Adoption Actions

	Recommendation	Management response/ action plan	Follow-up observations/audit testing	Further action required	Update March 2014
1	The Post Adoption Team should ensure that Adoption Allowance Agreements are in place for all adopted children to ensure that allowances are appropriately awarded to adoptive families. (**Medium priority**)	a) All adoption allowance files to be reviewed to identify those files where an agreement is not in place and then for the agreement to be signed. b) Procedure to be rewritten and strengthened to ensure that payments are not authorised until the agreement is signed.	a) Adoption Allowance agreements are now requested to be signed by families on an annual basis; the same time the financial commitments are confirmed. From a sample of ten families, one agreement had yet to be signed and returned (originally requested in September 2012). Payments had not ceased for this family although they had exceeded the required timescales by ten months. b) Although the Adoption Allowance guidance for families was updated in February 2012, and provides information on when an allowance is paid, rates, payment and the annual review, work is currently ongoing to develop the internal procedural guidance for the service.	a) Implemented; and b) Partly implemented. **Revised management response and implementation deadline:** Internal procedures are in development" expected to be completed by January 2014.	Procedures have been amended and implemented ensuring that all allowances have a signed agreement. The revised Adoption Allowance Procedures reflecting this are in the final stages of development

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2	The Post Adoption Team should: a) Consider reviewing the annual declarations to ensure they are up to date and that they reflect all conditions associated with the allowance; and b) Review guidance to specify the minimum conditions of employment. (**Medium priority**)	This proposal is agreed.	a) The annual declarations have been reviewed and updated to reflect the conditions of funding, and any associated recoupment of monies in the event of either a reduction in allowance or lack of documentation; and b) As per Recommendation 1b).	a) Implemented; and b) Partly implemented. **Revised management response and implementation deadline:** Internal procedures are in development expected to be completed by January 2014.	Clear information is provided in the revised procedures which are almost completed to recipients of the allowance that any changes in circumstances must be reported and that overpayment will be recouped in the event that relevant information has not been provided.

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3	Proactive checks should be performed on a termly basis to ensure the child continues to attend the stated school/ college. This check could be limited to those children where schooling is not a statutory requirement (i.e. for those children over 16 years old). (**Medium priority**)	It is noted that the post adoption team have access to the relevant database. This is primarily an admin task and there will need to be discussions with ICT to ensure that admin staff can access the data base. A further complication is that at least 25% of the children placed for adoption are placed outside the Lancashire area where the service will not have access to the data base. Management support the concept of more rigorous scrutiny of statements provided by adopters and will consider how this can best be achieved.	The service will be issuing 16-18 education providers with a declaration in August 2013 to confirm that the children currently attend their establishment.	Partly implemented. **Revised management response and implementation deadline:** Internal procedures are in the process of development expected to be completed by January 2014. The procedures will incorporate the requirement to obtain a declaration from adopters in relation to an adopted young person continuing in education.	School/college declarations are sent out routinely in all cases where relevant. Evidence of attendance is required and payment of the allowance is placed on hold if this is not received within the agreed timescale.

	Recommendation	Management response/ action plan	Follow-up observations/audit testing	Further action required	Update March 2014
4	Consideration should be given as to when the annual declarations are issued to ensure up to date information is received from the adoptive families. (**Low priority**)	The issue is whether we change the date for all children or do a recheck of children aged 16+ receiving the allowance which is a relatively small number. Management propose to recheck information for children aged 16+ in September to determine if the educational placement is as forecast in February.	Families are now reviewed on an annual basis by the Business Support Team. The central monitoring by the team also ensures that those children approaching a significant age specified within the guidance (i.e. 18) are identified at the beginning of the financial year and considered appropriately. From the sample tested, all families had been requested for documentation to support their financial assistance.	Implemented.	Has been implemented in full

	Recommendation	Management response/ action plan	Follow-up observations/audit testing	Further action required	Update March 2014
5	All financial assessments completed by families should include a clause informing the families that the council may recoup allowances in the event that evidence cannot be provided to support the claim. (**Medium priority**)	This is agreed.	Families are now made aware of potential claw back in the event of non-compliance through the annual declaration. From the sample tested, all families had received such a letter. However, it was evident that: a) Four families from the sample of 15 had not sent their supporting documentation within the stated timescales, and payments had not ceased or been recouped; and b) Following a recalculation in the financial assessment, the resultant decrease in funding for two families had not been recouped. Also see Audit Finding 13.	Implemented.	Payments are ceased in all cases in the event that recipients have not returned the required documentation within the required timescales.

