Improvement Plan, April-May 2020

Introduction

The Improvement Plan, May 2020, has been updated in the context of the international Covid-19 crisis which is having a significant impact on some of the activity in the plan. The positives that have emerged are associated with assessing risk, an increased focus on professional curiosity, analysis of information and grip and control through management oversight. The whole service has been, and remains, acutely aware of the risks inherent in conducting social work via 'virtual means' and this has led to intense activity in satisfying ourselves that children and families are safe and ensuring the right circumstances trigger a home visit Given that large parts of a child's plan involve 'non-virtual' activities, including direct work, we are not in a position to fully comment on the progression of plans at this time. This is not to say that there is no activity in this area at all; it is partial and under regular review. Similarly, although there are assessments taking place in the broader sense, particularly around the content of virtual visits, it cannot be said that assessments in the traditional sense are being completed. Therefore, current performance in relation to assessments will not be scored in this document.

The uncertainty inherent in the current pandemic crisis is likely to have a significant impact on the service as restrictions are lifted. Whilst the full impact is not yet known on children's services departments across the country, the local view indicates that the following issues are likely to be prominent:

1. The emotional impact on staff from both a personal and professional level. A number of staff have experienced loss and bereavement in the family networks and friendship groups and some staff have also been infected themselves. In addition, there is a very real sense of a general increase professionally in the amount and nature of disturbing scenarios that individuals and teams have been dealing with. This, coupled with remote working, where providing direct support is that much harder and the amount of hours the majority have been working will impact on workforce resilience.
2. Open casework that the service held going into the Covid-19 period will require a degree of remedial action as soon as restrictions are lifted. This will be focused upon home visiting and direct work with children. It is sadly inevitable that some level of escalation will occur in some cases because of what is subsequently discovered or disclosed. We know the increased pressure felt by everyone will be magnified in some families and particularly those known to children's social care. Whilst a level of pragmatism can be used in evaluating which cases require the most attention, this factor will drive up activity levels after restrictions in society are lifted.
3. Casework that is new and started during this current period will require a level of home visits and direct work before assessments can be formally concluded and decisions about next steps, thresholds, immediate actions and plans can be made. This will increase activity levels.
4. Again, very sadly, it is inevitable that when schools re-start there will be a spike in referrals to children's social care. It is difficult to judge what the volumes or time period this spike will continue for, but this is likely to have an impact on the service.

The factors outlined above will not be unique to Buckinghamshire and so in addition to there being a local response by each local authority in terms of planning and mitigation, there will also be a need for a sector wide debate and decision making. In particular, it will be important for there to be a clear understanding of what can reasonably be expected of local authorities post restrictions. Specifically to our local circumstances of being in intervention, it will be very important to have a shared view of expectations over the next three, six and twelve months and how these will be measured.

Priorities

1. Address the recruitment and staffing issues in the Wycombe Assessment Team, Children in Care Teams and the Disability Service.
   This has largely been completed and there has been evidence of significant improvement as a result. Support for managers and robust management of performance issues with some staff in Wycombe Assessment team has resulted in, for example 100% of the cases dip sampled on 20 April from the team having up-to-date management oversight. There are some issues to address in terms of the quality of this oversight as it can be improved, but this coupled with the quality of transfers and strong performance data it indicates clear improvement. A new management team has been recruited into the Wycombe Children in Care Team, a number of longstanding Personal Advisors have chosen to move on and new appointments into these posts are about to be completed. This has resulted in a significant change in grip and control of the service, no unallocated work and improved interaction with care leavers. Care services cases dip sampled showed 90% had management oversight, with a number of examples of good practice. The disability service has, at the time of writing, two vacancies and no unallocated work. There have been numerous examples of good practice highlighted in relation to their virtual contact with children and young people, especially those with autism. It is likely that virtual interactions with some cohorts of young people will continue after restrictions are lifted, because of the greater impact they have.

2. Set minimum standards for virtual contacts and ensure these are met.
   The service took the initiative and set out expectations before any national guidance was published in respect of virtual visits. The expectation was based on the need to have video interaction with children and their families and to try and see children as much as possible on their own. Audit and case sampling activity demonstrates an upward trajectory and an acceptable level of performance. It should be noted that both activity levels and the quality of this activity has been considered. Individual workers, supervisors and team managers have responded well to this and there is evidence of remedial action being taken and advice acted upon. No children have been found to be at risk of immediate harm and no serious or widespread failures leading to children being harmed or likely to be harmed.

