approach regarding exemption. Target evidenced by care leavers having an awareness of their entitlement and are supported to claim, resulting in a reduction of young people with arrears in reports from the leaving care monthly funding panel.	March 2020	
	• Work underway with corporate colleagues to explore financial impact of exemption with a view to implementation in April 2021. List of Ealing care leavers and analysis of NRPF to be submitted by 10th July.		G
4.1.2	Policy for use of risk assessments and visiting frequency in relation to all placements will be revised, implemented and monitored for effectiveness. Evidenced by the revised policy being implemented.	Jan 2020	
	• Policy in use. Outcome completed.		B

4.1.3	Referrals for new placement type will be required to include updated risk assessment in order to be processed by ART team. Evidenced by the number of referrals for new placement type including updated risk assessment in Mosaic. Target – 100%.	Jan 2020	
	• February audit of risk assessments completed for change of placement – 100%. A second audit will take place in June 2020.		G

4.2 We will have better quality and range of provision for LAC, UASC and care leavers and have confidence in the quality of the unregulated options in partnership with WLA and providers.

	Outcome	Timescale	RAG
4.2.1	We will have better quality and range of provision for LAC, UASC and care leavers and have confidence in the quality of the unregulated options in partnership with WLA and providers. Evidenced by increased housing options available to care leavers through engagement with key stakeholders. Target to be confirmed with stakeholders.	April 2020	
	• Awaiting confirmation from Housing re quota numbers for 20/21. Ongoing work with Housing colleagues with regards to private rented accommodation for care leavers. List now updated and set against current needs and weekly costs to prioritise moves.		A
4.2.2	We will have better quality and range of provision for LAC, UASC and care leavers and have confidence in the quality of the unregulated options in partnership with WLA and providers. Evidenced by improved standards of semi-independent provision through quality assurance accredited scheme of WLA. Target to be confirmed with stakeholders.	Mar 2021	
	• Accreditation scheme update as at 15/4/20 - there have been 105 applicants, 83 have gone through stage 1 desktop checks. Out of those, 23 have had live or virtual inspections and have been awarded Accredited status. There have been several applicants failing at stage 1 or 2. • Temporary Accreditation Officers are clearing the backlog of stage 2 inspections caused by recruitment issues. • WLA have not progressed to stage 3 inspections of individual properties as yet but have plans in place to conduct those as virtual should circumstances dictate. These will be linked to the DPV on CarePlace for brokerage by ART. The DPV has been slightly delayed due to the current Covid-19 situation. There have been 50 applicants for the DPV thus far and are evaluating them currently.		G
4.2.3	We will have an increased level of provision of Ealing Local Authority housing for care leavers. Evidenced by increased number of local small units available for care leavers. Target to be confirmed with stakeholders.	Mar 2021	
	• No update available due to disruption caused by COVID 19.		G

4.2.4	We will have an increased level of provision of Ealing Local Authority housing for care leavers. Evidenced by satisfaction surveys which will be ongoing throughout 2020 and will be triangulated with young people's feedback from pathway plans. Target 80% of care leavers state overall satisfaction with their accommodation in online survey.	Mar 2021	
	• General survey for care leavers conducted January. • Survey undertaken in May 2020 - 37% response rate with 78% expressing satisfaction with their worker and care package. Of the 22% expressing dissatisfaction, the primary area of concern was accommodation.		G

4.3 We will enhance care leavers preparation for adulthood by ensuring pathway plans are of a high quality and developed in partnership with young people.

	Outcome	Timescale	RAG
4.3.1	Young people have access to their health histories, consistent planning around their education post-16 and strong relationships with their workers. Evidenced by care leavers receiving their health passport within six weeks of their final LAC health assessment. Target 100%.	Mar 2020	
	• Health passport spreadsheet set up for 6 monthly reminders to log care leavers wishes regarding whether they want a copy of their health passports. (March 20 and September 20). The majority of care leavers wish for their passports to be held on the files.		**B**
4.3.2	Young people have access to their health histories, consistent planning around their education post-16 and strong relationships with their workers. Evidenced by following a reconfiguration of the leaving care service, pathway plans are reviewed in meetings chaired by a Manager. Target 100%.	April 2020	
	• Pathway plan reviews - This new process is delayed partly due to the Covid 19 Pandemic and long term sickness of the manager. The work is now being completed and a MOSAIC process has been designed.		**B**

Recommendation 5: Achieve quality and accuracy of performance reporting and quality assurance activities.