	Recommendation	Management response/ action plan	Follow-up observations/audit testing	Further action required	Update March 2014
6	The Finance Team should consider requesting a P60 from the adoptive families to enable the council to calculate the allowance more accurately. (**Medium priority**)	This is agreed. In consultation with Finance, it was agreed that 3 pay slips would be requested and if self employed, a copy of the annual audit documentation.	The service now operates an annual review for each family, but the timing throughout the year varies. We reviewed a sample of financial assessments to ensure the calculations were held on each file. For one of the sample of 15, we could not evidence the financial assessment as it was not held on file.	Partly implemented. **Revised management response and implementation deadline:** The revised procedure will include reference to the fact that a copy of the financial assessment must be retained on the file. The Adoption Service Manager will issue a reminder to business support officers responsible for implementing the adoption allowance scheme to ensure that a copy of the assessment is retained on file.	All financial assessments are held on file

	Recommendation	Management response/ action plan	Follow-up observations/audit testing	Further action required	Update March 2014
Residence Order Allowances/ Special Guardianship Orders					
7	The service should ensure that a regular review of allowances is undertaken to ensure the needs of the child and/ or families are met. (**High priority**)	This is agreed. Discussions between Finance, Adoption Service and Children Social Care to be held to determine process and accountability. There should be no need for social workers to visit families for this purpose alone.	From the sample of ten SGO allowances undertaken, one child received an enhanced payment due to the level of care they required. Such enhancements should be reviewed by Children's Social Care every two years; however this had not been done in this case.	Not implemented. **Revised management response:** The Financial Administration Team Manager is to provide a list of all enhancements to the Acting Deputy Head of Children's Care for review, with the possibility of ceasing overdue reviews with immediate effect. The functions of Protocol will also be examined to ensure that either the Social worker is prompted to perform a re-assessment, or that a report can be run on a regular basis to determine all reviews requiring a re-assessment. **Responsible Officers:** Financial Administration Team Manager and Acting Deputy Head of Children's Care **Implementation Date:** March 2014	Relates to SGO Allowances which are managed by CSC and not the Adoption Service CSC update - Implemented – all historical ROA and SGO allowances have been reviewed. The protocol has been agreed with finance for annual reviews with an automatic cessation of payment and re-assessment for change in circumstances and failure by carers to respond to review notices.

	Recommendation	Management response/ action plan	Follow-up observations/audit testing	Further action required	Update March 2014
8	All annual declaration forms should be amended to reflect the implications of not declaring up to date information, and the possibility of recoupment. (**Medium priority**)	This is agreed.	From the sample of allowances tested, all declarations had been updated to reflect the need to declare valid information, with the possibility of recoupment if this is not complied with. However, from the sample of 20 SGO/ ROA families tested, two families had last submitted their declarations in 2011, without recoupment. Also see Audit Finding 14.	Implemented.	Has been implemented in full
9	The service should consider performing proactive checks on the location of the children. For example, with schools, health authorities etc. Such information may be obtained from within the council. (**Medium priority**)	This is agreed.	There was no evidence to support that such checks had taken place. From the allowance testing, we identified a miscoded payment. Through further investigation, the adoption allowance should have been coded as a boarding out payment.	Not implemented. **Revised management response:** Agreed that the Financial Administration Team Manager will ensure that all allowances accurately reflect the status of the child so that they are coded correctly in Oracle. This process will be implemented for the introduction of Protocol. **Responsible Officer:** Financial Administration Team Manager **Implementation date:** March 2014	Require action by the Financial Management Team as opposed to the Adoption Service CSC update – Implemented annually

	Recommendation	Management response/ action plan	Follow-up observations/audit testing	Further action required	Update March 2014
10	The service should consider implementing a consistent policy for families who do not return the annual declaration, and stopping allowances in such an event. (**Medium priority**)	This is agreed.	The annual declarations now state that allowances would cease if not returned. From the testing conducted in Recommendation 8, this did not happen, and allowances continued to be paid.	Not implemented. **Revised management response:** Families will continue to be sent initial and reminder annual declarations. If the family does not respond within 28 days, payments will cease automatically and review can be requested **Responsible Officer:** Financial Administration Team Manager **Implementation date:** Immediate effect	Require action by the Financial Management Team as opposed to the Adoption Service
11	Appropriate authorisation for SGO/ ROA allowances should be sought prior to approval. (**Medium priority**)	This is agreed.	For one of the sample of ten ROA allowances tested, the ROA6 form ("*Permanence Panel - Request for Approval of Post Residence Order Support*" form) had not been signed by either the Team Manager or Area Manager; only the Social Worker.	**Revised management response:** Agreed. The Head of Children's Care will remind staff of the importance to gain all relevant approval prior to submission. **Responsible Officer:** Head of Children's Care	CSC update – Implemented

	Recommendation	Management response/ action plan	Follow-up observations/audit testing	Further action required	Update March 2014
12	The service should ensure they receive and retain a copy of all SGA3 forms prior to approval for payment. (**Medium priority**)	This is agreed.	For one of the sample of SGO allowances tested, payments had begun in May 2013 prior to receiving the SGA3 form.	Partly implemented. **Revised management response:** Agreed. The Acting Deputy Head of Children's Care will remind staff of the importance to gain all relevant approval prior to submission. **Responsible Officer:** Head of Children's Care	CSC update – Implemented

From the follow up observations, it was identified that a number of controls previously operating effectively, did not continue to do so. We have reported these issues separately from the above recommendations.