3. Set high expectations for frequency and impact of management oversight.
   As part of setting standards for virtual contacts the service insisted in significant management oversight on casework. This action was reflective of the increased risk. Consecutive dip sampling and audits (at the time of writing) have demonstrated strong performance in this area with very high percentage of cases dip sampled having recent management oversight recorded. In the first audit of cases (which was one week after the start of restrictions, 1 April) 42% of cases had management oversight. The second round of auditing, which was reported on 20 April, showed 82% of all cases had management oversight since 23 March.

Improvements and Changes

The current plan highlights a number of positive changes. There are also a number of areas which are still red because they are not where we would like them to be. Overall, the trajectory is positive and the dip sampling, quality assurance activity and oversight from Heads of Service all indicate that the outcomes achieved for children are improving albeit there is still a significant amount of improvement work to do.

The areas of the plan that have changed positively relate to management oversight and supervision, and chronologies. The evidence from quality assurance activity indicates that there has been a step change in both the frequency and the effectiveness of management oversight and supervision. The data return to the DfE shows that 87% of 2142 open cases had management oversight and/or supervision note on file in April 2020. In addition, our quality assurance activity on over 350 cases indicates that 67% of all management oversight and supervision recordings meet the necessary quality standards of addressing risk and being evaluative. There is more to do in this area and it continues to be subject to close scrutiny, but this is positive improvement. Before, the Covid-19 pandemic, significant work had taken place in relation to chronologies. This included embedding changes in the electronic social care recording system (LCS), using ASYE staff to create chronologies on open cases and team based improvement work on maintaining chronologies to the required standard. Quality assurance work that followed these activities demonstrated high levels of compliance and a positive response from the workforce. The changes to LCS now allow reporting on performance in relation to chronologies. This will be run again in October to ensure standards are maintained.

In the current circumstances and the prominence of virtual visiting to children and young people, the decision has been made not to specifically report on the quality of assessments and plans. The rag rating in relation to assessments and plans in this report is red for this reason. This is not to say assessment and planning has not been happening, it absolutely has. However, without direct contact with children and their families it is very hard to judge the quality of both. It is therefore thought to be prudent to not consider any improvement as having been made at this current time. The robust and intensive work of the social work teams to manage risk in the current environment has enabled there to be a significant focus on assessing risk and creating plans to manage presenting risk. This gives grounds for optimism in relation to both assessment and planning being improved. However, making any judgements on this will be reserved until such time as direct work can resume.

There are no new areas of concern or emerging weakness. Overall, there has either been improvement or no change. The circumstances in the Children in Care teams have improved in that there have been positive staffing changes in both Personal Advisor and manager roles. There is a brand new management team in Wycombe and we have successfully recruited a number of new Personal Advisors. The foundations are in place in both teams to make the improvements in practice and there are some early signs of impact. The staff in these teams are aware of the expectations upon them and weekly performance meetings are in place to ensure there is robust focus. It is too early to record significant improvements at this stage, more consistency and secure evidence is required. The service is aware of the need to work with pace and that by September there must be clear evidence of sustainable change.

1. First Response (MASH)

What do we want to see?

1. Professionals identify children and young people in need of help and protection. They make appropriate referrals to children's social care and are able to access social work advice. There is a timely and effective response to referrals, including out of normal office hours.
2. Professionals understand thresholds and this leads to children and families receiving effective, proportionate and timely interventions, which improve their situation.
3. Children and families experience child protection enquiries that are thorough and lead to timely action, which reduces the risk of harm to children.
4. Neglect, sexual abuse, physical abuse and emotional abuse are effectively identified and responded to. Children and young people who live in households, where at least one parent or carer misuses substances or suffers from mental ill-health or where there is domestic violence, are helped and protected.
5. Social workers recognise the factors that can make children more vulnerable and tailor their interventions appropriately. This includes, but is not limited to, disabled children, children who are privately fostered, children not attending school, vulnerable adolescents and children at risk of radicalisation or exploitation or becoming involved in gangs.
6. Children and young people who are missing from home, care or full-time school education (including those who are excluded from school) and those at risk of exploitation and trafficking receive well-coordinated responses that reduce the harm or risk of harm to them. For those who are missing or often missing, there is a clear plan of urgent action in place to protect them and to reduce the risk of harm or further harm.
7. Information-sharing between agencies and professionals is timely, specific, effective and lawful.

What needs to change?