5.1 We will ensure that robust performance reports are delivered by implementing phases 1 and 2 of the corporate Performance Management Improvement Project.

	Outcome	Timescale	RAG
5.1.1	Governance and resources are in place to enable the performance improvement project, including recruitment of data quality team. Evidenced by internal and external resource needs are identified and in place.	Feb 2020	
	• Procurement process currently underway for Mosaic project.		G
5.1.2	A robust grip on operational management and statutory reporting requirement is achieved. Evidenced by priority reports developed, monthly performance data reporting in place, weekly performance data provided to managers at all levels of the service and that Year-end performance reporting can be delivered effectively.	Mar 2020 April 2020	
	• All report specs are now signed off. Slightly behind schedule due to Covid-19 but reports now being used by the services and data quality is being tested, particularly with regards to the CIN Reports.		A
5.1.3	Full compliance of Mosaic users results in to up to date, accurate case records. Evidenced by audit activity of Mosaic reports, weekly performance clinics and a user group established. Target 90%.	Mar 2020 Oct 2020	
	• CIN and LAC reports only recently released. • Weekly performance clinics have continued. Significant progress across CONNECT and Leaving Care, progress across MAST slower, which is in keeping with the fact that that part of the service was under considerably more pressure in terms of caseloads.		G
5.1.4	Long term vision for MOSAIC usage and performance reporting agreed and roadmap to get there. Evidenced by structured assessment of workflow problem areas, clarity on preferred architecture for performance reports and a timetable covering the move to hosted and group-based records.	Mar 2020	
	• Procurement process currently underway for Mosaic project.		G

5.2 We will conduct a structured review of the vision, people, process, technology and organisational factors of Performance Management by implementing phase 3 of the Performance Management Improvement Project.

	Outcome	Timescale	RAG
5.2.1	First class performance management and business intelligence is achieved; improved user engagement and confidence in the system is evidenced which will result in greater efficiency and productivity through a simplified and effective process. Our vision and expectations are defined and a review of governance and performance management has been completed; Consideration has been taken re the of capacity to deliver against vision and any structural changes completed. Review of all reports in report library completed. All priority workflows reviewed. Migration of reports to preferred architecture where appropriate Training and user guidance on new reports. Ongoing data quality governance process in place.	Phase 3 Mar 2021	
	• Procurement process currently underway for Mosaic project.		G

5.3 Ensure mandatory Mosaic training is available and completed by all staff.

	Outcome	Timescale	RAG
5.3.1	New Mosaic training modules are available and 100% of Mosaic users attend relevant training and development sessions. Evidenced by attendance monitoring by CPD record and the impact monitored by audit activity. Target is for all new Mosaic modules are available and 100% Mosaic users attend relevant training and development sessions.	May 2020	
	• SAFE staff complete this upon starting the team. Current new training is in place to support new group family working. Administrators are currently enrolling on this. Ken Bywaters providing guidance to practitioners to support current Golive dates (for new cases). Developed a detailed training schedule for 2020/2021 with several new course modules. • We have arranged with all providers (bar one – neglect) to provide the training sessions virtually on Teams. • Training & Development have been working in conjunction with the C&F Quality Assurance Officer to produce a Mosaic audit checklist tool to be added to the routine case audit/health checks performed by managers. This will be supported by an introductory training for all relevant staff and by ongoing support. • The Mosaic trainers working very closely with Heads of Service and service areas to improve workflows, usability and to strengthen the design of workflow steps to reduce errors.		G

	• Training & Development have also proposed a technical audit role for the Mosaic trainers, serving both for an additional quality assurance on live cases and also to measure the effectiveness of Training & Development's message. • We have developed a tracking mechanism to track attendance at training sessions so will be able to monitor and report on this over time.		

5.4 Management oversight will ensure that work is recorded in a timely and accurate way in the system and action is taken swiftly if quality, consistency, or compliance are not of a high standard. This will be strengthened by weekly performance clinics, regular supervision and accurate performance reports.