	Audit findings	Implications	Residual risk	Agreed actions, responsible officers and implementation dates
Adoption Allowances				

13	It was evident that: a) Four families from the sample of 15 had not sent their supporting documentation within the stated timescales, and payments had not ceased or been recouped; and b) Following a recalculation in the financial assessment, the resultant decrease in funding for two families had not been recouped.	Allowances become harder to recoup in the event that they may have been incorrectly claimed.	Medium	In line with the guidelines introduced in 2013, payments will cease to families without the necessary supporting documentation in place. **Responsible Officer:** Financial Administration Team Manager **Implementation date:** Immediate effect.
Residence Order Allowances/ Special Guardianship Orders				
14	From the sample of 20 SGO/ ROA families tested, two families had last submitted their declarations in 2011, without recoupment.	Allowances paid may be inaccurate.	Medium	Payments will cease to families without the necessary declarations in place. **Revised management response and implementation deadline:** Families will continue to be sent initial and reminder annual declarations. If the family does not respond within 28 days, payments will cease automatically and review assessment offered. **Responsible Officer:** Financial Administration Team Manager Implemented.

Independent Reviewing Officers Actions

	Recommendation	Management response/ action plan	Follow-up observations/audit testing	Further action required	Update March 2014
1	Starred recommendations should be:	Senior IRO's have been reminded of their responsibility to update the Problem	From the testing conducted on the 2012/13 starred recommendations log, it was found that:	Not implemented. **Revised Action 1**	Starred recommendations are now fully detailed in the problem resolution log.

	Recommendation	Management response/ action plan	Follow-up observations/audit testing	Further action required	Update March 2014
	a) Fully documented in the Problem Resolution Log to ensure actions are easily identifiable and implemented in a timely manner; b) Discussed on a more formal basis with senior management to ensure all cases have been actioned appropriately; and c) Reported to SMT on a regular basis, with all current outstanding starred recommendations clearly identified/ explained. **(High priority)**	Resolution Log. This will be randomly checked through supervision. A quarterly IRO quality assurance report will be produced detailing all starred recommendations and their progress/outcome and reported to the District/IRO Cluster Meetings and the Safeguarding, Inspection & Audit SMT. Starred recommendations are included in the IRO Annual Report, which is reported to DLT, the LSCB, the Children's Trust and the Corporate Parenting Board and is also a public document.	a) Not all actions had been fully documented or implemented in a timely manner. Through confirmation with the Quality & Review Manager, all actions had been implemented, however the log did not reflect this; b) Although the starred recommendations were raised as part of the Annual Report, the number and status of the actions did not reconcile to the log, therefore suggesting that management may not be aware of all cases; and c) Starred recommendations are raised as part of the monthly SMT meetings, however it was agreed it would be raised to management as part of the Quarterly Assurance Report which has not been produced.	The service should continuously update the 2013/14 starred recommendations log to ensure that: a) All actions are easily identifiable, implemented in a timely manner and agree to reported performance data; and b) Reported to senior management as part of a Quarterly IRO Quality Assurance report. **Implementation date**	One Quality and Review Manager now has lead responsibility for overseeing and auditing starred recommendations on a monthly basis. Discussions take place with the responsible Senior Manager regarding any outstanding starred recommendations. This arrangement commenced in November 2013. Recording of audit activity is retained in the IRO Team, Starred Recommendations folder on the 'R' Drive. Starred recommendations are a standard item on the agenda of monthly Quality & Review Management team meetings. Starred recommendations are also reported to SMT meetings. Work has commenced in respect of a Quarterly IRO report. The first report will be completed in March 2014.
2	The Safeguarding Manager should agree a series of management controls that need to be implemented on a regular basis. These controls should be documented and	Completed. Regular monitoring of management controls is undertaken through supervision of the Senior IRO's and monitoring of reports produced. Work shadowing also takes place to quality assure practice and dialogue takes place with District	There are now standing agenda items within supervision meetings to discuss starred recommendations and caseloads within the team. For all supervision notes sampled, it was evident they were discussed and relevant action taken by the Directorate Safeguarding Manager	Implemented.	

