Ofsted Recommendation	Action	Progress
Recommendation 1 required, an audit of all cases closed in the last 3 months and to risk assess all current cases; ensuring this leads to appropriate action to protect children effectively.	An independent audit of all 1,400 cases, using OFSTED criteria was carried out in November 2012 to January 2013. Key themes found through the audit mirror those found in the Ofsted inspection including frontline management decision and oversight; eligibility for service; lack of analysis or enquiry; supervision skills; interagency working, casework practice and recording. The summary report gives a good baseline position and will lead to further improvement actions. Immediate action on individual cases has been taken and individual members of staff have had feedback. As anticipated, the audit identified a range of quality of practice ranging from inadequate to outstanding. Actions in the Improvement Plan are already addressing areas found by the inspection and this audit, with the aim of ensuring all practice becomes at least good. As part of our improvement programme a comprehensive audit plan is in development through the Herefordshire Safeguarding Children Board. This will ensure that a robust quality assurance framework is in place and carried out, leading to reflection on and improvement of outcomes for children and young people, with learning informing improvements in practice.	The recommendation has been fully actioned.
Recommendation 2 required the authority to ensure that statutory child protection guidance is followed for all strategy discussions and S47 (child protection) enquiries.	Multi-agency workshops with frontline practitioners and managers, have taken place to agree a consistent approach to strategy discussions, strategy meetings and child protection enquiries. Procedures underpinning this new approach are written and being implemented.	This recommendation has been fully actioned
Recommendation 3 required the authority to ensure thresholds for child	The action taken is the same as in recommendation 2	This action has been fully

protection enquiries are consistently and appropriately applied, leading to sound assessment of risk and effective information sharing.		actioned.
Recommendation 4 required the authority to ensure that legal advice is consistently sought in a timely way and that this leads to timely legal planning meetings and interventions.	Minutes of previous meetings have been reviewed to ensure that all previous responses were timely and that there were no cases lacking a timely response. Further training for frontline staff and managers on developments related to the Family Justice Review, was undertaken on 14 <sup>th</sup> February, 2013. The Service Manager of the Planning and Review team will provide training on the Family and Friends and Connected persons guidance. All Public Law Outline cases are clearly tracked and the Legal Planning Panel have a maximum standard period of no longer than 4 months for a child to be in the legal planning phase. Legal planning panels are now happening on a weekly rather than fortnightly basis, and staff are aware that emergency panels can also be held at short notice to avoid any unnecessary delays. All staff have been reminded of the need to be timely, and amendments have been made to legal planning processes to tighten up decision making and timescales for action	This recommendation has been fully actioned
Recommendation 5 required the authority to ensure that children in need and those subject to child protection enquiries are visited regularly by social workers.	Frontline managers now have access to daily information alerting them to when visits are due related to children subject to child protection plans and looked after children. A Frameworki mechanism for monitoring how often children are seen between the initiation of a child protection concern and a child protection conference taking place is in development, with manual systems being used currently. These new systems tell us that in January, 2013 49.5% of all referred cases had a visit within 5 working days. The system will be further developed to report on frequency of pre-child protection plan visits for children subject to Child	This recommendation has been fully actioned. Due to the significant additional workload from September to November 2012, it was not possible to enhance the regularity of visits immediately. New enhanced team arrangements are in place in the FAST team which is now evidencing improvement

Recommendation 6 required the authority to ensure that inter-agency thresholds for statutory intervention are understood and applied by all agencies, leading to children and their families receiving appropriate and timely services in accordance with their assessed.	Protection Plans and the last three months indicate an improving trend following a significant dip in November 2012. The current percentage of children seen within 30 days of a snapshot end of month date is 55.9% (January 2013). Multi-agency workshops have reinforced the importance of this practice. Social Workers have been reminded of requirements, reinforced by simplification of recording and reporting in Fwi. Managers have been tasked with focusing on improvement in supervision and team meetings. Visits in other social work teams are improving month on month and are very close to target. This is being addressed through a number of areas of activity. The Levels of Need document has been widely circulated and used in a variety of single and multi-agency training for some time. To ensure and demonstrate a consistently high level of common understanding across all agencies will only be achieved over a longer time scale than set out in the recommendation. The Quality Assurance sub-group of the Herefordshire Safeguarding Children Board (HSCB) is establishing a rigorous programme of Single agency reviews and audits reporting back to the HSCB. A programme of themed multi-agency audits will test common understanding and application of Levels of Need through CAF, CIN and CP processes. The HSCB training strategy is being amended to ensure that understanding of 'Levels of Need' is a key priority in all safeguarding training.	This recommendation has been fully actioned.
<u>Recommendation 7</u> required the authority to improve the quality and consistency of management oversight and decision making to ensure that the child's experience, risk and their needs are well considered, and lead to appropriate and timely action.	External coaching and mentoring was delivered to frontline managers during November and December ahead of the introduction of a further professional development framework and support in place so that it can be delivered to frontline managers as they are recruited to the authority. A recruitment and retention strategy in relation to frontline managers has been agreed and a recruitment programme is underway with an expected timeline of having new recruits in place between May and July 2013. Reports on strengthening	This recommendation has been actioned. A more permanent stable management group needs to be in place as soon as possible to secure long term improvement.