	Outcome	Timescale	RAG
5.4.1	New Mosaic training modules are available and 100% of Mosaic users attend relevant training and development sessions. Evidenced by weekly performance clinics and audit activity. Target 90% audit completion compliance.	Mar 2020	
	• CWD – Mosaic training compliance – 100% met. • SAFE performance reporting is improving. MOSAIC team and the performance team are working to provide workflows that are easier to navigate, and reports created for outstanding areas not reported on via MOSAIC ie: Visit/direct work record, plans incomplete, TAFs incomplete, accurate reporting on the service a family receives once referred to SAFE. • SAFE Counselling Monthly Summary report will commence 20th July. • Some teams have met 100% compliance, but training for other teams has been postponed until June due to the COVID crisis. Tracking is in place once training commences.		**B**
5.4.2	Permanency Tracker is in place and used as intended to track timescales and address delays and other gaps in permanency planning. Evidenced by the Permanency Panel having ToR in place.	Feb 2020	
	• Completed. ToR in place.		**B**

5.4.3	Permanency Tracker is in place and used as intended to track timescales and address delays and other gaps in permanency planning. Evidenced by Permanency cases are monitored and escalated as needed to Permanency Panel.	Mar 2020	
	• Completed. Procedure is in place and is working effectively.		**B**

5.5 We will review and refresh the audit cycle, leading to a better understanding of the work in the system and consequently to continuous improvement.

	Outcome	Timescale	RAG
5.5.1	The Quality Assurance Framework is to be refreshed and to be launched. Learning events from multi-agency audits will be held, feeding into ESCP training and development subgroup within the governance of the children's safeguarding partnership. Evidenced by ongoing annual quality assurance activity taking place, ESCP subgroup minutes and inclusion in training offer for ESCP multi-agency partners.	Mar 2020	
	• Comms finalised in March. • COVID has meant a refocusing on QA work to monitor practice during the pandemic.		B

Recommendation 6: Improve the quality of responses to children and young people who are at risk of being homeless, and children on the edge of care.

6.1 We will review and strengthen pre-proceedings processes.

	Outcome	Timescale	RAG
6.1.1	Legal planning meetings take place in a timely manner. Evidenced by audit activity, pre-proceedings tracker, Legal Proceedings Panel minutes and feedback from Legal Team. Target 100% legal planning meetings taking place.	June 2020	
	Connect and Fostering - Senior managers now give agreement for LPM to take place and are accountable for decisions around timeliness. Tracker is in place although data is helpful there needs to be a focus on the timeliness of pre-proceedings process (some delay due to Covid). Plan is to roll our Pre-proceedings training to all the MAST managers with renewed focus on process and timely interventions Timescale: Sept 20. • • HoS have agreed that HoS need to give consent for legal planning meeting to take place. • Legal Pre-proceedings tracker developed and Legal Panel coordinator is inputting data. Training planning with all DTMs around the PLO process to be scheduled.		G
6.1.2	Legal Proceedings Panel tracker is improved, regularly updated and incorporated into care planning process. Evidenced by legal proceedings tracker being fit for purpose and used at 100% of Legal Proceedings Panel Meetings.	Feb 2020	
	• Completed. Tracker fit for purpose and is being used.		B

6.1.3	Pre-proceedings letters and minutes of meetings are uploaded to Mosaic within 48 hours of date of letter/meeting. Evidenced by audit activity. Target 100% letters and minutes uploaded within 48 hours.	Mar 2020	
	• Mosaic report to track. • PLO training being delivered to all Managers.		G
6.1.4	Pre-proceeding letter is revised to ensure better and more meaningful engagement of families in in the PLO process.	Feb 2020	
	• Completed. All staff have attended training session.		B

6.2 Children and families will live in accommodations appropriate for their needs.

	Outcome	Timescale	RAG
6.2.1	Review of the financial impact of service acting as guarantor vs paying block rental payments has been conducted. Evidenced by reviewing the financial impact of service acting as guarantor vs paying block rental payments has been conducted.	Feb 2020 Mar 2020 (tbc)	
	• Meeting between HST service and Housing in April. 3 families have successfully moved from B&B to accommodation in Hounslow as a result.		B
6.2.2	Review of the financial impact of service acting as guarantor vs paying block rental payments has been conducted. Evidenced by families being placed in accommodation appropriate to their needs.	April 2020	
	• Meeting between service and Housing in April. 3 families have successfully moved from B&B to accommodation in Hounslow as a result.		B