	Recommendation	Management response/ action plan	Follow-up observations/audit testing	Further action required	Update March 2014
	monitored as part of future supervision meetings. Controls should be designed to ensure that any significant issues are detected within the service. **(High priority)**	Managers in respect of performance.	where necessary.		
3	The Children's Social Care Teams should: a) Be reminded to provide the IROs with the relevant information/ reports prior to a CP Conference to ensure they can review the case appropriately; and b) Produce reports identifying outstanding LAC reviews, with CSC Team Managers addressing any actions arising. **(Medium priority)**	This issue has been highlighted in the CLA IRO Annual Report and will be raised again at the Children's Social Care SMT. Monitoring of this issue will continue via the IRO/District Cluster Meetings. Further discussions will take place between the Directorate's Safeguarding Manager and the Head of Children's Social Care to interpret the statutory legal obligations of the IRO Handbook, and set out detailed proposals for the CSC Manual.	From the testing undertaken, it was found that: a) Only 50% of the cases sampled had the ICPC reports completed by the Social Workers more than 3 days prior to conference; and b) From a sample of 10 looked after case reports, only two had been approved by the Team Manager within reasonable timescales.	Not implemented. **Revised Action 2** The Head of Children's Social Care should remind staff of the importance to complete and authorise reports within statutory timescales. **Implementation date**	Teams briefed: a) but impact of service demand upon capacity. b) Liquid Logic will facilitate activity to produce reports – no facility currently. Liquid Logic going live in March c) Work being undertaken to develop a CP document portal which reminds staff of the need to complete social work report to CP conferences in order that this can be shared with other professionals including the IRO. A tentative date for this to go live as May 2014.
4	Once the service is operating at capacity, the IROs should be reminded to produce the full written record of the case and the QA	All IRO's are aware of this requirement and this will continue to be monitored via the Senior IRO's through supervision. As outlined above there are presently capacity	From the sample of 10 cases tested, we looked at both the initial and second review taking place, and found that 90% had taken place within the correct timescales, but only 40% had	Not implemented. **Revised Action 3** IROs should be reminded of the importance of the review taking place and	Caseloads continue to rise due to the increase in the number of CLA and children subject to a CP Plan. DLT approved a request to make two temporary IRO posts

	Recommendation	Management response/ action plan	Follow-up observations/audit testing	Further action required	Update March 2014
	forms within the required timescales, and the relevant performance achieved reported to SMT. **(Medium priority)**	issues as a result of a number of IRO vacancies. Efforts are being made to address this as well as restructuring of the IRO Service to reduce caseloads.	been written within the timescales. It is acknowledged that although the service will soon be operating at full capacity, the number of children becoming looked after has increased significantly, therefore impacting on IRO caseloads. See Recommendation 10 for QA form actions. Performance has been reported to the SMT as part of the 2012/13 Annual Report.	completing written records within required timescales. **<u>Implementation date</u>**	permanent in October 2013. There are currently 4 FT IRO vacancies in the team which impacts on performance in this area. Appointments have been made to two of the posts. Staff will take up these positions in April/May 2014. Interviews are taking place in February in relation to the remaining FT vacancy. External recruitment is being progressed in respect of one FT temporary post. Two agency Grade 9 IROs have been appointed pending recruitment to the vacancies. A periodic sample audit will be completed to monitor compliance with recording requirements and these are reported to DLT on a quarterly basis.
5	Once the service is operating at capacity, they should consider the allocation of cases in accordance with the IRO Handbook. This would enable the service to utilise SMART ways of working, for example, district-based portfolios.	As outlined above there are presently capacity issues as a result of a number of IRO vacancies. This has been recognised by DLT and 4 additional IRO posts have been created (2 temporary and 2 full-time). Recruitment to vacancies is ongoing and a restructuring of the IRO Service is being undertaken in order to reduce	Due to caseloads still being substantially over the stated thresholds in the IRO Handbook, Quality & Review Managers still have to consider caseloads alongside locality for the IROs. The Quality & Review Managers ensure that: a) The same IRO is kept for those CP cases who then become looked after;	Implemented.	

	Recommendation	Management response/ action plan	Follow-up observations/audit testing	Further action required	Update March 2014
	(Medium priority)	caseloads.	b) Caseloads are kept up to date and used as part of the allocation process; and c) Locality is reviewed to allocate the relevant IRO. From the testing performed, IROs have been allocated in line with the current policy.		
6	The service should consider the outcomes of the centralised booking system pilot, and implement a more consistent approach to case allocation. **(Medium priority)**	Agreement made to pilot a centralised booking system for child protection conferences, with this being attached to the Mobile Minute Taking & Transcription Service (MMTTS). Review will take place 6 months after implementation date. Discussions are taking place re the creation of a new post within the service which will manage this area of work.	For the sample of ten CP conferences tested, all had been recorded and set up within the centralised booking system; now managed by the recently introduced administration post.	Implemented.	
7	The Children's Social Care teams should be reminded that: a) The appropriate reports/ processes are discussed with the family 3 working days prior to CP Conferences; and b) Team Manager approval should be sought prior to the	The IRO handbook relates to CLA IRO activity and not the Safeguarding IRO role as outlined under the issue section. However, the timescale for the sharing of child protection reports outlined is correct. This issue has been highlighted in the safeguarding IRO Annual Report and will be raised again at the Children's	From a sample of ten CP conferences, it was found that: a) Only five of the ten cases had been recorded in ISSIS as being discussed with the parent more than 3 days prior to conference. For those children over the age of ten (six of the sample), only two had been spoken to by the Social Worker prior to conference; and b) Team Managers had	Not implemented. **Revised Action 4** The Children's Social Care Teams should be reminded to discuss all conference reports with the families within required timescales, and for Team Managers to review and approve reports prior to	Briefed January 2014 but service demand impacts upon capacity. This was further reiterated at briefing launches outlining changes to CP business processes. See above regarding progression of CP Portal.