1. Managers in the MASH ensure a timely and effective response to concerns regarding domestic abuse. The recently introduced daily triage meetings provide a forum for reviewing lower risk domestic abuse notifications from the police. These result in timely and appropriate decision-making about next steps, but no record is kept of these important decisions. This has the potential for the assessment of risk or need to not be informed by important historic information.
2. When children need protecting, the response is mostly effective, but the threshold for child protection intervention is not consistently applied. Although managers in the MASH recognise when children are at risk of, or have suffered from, significant harm, strategy discussions are not consistently held in a timely manner, which causes unnecessary delay and leaves children in situations of unassessed risk of potential harm. In addition, in a small minority of children's cases, not all relevant agencies are consistently engaged in strategy discussions, particularly health partners.
3. There is lack of consistent and effective management oversight and supervision.
4. Improve the quality of case recording to ensure that the reader can easily understand the application of thresholds as well as the presenting issues.

Ref	***Outcome***	***Lead***	***RAG***
1.1	Regular supervision takes place which promotes a reflective and analytical approach to children and families' needs. Supervision is utilised to increase workers' confidence, competence and their ability to think critically leading to improved decision making and effective interventions with children and families.	Team Manager and Assistant Team Managers	
1.2	Regular management oversight to be consistently evident in decision making and easily located on the child's case file.	Team Manager and Assistant Team Managers	
1.3	Cases consistently demonstrate an understanding of the history and take that into account when applying threshold.	Social Workers	
1.4	Analysis and recommendations consistently link to threshold guidance.	Social Workers	
1.5	All relevant agencies are consistently engaged in strategy discussions/meetings to inform identification of risks to children, when assessing the need for child protection intervention.	Head of First Response and Team Manager	
1.6	Staff understand and effectively apply threshold for child protection intervention to minimise delay in convening strategy discussions/meetings.	Head of First Response and Team Manager	

2. Assessment Teams

What do we want to see?

1. Assessments and plans are dynamic and change in the light of emerging issues and risks.

2. Assessments are timely and proportionate to risk, informed by research and by the historical context and significant events for each child.
3. Assessments lead to direct help for families if needed and are focused on achieving sustainable progress for children. Help given to families is proportionate to the level of need.
4. Information-sharing between agencies and professionals is timely, specific, effective and lawful.
5. Decisions are made by suitably qualified and experienced social workers and managers. Actions are clearly recorded. Systematic and effective management oversight of frontline practice drives child-centred plans and actions within the timescales appropriate for the child.
6. Children, young people and families benefit from stable and meaningful relationships with social workers. They are consistently seen and seen alone by social workers if it is in the best interests of the child. Practice is based on understanding each child's day-to-day lived experience. Children are safer as a result of the help they receive.
7. Children and young people are listened to. Practice focuses on their needs and experiences and is influenced by their wishes and feelings.

What needs to change?

1. Improve the quality of assessment and planning to ensure that risk is identified and responded to promptly, especially when risks escalate.
2. Ensure that assessments and plans identify the unique needs and experience of each individual child, particularly when they are part of a large family of brothers and sisters.
3. Assessments, including those of unborn children, are too descriptive of families' circumstances and some lack insight into the child's experience.
4. Ensure that care plans for children reflect their diverse needs and individual identities, and are realistic about achieving change. The quality of children's plans is too variable.
5. There is lack of consistent and effective management oversight and supervision.
6. Social workers do not demonstrate enough professional curiosity to find out what is happening for children to understanding what life is like for them.
7. The quality of children in need and child protection plans is too variable. Plans include too many actions, making it difficult for families and professionals to understand where to focus their attention. In addition, some plans do not explain the consequences or contingencies if the changes are not made.
8. The majority of care plans are not up to date or specific enough to understand the child's lived experiences or the risks and difficulties that they face.
9. Sometimes initial visits to children take too long and there can be gaps in visiting after initial intervention.

Ref	***Outcome***	***Lead***	***RAG***			
			Aylesbury	**Wycombe**	**Chilterns**	**Overall**
2.1	Regular supervision takes place which promotes a reflective and analytical approach to children and families' needs. Supervision is utilised to increase workers' confidence, competence and their ability to think critically leading to improved decision making and effective interventions with children and families.	Team Managers and Assistant Team Managers				
2.2	Regular management oversight to be consistently evident in decision making and easily located on the child's case file. Management oversight should demonstrate the clear rationale, assessment of risk and evidence base for decisions, including the anticipated impact on the child.	Team Managers and Assistant Team Managers				
2.3	Where required, cases consistently have succinct, clear chronologies and case summaries which support the reader to understand the child's current circumstances quickly.	Social Workers				
2.4	Assessments effectively identify and analyse risks and needs including current and historic factors, are individualised for each child in the family, take account of the child's identity and routinely consider parental capacity.	Social Workers				
2.5	Robust child-centred plans are SMART, reflect the needs identified in the assessment, timely and reviewed to mitigate against drift and delay.	Social Workers				

3. Help and Protection

What do we want to see?