	interim management arrangements in frontline teams have been completed and approved. Implementation is underway, and a restructure associated with recruitment activity is planned. Training for all frontline staff on the Risk and Resilience model of assessing families is taking place. This model provides a clear and consistent framework for analysing families where children may be at risk of harm. The Safeguarding Board will be considering the further extension of this across the partnership, following the training. Further file audits will demonstrate whether or not these actions impact on the quality of management oversight and decision making	
Recommendation 8 required the authority to ensure that supervision is regular, reflective, challenging and monitors social workers' and their managers' compliance with statutory guidance policy and procedure	A new supervision approach has been agreed and circulated, with clear guidance on how to record this on Frameworki in a simplified process. Audit will clearly benchmark improvements.	This recommendation has been fully actioned. A permanent management group needs to be in place to secure long term improvement.
Recommendation 9 required the authority to ensure that assessments are analytical, timely, comprehensive and up to date, and robustly identify needs, risks and protective factors leading to appropriate and timely action.	A training programme based upon The Risk and Resilience model has been commissioned and started. A training programme has been developed for delivery to frontline practitioners from February, 2013.	Action to address this recommendation has commenced.
Recommendation 10 required the authority to ensure that assessments of children and families are dynamic and that new information or concerns lead to a review of the current plan for the child	The response is as in recommendation 9	As above.

and when required additional action.		
Recommendation 11 required the authority to ensure that child protection case conferences effectively involve parents and children.	A new model called, 'Strengthening Families' is in development as an approach at child protection conferences to involve families. This will be operational from August, 2013. A consultation document for child protection conferences for children and parents has been completed in draft and will be operational in February 2013. A feedback letter will also be sent to parents.	All the building blocks for this recommendation are in place, this recommendation has not yet been completed.
Recommendation 12 required the authority to ensure that child protection and child in need plans are specific and measurable and focus on the key needs and risks and include robust contingency arrangements that are understood by parents as well as professionals.	The training programme referred to above is starting in February 2013 and is a focus area for new Advanced Practitioner group. Good practice from other Local Authorities is currently being considered to complete a new child protection plan format, which is more focussed and will make more sense for families. This links into the Strengthening Families approach and will be operational from August 2013.	As comment above
Recommendation 13 required the authority to ensure that core groups are regular and effectively develop and implement the child protection plan, and that these plans are monitored by child protection conferences.	Action has been taken to increase business support in order to build in systems to support core groups. The additional business support recruitment is underway with workers expected to commence in March 2013. Workshops on core groups were also held with staff in December 2012 and the performance monitoring system has also been amended.	All the necessary preparatory action has taken place, all the mechanisms will be in place by April 2013 and reports following this will indicate the success of the training and developments.
Recommendation 14 required the authority to ensure that first line managers have sufficient skills, knowledge and experience to effectively undertake their role.	ILM training for all first line managers, and recruitment strategy to ensure high calibre managers. See recommendation 7 and additionally, ILM training for all first line managers is in place.	See recommendation 7 and additionally, ILM training for all first line managers is in place.
Recommendation 15 required the authority to ensure that referrals are appropriately risk assessed and	Interim FAST arrangements approved for additional staff, and are being implemented resulting in smaller teams with a 1 to 4 manager : worker ratio and increased capacity at the contact	This action is therefore completed with further developments will take place