	Recommendation	Management response/ action plan	Follow-up observations/audit testing	Further action required	Update March 2014
	conference. **(Medium priority)**	Social Care SMT. Further discussions will take place between the Directorate's Safeguarding Manager and the Head of Children's Social Care to interpret the statutory legal obligations of the IRO Handbook, and set out detailed proposals for the CSC Manual.	approved seven of the ten Social Worker Reports prior to conference; however, two of those were approved on the same day as the conference. The Annual Report was discussed at the CSC SMT meeting in April 2013 to reiterate the importance of reports being outcomes on time.	conference to ensure that they are satisfied of the outcomes. **<u>Implementation date</u>**	
8	Once operating at full capacity, the service should consider that an IRO is responsible for those looked after children also subject to a child protection plan. This would ensure that the child receives consistent support and advice. **(Medium priority)**	A restructure of the IRO service is being undertaken which will ensure continuity of IRO where a child is subject to both child protection and looked after children status.	From a sample of 10 looked after cases, six related to children who had previously been subject to a child protection plan; all of which had retained their original IRO.	Implemented.	
9	The service should ensure that case file audits are undertaken in accordance with the agreed guidance produced by the Safeguarding Manager. It is acknowledged that the Senior IROs are developing an audit tool specific to the IRO Teams to enable them to perform more	A specific IRO audit tool has been developed and will be launched in December 2012. This will form part of the quality assurance of IRO practice during supervision.	The service introduced the audit tool, InfoPath in May 2013; however, this did not meet the needs of the directorate, and in October 2013, has been replaced with a Click Suite audit tool. This has yet to be embedded in line with the agreed case file audit quotas allocated to staff. We have reviewed a sample of IRO supervision notes and established that cases are	Not implemented. **<u>Revised Action 5</u>** The Directorate Safeguarding Manager should ensure that all IROs complete the necessary number of case file audits once the new audit tool has been embedded (a minimum of six audits per month).	Audit is a standard item in IRO supervision and at monthly IRO team meetings. The poor performance of the team in respect of case file audits has been addressed with the IRO team and has been addressed with individual IROs in supervision. Monthly reporting arrangements are in place to monitor compliance against the audit

	Recommendation	Management response/ action plan	Follow-up observations/audit testing	Further action required	Update March 2014
	detailed case file audits. **(Medium priority)**		discussed with the Quality & Review Managers on a monthly basis.	**Implementation date**	requirements for the team and a quarterly report is considered by the Directorate Leadership Team. A review of the Case File Audit Framework and tools are taking place in order to ensure we capture the quality of practice and that we have improved case file audit tools integrated within the new Liquid Logic Protocol case management system.
10	IROs should be reminded to complete QA forms within required timescales. **(Low priority)**	Safeguarding IRO's have been reminded of their responsibility for the completion of the quality assurance checklist following child protection conferences. This is done where child protection concerns have been identified and need to be escalated to the Team/District Manager. A target of 50% has been agreed, with this increasing to 100% completion once fully staffed.	QA forms were superseded in May 2013 through the introduction of InfoPath. However this audit tool did not perform in line with the required specification and in October 2013, was replaced with an alternative Click Suite package. For our sample of 25 cases for looked after children, all required the old method of QA for audit purposes, and it was found that only 45% of audits had been undertaken. It is acknowledged that since the previous review, it has been agreed that IROs complete a minimum of 6 case file audits a month rather than the previously agreed 50%. A sample of 7 IROs were selected, however, only 1 of the IROs had completed their quota of 6 case	Partly implemented. **See Revised Action 5**.	As above.