1. Children in need of help and/or protection have a plan setting out how they will be helped, how their needs are going to be met and how risk will be reduced within the timescales appropriate for the child. If families refuse to engage, clear contingency plans are in place. These are based on the assessment of need and risks to the child.
2. Decisive action is taken to avoid drift and delay. Plans and decisions are reviewed regularly.
3. Alternative decisive action is taken if the circumstances for children do not change and the help provided does not meet their needs, or the risk of harm or actual harm remains or intensifies.
4. Children who need protection are subject to a child protection plan that identifies the work that will be offered to help the family and the necessary changes to be achieved within appropriate timescales for the child or young person
5. Plans address all the identified needs from assessments. They are clear and easily understood. Families understand what is expected of them, and others, and by when and what will happen if they fail to make the expected progress
6. Children, young people and families benefit from stable and meaningful relationships with social workers. They are consistently seen and seen alone by social workers if it is in the best interests of the child.
7. Children and young people are listened to. Practice focuses on their needs and experiences and is influenced by their wishes and feelings. Children, young people and families have timely access to, and use the services of, an advocate. Feedback from children and their families about the effectiveness of the help, care or support they receive informs practice and service development.
8. Information-sharing between agencies and professionals is timely, specific, effective and lawful.

What needs to change?

1. Where stable, frontline managers are in place it is bringing increased rigour in ensuring appropriate supervision and case direction takes place. There is more to do to ensure managers consistently identify and address drift, delay and poor practice.
2. Significant action has been taken to improve the quality of assessments, but too much variability remains. Assessments often lack sufficient analysis to adequately identify need, manage risk and take effective decisions regarding next steps.
3. There is lack of consistent and effective management oversight and supervision.
4. Assessments do not always capture the impact of identity, culture and diversity on children and families' experiences including family dynamics and history.
5. There is inconsistency in the quality and effectiveness of plans within Help and Protection. More work needs to take place to ensure plans focus on clear, time bound interventions aligned to assessed need. Plans should be closely monitored with regular analysis that considers the impact of intervention on improving outcomes.
6. Contingency plans are not always in place, making it difficult for parents and professionals to be clear about the consequences should progress not be achieved.
7. Social workers visit children regularly and in some cases build effective relationships with them, taking time to understand their experiences; however practice remains inconsistent with not all children visited in accordance with their needs and visits are not always appropriately recorded.

Ref	***Outcome***	***Lead***	***RAG***			
			Aylesbury	***Wycombe***	***Chilterns***	***Overall***
3.1	Regular supervision takes place which promotes a reflective and analytical approach to children and families' needs. Supervision is utilised to increase workers' confidence, competence and their ability to think critically leading to improved decision making and effective interventions with children and families.	Team Managers and Assistant Team Managers				
3.2	Regular management oversight to be consistently evident in decision making and easily located on the child's case file. Management oversight should demonstrate the clear rationale, assessment of risk and evidence base for decisions, including the anticipated impact on the child.	Team Managers and Assistant Team Managers				
3.3	Cases consistently have succinct, clear chronologies and case summaries which	Social Workers				

	support the reader to understand the child's current circumstances quickly.					
3.4	Robust child-centred plans are SMART, reflect the needs identified in the assessment, timely and reviewed to mitigate against drift and delay.	Social Workers				
3.5	Assessments are routinely updated every six months for those under 1, every 12 months for those over 1 and whenever there is a significant change in a child's circumstances. This includes those on CIN plans.	Social Workers				

4. Children in Care and Care leavers

What do we want to see?