6.3 Review the AROH process in order to ensure consistent decision making of 16- & 17-year olds at risk of homelessness.

	Outcome	Timescale	RAG
6.3.1	Young people at risk of homelessness will be appropriately supported in a consistent way. Evidenced by audit activity and minutes from AROH Panel which demonstrate consistent decision-making for all 16 and 17 year olds.	Mar 2020	
	• AROH - UT completed on the Mosaic episode. ART once again able to administer the panel from 26/5/20. New episode ready to launch from 9th June. Practice guide developed for SWs and ART.		G

Recommendation 7: Seek, represent and listen to the voices of children and families.

7.1 Children and families are consistently informed about and involved in procedures, decisions, concerns and plans at key points of their journey through the social care system.

	Outcome	Timescale	RAG
7.1.1	CIN review points use newly created template to ensure capturing views of children and families on the CIN plan and interventions, similar to processes used in CP conferences. Evidenced by audit activity of case files.	April 2020	
	• Completed December 2019. Training completed.		B
7.1.2	Monitoring process for participation and engagement of children/young people in CP conferences is developed and participation is actively encouraged where appropriate. Evidenced by audit activity and supervision in all appropriate cases.	March 2020	
	• **Progress delayed – timeline to be clarified.**		A
7.1.3	Participation of children/young people is consistently monitored in LAC reviews and continues at high levels of engagement. Evidenced by case audit files and supervision activity, Mosaic performance reports and surveys with children and families. Target 100% reviews, include participation code and 90% of meaningful participation.	March 2020	
	• Participation reviews for LAC still high – 99%.		G
7.1.4	Children/young people make use of independent visitors where appropriate. Evidenced by the use of independent visitors/advocates where request is documented in LAC reviews and pathway plans.	March 2020	
	• Meetings with Commissioning team and Coram Voice are back in place follow delay due to Covid and focus on having clear process in which to access advocacy ensuring teams are aware of statutory obligations.		G
7.1.5	Children/young people benefit from high quality IRO plans, which ensure that the voice of the child is heard. Evidenced by audit activity. Target 100% and IRO plans are of high quality.	March 2020	
	• Process in place and is working. New plans only included in target. HF to spot check plans throughout March. On track to be completed by March.		G
7.1.6	Feedback from created for young people in AROH panel to capture their understanding and satisfaction with the decision making process. Evidenced by changes to practice based on feedback received.	March 2020	
	• Young people's forms for AROH have been sent from Panel 26 May - awaiting outcome.		G

7.1.7	During pathway plan reviews, managers explicitly seek the views of young people on their satisfaction with accommodation. Evidenced by format of pathway plans changed.	April 2020	
	• Awaiting new referrals for Private Fostering. Huge launch of materials to raise awareness across multi agency platforms has taken place.		G

7.2 Outcome measures tools and surveys are systematically used to capture the voice of children and families and integrate the results into service planning and to ensure that we use that continue to develop and improve our practice.

	Outcome	Timescale	RAG
7.2.1	Audits demonstrate that social workers complete relevant outcome measures tools as appropriate. Evidenced by audit activity and Mosaic performance reports. Target – established in team level action plan.	Mar 2020	
	• CWD - Audit demonstrates use of appropriate tools – partially met. Will include quantitative data from Audits in next report. • CWD team audit shows that tools are being used, but this remains inconsistent in other teams.		G

7.2.2	Teams conduct satisfaction surveys with children & families as appropriate and meaningful for their service area. Evidenced by survey documentation. Target – established in team level action plan.	Mar 2020	
	• CWD survey to be issued in May 2020. (delays due to COVID). This will now be conducted in the second half of the year. • Care Leaver survey in May 2020. 37% response rate, 78% satisfied with support. Accommodation biggest area of concern. • Children in Care and CIN surveys to be carried out later this year.		G