	Recommendation	Management response/ action plan	Follow-up observations/audit testing	Further action required	Update March 2014
			file audits for September and 2 of the IROs had not completed any case file audits in September.		
11	The process to notify IROs of a change in a child's looked after status should be considered as part of the process mapping exercise when implementing the replacement system for ISSIS. **(Low priority)**	Agreed. CERMS is being superseded by the Resolution Centre, in conjunction with the replacement of ISSIS.	The Resolution Centre has yet to be implemented as part of the replacement project for ISSIS. Process maps have been created in preparation for the implementation of Protocol. IRO processes and procedures have been considered as part of the wider Children's Social Care procedures; mainly the looked after children and child protection process maps. Protocol has yet to be introduced.	Action yet to be taken.	Protocol goes 'live in March 2014.
12	Minutes from conferences should be distributed within required timescales. **(Low priority)**	Delays in the distribution of child protection conference minutes can be attributable to capacity issues within the IRO service, the MTTS and also the local ops admin teams. Managers in the three services are monitoring output and plans are in place to improve turnaround time. Additional capacity has been created within the IRO service and future restructuring should deliver lower caseloads (dependent upon the reduction of children looked after the children subject to a CP plan). The MTTS is in the process of	Decision sheets were only distributed within 48 hours in three out of ten cases sampled. Of these ten, the IROs had actually reviewed the decisions in six cases within timescales, but had not been distributed by the local admin teams.	Not implemented. **Revised Action 6** IROs should be reminded that decision sheets be reviewed and distributed within 48 hours of a conference; and The service should review internal processes to ensure all efficiency savings are identified and implemented with regards to the distribution of decision sheets. **Implementation date**	Reminder sent to IROs regarding the requirement to distribute the conference decision sheet within 48 hours. Periodic sample audit to be completed to monitor compliance with this requirement. Work continues to be moved between teams to address any imbalance of staff/workload ratios. Increasing use is being made of electronic systems for the distribution of documents to professionals, including the future introduction of a child protection document portal as outlined above.

	Recommendation	Management response/ action plan	Follow-up observations/audit testing	Further action required	Update March 2014
		recruiting staff to the vacant minute taker posts within the team. Once staff are recruited and trained up the team should once again be able to turn around all minutes within four working days. Local ops admin teams have had an imbalance of staff/workload ratio across the county and work has been done to move work across teams to address this. Options for centralisation of the post meeting admin work are now being piloted/ considered, with a view to making further improvements to turnaround times for distribution of approved decision sheets and minutes. No additional monies have been provided to MTTS or Ops Admin in relation to growth, therefore as the number of meetings increases there is likely going to be an adverse impact on these two teams being able to deliver in a timely manner.			In addition, at the request of DLT, CYP Business Support Manager colleagues working alongside Admin Managers are undertaking a review of Case Support across CSC and F&A. The initial focus of the review is to deploy additional resources to clear all outstanding backlogs of critical CSC work. The review will also present a longer term plan to effectively manage case support resources across the Directorate in line with operational requirements which will include child protection processes.

Further Findings/Action Plan – Independent Reviewing Officers

Control	Audit findings	Implications	Residual risk	Agreed actions, responsible officers and implementation dates

Control	Audit findings	Implications	Residual risk	Agreed actions, responsible officers and implementation dates
C5	**Contingency arrangements have been approved in the event of loss of key staff including allocation of cases.** From the testing of recent leavers of the service, it was found that two service users originally allocated to a Quality & Review Manager had not been reallocated. The cases were raised with the service, and they have since been reallocated. The service stated that an exception report will be extracted going forward to identify all cases allocated to leavers of the council.	A child may be placed under significant harm if the case is not reallocated.	High	**Action 7** All IRO leavers/ IROs on long-term sickness should have their caseloads reallocated with immediate effect by the Quality & Review Managers. This should be done by producing regular caseload reports to ensure all cases have been reallocated appropriately. **Responsible officer** Monthly exception report of cases without an allocated IRO is being provided. Any cases identified are immediately allocated. The service will prioritise the reallocation of cases, taking into consideration the timescale for CLA reviews and Review Child Protection Conferences. **Implementation date** 1/02/2014
C6	**The IROs are informed of children becoming looked after twice weekly.** In four cases (16% of the sample), the IRO service were only informed of the child becoming looked after at least ten days after this change in status. In one case, the service was only informed 22 days	A child may be placed under significant harm if the case is not reallocated.	Medium	**Action 8** The Children's Social Work teams should inform the IRO service of a child becoming looked after within reasonable timescales.

Control	Audit findings	Implications	Residual risk	Agreed actions, responsible officers and implementation dates
	after the child became looked after.			**Responsible officer** Admin function via SS14. **Implementation date** Briefed January 2014.
C9	**Social Workers should complete their reports within 5 working days of the review.** Of the 25 looked after cases reviewed, one Social Worker report had been prepared and outcomed by the same Social Worker.	Reviews may need to be adjourned in the event that the Team Manager identifies concerns regarding a case.	Medium	**Action 9** The Children's Social Work teams should review all access permissions to ensure that Social Workers are unable to prepare and outcome care plans. **Responsible officer** **Implementation date** Briefed January 2014 but service demand impacts on capacity.