1. Children and young people become looked after in a timely manner and in their best interests. Decisions that children should be in care are based on clear, effective, comprehensive and risk-based assessments, involving, if appropriate, other professionals working with the family.
2. All agencies and professionals work together effectively to reduce any unnecessary delay in receiving support and achieving permanence for children.
3. The wishes and feelings of children, and those of their parents, are clearly set out in timely and authoritative assessments and applications to court. Assessments of family members as potential carers are carried out promptly to a good standard.
4. Children's care plans comprehensively address their needs and experiences, including the need for timely permanence. Children's plans are thoroughly and independently reviewed with the involvement, as appropriate, of parents, carers, residential staff and other adults who know them. Plans for their futures continue to be appropriate and ambitious.
5. Children are seen regularly and seen alone by their social worker and children understand what is happening to them. Children have positive and stable relationships with professionals and carers who are committed to protecting them and promoting their welfare.
6. Children in care and care leavers are helped to understand their rights, entitlements and responsibilities. Children and young people have access to an advocate and independent visitor when needed. Care leavers are well-informed about access to their records, assistance to find employment, training and financial support.
7. The local authority celebrates the achievements of children in care and care leavers. It shows it is ambitious for their futures.
8. Children in care and care leavers are in good physical and mental health, or are being helped to improve their health. Their health needs are identified and met.
9. Children and young people make good educational progress at school or other provision since being in care. They receive the same support from their carers as they would from a good parent.
10. Care leavers have timely, effective pathway plans (including transition planning for children in care with learning difficulties and/or disabilities). These plans address all young people's needs. Reviews of plans for care leavers are thorough and involve all key people, including the young person, who understands their pathway plan and contributes to its development.
11. Information-sharing between agencies and professionals is timely, specific, effective and lawful.

What needs to change?

1. The detailed knowledge individual social workers have about their children is not always reflected in the information recorded on case files.
2. Poor historical leadership in both CiC teams has resulted in gaps in knowledge and practice amongst the workforce.
3. There is lack of consistent and effective management oversight and supervision.
4. Actions to address poor practice has led to turnover of staff and caseload pressures. This has not assisted in ensuring that there is consistency and good planning for our children and young people.
5. Achieving consistent levels of compliance has been and remains variable.
6. Audits and case sampling indicate that there needs to be improvements in understanding the history (chronologies), current assessments, permanency tracking and the ability to plan effectively. This is particularly apparent with older long term LAC.
7. Continue to improve the performance to ensure that the health needs of children in care are met through timely health assessments and care leavers have access to their health history.

8. Joint work with CAMHS has and is improving, particularly in relation to local LAC. Challenges remain in some instances for out of county LAC.
9. Responses to changing circumstances of children and young people are not always robust or timely enough.

Ref	***Outcome***	***Lead***	***RAG***		
			North	***South***	***Overall***
4.1	Regular supervision takes place which promotes a reflective and analytical approach to children and families' needs. Supervision is utilised to increase workers' confidence, competence and their ability to think critically leading to improved decision making and effective interventions with children and families.	Team Managers and Assistant Team Managers			
4.2	Regular management oversight to be consistently evident in decision making and easily located on the child's case file. Management oversight should demonstrate the clear rationale, assessment of risk and evidence base for decisions, including the anticipated impact on the child.	Team Managers and Assistant Team Managers			
4.3	Cases consistently have succinct, clear chronologies and case summaries which support the reader to understand the child's current circumstances quickly.	Social Workers			
4.4	The child or young person's circumstances are reflected in updated assessments prior to each review or equivalent. In the event of a trigger event (such as first missing episode or contextual safeguarding incident) the assessment is updated.	Social Workers			
4.5	Workers have sufficient knowledge and understanding of statutory procedures and compliance.	Head of Children in Care and Team Managers			
4.6	Effective direct work that is linked to the plan and current assessment of need must be evident, with impact on outcomes recorded on the child's case files.	Social Workers			
4.7	Health needs of children in care are meet through timely health assessments and care leavers have access to their health history.	Social Workers			
4.8	Monitoring and visiting arrangements to all children looked after in placements with parents are sufficiently robust to ensure their safety and progress until these arrangements are formally resolved.	Team Managers and relevant Head of Service			
4.9	An effective procedure for accommodating and supporting unaccompanied asylum-seeking children, including those who arrive outside office opening hours, to ensure that their immediate needs and vulnerabilities are appropriately assessed.	Service Director and Head of Children in Care			
4.10	Children in care have a clear permanency plan by their second CLA review.	Social Workers, Team Managers and Independent Reviewing Officers			

5. Child Protection Advisers and Independent Reviewing Officers

What do we want to see?