prioritised within the family assessment and safeguarding team (FAST).	desk. This will also address issues of timeliness. A specific Risk Assessment Model is being delivered via training commencing in February 2013. Meanwhile the Multi-Agency Safeguarding Hub is in development and will be implemented on a phased basis from April, with full implementation by July 2013. This will lead to more effective multi-agency risk assessment and priorisation.	this year to strengthen and embed these improvements.
Recommendation 16 required the authority to establish a robust quality assurance framework for child protection enquiries, which monitors the quality of decision making.	Performance management reporting is being developed in a number of areas, for example supervision and child protection visits as referred to above. Increased management capacity in FAST as referred to above, has been agreed. A quality assurance programme is being established that will see agencies presenting on their internal safeguarding performance and quality assurance monitoring activity at the HSCB Quality Assurance sub-group meetings. This will involve robust critical evaluation of what is presented and challenged where necessary. In addition, there will be a programme of multi-agency themed audits throughout the year 2013-14. A process of sampling service user views and incorporating them into quality assurance activity is being established. A service user involvement strategy 2012-14 has been produced.	All the necessary building blocks are in place for this recommendation although not yet embedded.
Recommendation 17 required the authority to ensure professionals from all agencies, including children's social care understand their responsibilities with regard to child protection and make use of escalation procedures if they believe that children are not receiving appropriate services.	The recently completed independent audit will inform what activity is required to develop the common understanding that all agencies have concerning their child protection responsibilities. Awareness of the 'Levels of Need' document and West Mercia Child Protection Procedures will be key priorities for the training strategy under development currently and next year's HSCB Business Plan. It is not currently possible to identify the extent to which the current escalation policy is being used and this is being addressed by the Quality Assurance sub-group of the HSCB so that use of the policy can be monitored.	This recommendation has been progressed through several strands of activity.
Recommendation 18 required the authority to ensure effective communication takes place between	Multi Agency Risk Assessment Committee (MARAC) and Multi Agency Public Protection Arrangements (MAPPA) arrangements have been clarified in November, 2012 and the new Multi-Agency	This action recommendation has been fully actioned.

probation services and children's social care services when making plans for offenders who have significant contact with children and young people known to them.	Safeguarding Hub (MASH) will also support this action.	
<u>Recommendation 19</u> required the authority to reduce the number of changes of social workers experienced by children and their families and improve the consistency and quality of direct work.	Three areas of work are addressing this recommendation, Firstly a 'Child's Journey' 6 week project is underway to analyse safeguarding and social work through Lean Systems Thinking in order to inform the organisational structure and practice. Secondly an improved career structure is being developed to complement the recruitment and retention plan to create greater stability within the workforce, and thirdly a risk and resilience plan is in development. The department is also piloting a social worker apprenticeship scheme with the aim of encouraging local people to join the department on a long term basis.	The range of actions taken will address this recommendation. However, until there is a more stable permanent workforce, the number of changes of social worker will remain an issue.
Recommendation 20 required the authority to ensure that the Herefordshire Safeguarding Children Board has sufficient, high quality information so that it can effectively monitor and challenge the effectiveness of child protection practice.	In terms of performance, this development is being managed by the development of a HSCB data set that informs the Board on how effective it is being in managing core responsibilities and priority areas of activity. The series of audits currently being managed will inform the Board on the quality of the work being done, as will the internal review processes being managed within all agencies.	Action has commenced for this recommendation.
Recommendation 21 required the authority to ensure that effective performance monitoring and quality assurance arrangements are put in place which includes sufficient qualitative information including service users' views, to enable a clear understanding of current practice and performance in child protection, including the impact of	The development of this framework will be informed by the current process of audits and reviews being undertaken. The Chair of the HSCB presented to The Shadow Board of the Children and Young Peoples Partnership Forum in December 2012 with a view to enabling Children and Young People to have a strategic development influence. A performance monitoring framework has been developed and was first presented to HSCB at their meeting on 28th January 2013. Not all measures are currently available and it is anticipated that this will continue to evolve. A quality	This recommendation has been actioned with a developing programme of work.

services on children and their families.	assurance programme has been established that will see agencies presenting on their internal safeguarding performance and quality assurance monitoring activity at HSCB QA sub-group meetings. There will then be robust critical evaluation of what is presented and challenge where necessary. In addition, there will be a programme of multi-agency themed audits throughout the year 2013-14. To date, there has been no service user involvement in the quality assurance process and the need for the experience of children and families receiving services to be included in quality assurance activity has been recognised. A process of sampling service user views and incorporating them into quality assurance activity is being established. A service user involvement strategy 2012-14 has been produced. A quality assurance framework incorporating service user feedback strategy pilot, to develop a series of tools to track user involvement is planned.		
Recommendation 22 required the authority to ensure that there is a robust auditing programme that includes a focus on the experience of the child and the impact and outcomes of service provision and that this leads to the identification of themes and clear action plans which are robustly monitored and implemented.	<ul> <li>Whilst a quality assurance programme was already in place prior to the inspection, a quality assurance programme is being established that will see agencies presenting on their internal safeguarding performance and quality assurance monitoring activity at HSCB quality assurance sub-group meetings. There will then be robust critical evaluation of what is presented and challenge where necessary. In addition, there will be a programme of multi-agency themed audits throughout the year 2013-14.</li> <li>The themes and action plans will be monitored through the Safeguarding Board.</li> <li>The first multi-agency audit took place in February 2013 and a report on this is in development.</li> </ul>	This recommendation been fully actioned.	has