Working Together with Families Actions

Issue	Action	Timescale	Who By	Update March 2014
TFU / LCC definition of worked with	Liaise with DCLG: - Agree Lancashire definition of 'Worked With' - Provide Audit colleagues with evidence of above - Confirm definition with Analysts - Communicate to wider WTWF team and cascade to LMG's	December – January 2014	PH PH JBs Co-ordinators and Area leads	**Implemented** Confirmation of the 'worked with' definition was obtained from Russ Aziz on 30/9/13 and 26/11/13.
Claims Process • What we can claim for • From what date • At what rates • How can we obtain Anti Social behaviour data to support future claims • **Clarification with DCLG regarding families about claiming for families who meet 1 of the criteria and claiming for the family** • **Local criteria to be applied across Lancashire**	Liaise with DCLG:	December – January 2014	PH / JBu / JBs Analysts	**Implemented** Meeting undertaken with audit and analysts on 5th March which clarified the claim process. **Partially implemented** Ongoing discussions with DCLG regarding the claim process. Further to participation in the July 2013 and January 2014 spot checks we have developed a rationale to inform future claims which has been shared with DCLG and detail of which is provided in the fnance report for March Gov Group. I**mplemented** Via existing local nomination form.
Transition Phase • Mechanics/timetable claims • TFU's thinking on Phase 2	Liaise with DCLG - Discuss with WTWF Governance Group - Clarify claims timetable with Analysts - Engage wider WTWF team in discussion re phase 2 - Feedback LCC view to DCLG	January – March 2014	PH / JBu / JBs J Bs PH/JBu/JBs PH	**Implemented** Discussed at WTWF team meetings. Letter sent to DCLG on 16th January and response received on 24th February

National Evaluation	Confirm the levels of information and format required from LCC, (meeting with Ecorys 16/01/14)	January – March 2014	PH / PR	**Implemented** First set of Family Monitoring Data returns submitted on 28th February
Consent	Area Leads to follow up trackers for all 10 sample audit cases Area leads to chase all outstanding trackers and consent forms from LP's LMG's to be actively engaged in above process Report completed action to LCC Auditor	December – January 2014	LE / SA / SR LE to coordinate LE/SA/SR PH	**Outstanding** 10 sample audit cases completed and where a tracker was required this has been requested but not yet obtained. Ongoing as part of area lead role. Ongoing as part of area lead role. In all multi agency cases there will be explicit WTWF consent which forms the contract between the family and the lead professional and further audit testing will provide reassurances in relation to this. Where there is a single agency or information required response the north west data sharing protocol and support District LMG protocols supports the sharing of information between agencies. Also each single agency response will have a consent agreement with the appropriate individual within the family.
Future Claims	Invite LCC Audit colleagues to engage with claims process from beginning to aid understanding and gain expertise and advice on the process.	Jan - March 2014	PH / PR / IR	**Implemented** Jan 2014 claim audited. Meeting undertaken with audit and analysts on 5th March which clarified the claim process
Information Governance	Meet LCC Access to Information Manager to discuss data being processed by analysts. Identify who in the police has access to the programme data and ensure it is restricted to only the analysts. Two groups have access but we are not sure which users are members of this group.	January 2014	PH/ JB / JBu	**Partially Implemented** Information provided to the LCC Access Information manager and assurances sought. **Implemented.** Confirmed with the police that the 2 shared groups are IT support who require access to provide support.

Case File Audit Actions

	Issue	Implication	Residual risk	Recommendation and management response	Responsible officer and implementation date	Update re Action Taken
1	The Children's Social Care procedure manual includes a file audit framework which details the number of file audits that should be completed each month by management and the CYP audit team. A record of the file audits completed is sent to the CYP Senior Auditor and the results are collated on a spreadsheet. However from the records of completed file audits for 2012 a number of Children's Social Care Managers, District Managers, Senior Managers and the CYP Audit team had not completed the required number of audits. For the 3 month period April to June 2012 the following Districts had not submitted any case file audits – Pendle, Rossendale, Hyndburn Ribble Valley, Chorley and South Ribble, West	If the agreed quota and breadth of case file audits are not completed there is an increased risk that areas of best practice or areas of concern will not be identified and communicated.	High	The Head of Safeguarding, Inspection and Audit and the Head of Children's Social Care should discuss the process for completing case file audits and in particular should: a) Issue all staff with a reminder about completing case file audits; b) Agree a protocol for chasing up outstanding case file audits. It may be appropriate for business support to assist with the collation of case file audit data in the first instance; c) Improve the current monitoring spreadsheet to separately identify district manager audits; and d) Agree reporting	**Responsible officers**: Head of Safeguarding, Inspection and Audit and Head of Children's Social Care. **Implementation date**: 1 May 2013	a) **Aug / Sept 2013:** A consultation exercise was completed in conjunction with all Heads of CYP services. From these conversations, a new Case File Audit Framework was developed, which includes a breakdown of monthly audit submissions as a minimum requirement on a per capita basis by team and service. **Feb 2014**: The Framework is under review following a request from CYP DLT. All involved services are contributing to the revision to ensure an effective framework is in place which the Directorate is confident in implementing. Expected completion April 2014. b) Managers have access to improved information and reporting via a monthly summary report which identifies the cases audited, name of auditor and date of submission. As