1. Independent Reviewing Officers (IROs) and Child Protection Advisers (CPAs) offer strong, positive challenge via flexible and supportive actions to drive forward good practice and bring effective, timely support which prevents unnecessary drift and leads to improved outcomes for children and families.
2. CPAs make safe decisions at conferences and ensure measures are put in place to effectively safeguard children and young people. There is evidence of parental and child participation (where appropriate) within conferences, documents and case recordings.
3. CPAs work closely with professionals and families to effectively quality assure initial arrangements for and continued tracking against the child protection plan, overseeing and scrutinising outcomes for the child.
4. IROs apply robust scrutiny which impacts the care planning and review process for each child. IROs are strong advocates for children and young people and work diligently to ensure the child's wishes and feelings are given full consideration and that the care plan fully reflects the child's current needs. They work

collaboratively with children in care teams to prevent drift and delay and escalate, when necessary, to ensure positive outcomes for children.

5. Plans to make permanent arrangements for children and young people are effective and regularly reviewed by IROs.
6. IROs challenging any shortfalls in care plan actions and checking the progress of children in between their statutory reviews. They ensure that children are seen and supported to contribute to their review and to influence planning.
7. LADO expertise and advice is available to support other professionals in determining the best steps to take next where there are allegations or concerns about professionals or adults working with children. There is a timely and effective response to referrals and allegations.

What needs to change?

1. Evidence indicates that in the main, IROs and CPAs develop positive relationships with and detailed knowledge of their allocated children but they do not yet consistently challenge deficits in practice effectively. This means outcomes for children have, in too many cases, remained poor.
2. Limited management oversight across operational teams has led to drift, delay and poor practice in care planning. IROs and CPAs need to work more effectively to help secure the right outcomes for children and young people.
3. More work is required to ensure the resolution process for IROs is effective, perceived as constructive and results in proactive, timely responses positively impacting outcomes for children.

Ref	***Outcome***	***Lead***	***RAG***		
			CPAs	***IROs***	***Overall***
5.1	Regular supervision takes place which promotes a reflective and analytical approach to children and families' needs. Supervision is utilised to increase workers' confidence, competence and their ability to think critically leading to improved decision making and effective interventions with children and families.	Team Managers			
5.2	Regular management oversight to be consistently evident in decision making and easily located on the child's case file. Management oversight should demonstrate the clear rationale, assessment of risk and evidence base for decisions, including the anticipated impact on the child.	Team Managers			
5.3	Effective care plans and permanency plans aligned to the individual needs of the child/young person.	IROs			
5.4	Active participation from IROs in the updating of assessments prior to each children in care review.	IROs			
5.5	IRO contributions are focussed on improving outcomes for children and young people. Their level of expertise adds value to both casework and social worker development.	IROs			
5.6	IRO oversight considers both the health and educational outcomes of children in care and care leavers	IROs			
5.7	Robust child-centred plans that are SMART, reflect the needs identified in the assessment, timely and reviewed to mitigate against drift and delay.	CPAs/IROs			
5.8	Expert advice in relation to child protection work is consistently evident in case recording and the interventions of CPAs evidence impact on outcomes for children and young people.	CPAs			
5.9	Records of LADO strategy meetings reflect how the integrity of the investigation will be maintained and the decision making of what information to share with whom and when.	LADO			

6. Overarching themes

Ref	***Outcome***	***Lead***	***Timescale***	***RAG***
6.1	A more stable and permanent workforce than the previous quarter, reducing our reliance on agency workers from 30% (October 2019) to 25% by April 2020 and 20% by September 2020.	HR Business Partner	April 2020	

6.2	What we expect good social work practice to look like in Buckinghamshire features in recruitment, induction and appraisal procedures.	HR Business Partner	February 2020	
6.3	First and second line managers have the knowledge, skills and ability to plan, direct and shape assessments that enable robust plans and strong risk management to be created.	Service Director and Heads of Service	February 2020	
6.4	A fit for purpose electronic recording system, processes and workflows that support good social work practice.	Service Director and equivalent from ICT and Business Intelligence	April 2020	
6.5	All performance management information is based on accurate data, and that managers and leaders use it effectively to measure and inform service improvements.	All CSC workforce and Business Intelligence	April 2020	
6.6	A co-orientated, multi-layered approach to auditing that provides a service wide view of the quality of practice.	Head of Quality, Standards and Performance and SMT	December 2019	Completed
6.7	Case files demonstrate good and effective knowledge of contextual safeguarding which is reflective of a skilled and aware workforce.	Service Director and Heads of Service	February 2020	