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	Lancashire and the Audit Team. In addition, only 1 District Manager had submitted a case file audit during the same period. Reminders had not been issued for the outstanding case file audits by the CYP Senior Auditor during this period. We contacted 3 of the districts who had not reported any file audits for the period April to June 2012. 2 of the districts stated that they had performed file audits but that they had not completed the required number. In addition, not all been documented and in some cases there was no record of the case files that had been audited. In the event of an inspection the districts would find it difficult to provide details to Ofsted. The 2 districts had identified themes and shared this with their teams at their district team meetings but not with the wider CSC			arrangements for escalating details of non reporting/ completion. **Management response:** The file audit framework is under review and once agreed will be re-issued to the relevant managers outlining their audit requirements. There is a process in place for the Auditor collating the monthly audit figures to alert relevant managers and escalate to the HOSC where teams have not completed audits Monitoring spreadsheet will be amended to differentiate managers from seniors managers		such, they can easily identify within their own teams who have or have not completed audits and they are in a position to follow this up as necessary. c) Separate spreadsheets are in place and analysed each month for each type of audit completed, including by service area. These capture the designation of the auditor as standard. This means that filters can be applied at any time to identify which managers have undertaken case file audits by process completed and month of submission. d) Monthly audit counts are produced on a scorecard which breaks down the number and type of audits completed by each service. This is shared with Head of Safeguarding, CSC Head of Service and cascaded to senior managers across the directorate. A detailed

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	teams. 1 of the district managers has failed to respond to several of our emails and phone calls. We have passed these details onto the Head of Children's Social Care.					quarterly report is also provided to CYP DLT.
2	The case file audit framework also requires other senior managers to complete 1 audit per month but it was not clear who this requirement related to and if they had performed the audits. We have discussed this with the Head of Children's Social Care who has advised us that whilst he does not complete the standard template he does review cases as and when he is required to, for example court cases. Case file audits are also required to be performed by other teams within the directorate such as the Inclusion and Disability Support Service (IDSS) and the Adoption Service. The results of these case	If the agreed quota and breadth of case file audits are not completed there is an increased risk that areas of best practice or areas of concern will not be identified and communicated. Any monitoring reports to senior management may not represent all of the case file audits completed.	High	a) The spreadsheet used to monitor the return of file audits should be extended to also identify and monitor audits completed by district managers and other senior manager audits; and b) The monitoring spreadsheet should also be extended to cover audits completed by other social care teams such as IDSS and the Adoption Service. **Management response:** See above Monitoring spreadsheet has been amended to	**Responsible officer**: Head of Safeguarding, Inspection and Audit. **Implementation date**: See above Completed	a) Now being captured monthly – see above b) The new monitoring spreadsheets identify which individuals and services have submitted audits across all CYP service areas including IDSS and Adoption. There are also supporting spreadsheets for capturing any additional QA / audit work undertaken by teams. These also capture emerging themes / trends and feed into the analysis. c) All audits are collated through the Audit team and the Senior Auditor undertakes monthly overview and analysis work with formal DLT reporting on a quarterly

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	file audits are not reported to the CYP Senior Auditor to allow completion to be monitored and common themes. We have met with a Senior Manager within IDSS and have confirmed that they do complete case file audits. IDSS have recently discussed case file audits and have re-confirmed the need to ensure these are completed each month. A paper has also been produced by IDSS identifying the common themes arising from the audits and this has been shared throughout the IDSS team.			include all frontline CYP services		basis. This includes a report on key findings including good practice. An example of how audit work has developed is the cross-service process, which now tracks cases monthly across all DCYP services, allowing an informed overview of the child's (and family's) journey through the CoN prior to becoming open to CSC. Services contributing include: Early Support (and CAF), WTWF, ACERS, Pupil Access, Children Missing Education, Children's Centres, YPS, Parent Partnership, IDSS, YOT and others, alongside a deep-dive of open CSC case files.
3	Discussions with some of the district managers identified that case file audits are not all recorded. For a sample of 20 case file audits that had been reported as completed we could not locate the audit checklist for 9 of the 20 audits. We acknowledge that there are known issues with the	Management are unable to demonstrate that the case file audit has been completed or that it has covered the necessary areas. Issues arising from the case file	High	a) Staff should be reminded of the need to record all case file audits on the checklist and to save the checklist on CERMS; and b) Managers completing case file audits should ensure that all actions	**Responsible officers**: Head of Safeguarding, Inspection and Audit and Head of Children's Social Care. **Implementation date**: **1 May 2013**	a) The interim processes currently in place will last until the audit process in the new LCS (Liquid Logic) system is fully operational, Current methods provide the Audit team with all online audits completed for analysis purposes. As part of this, there are two options for auditors to

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	CERMS system which makes it difficult to find or confirm what documents have been stored in CERMS. The case file audit checklist includes a section for the auditor to record any required actions and also a section for the actions to be signed off and dated when completed. For the 11 case file audits that had been documented and saved on CERMS a number of actions had been documented as being required. However, none of the checklists had been updated to indicate that the necessary action had been taken despite there being a section on the checklist to record this.	audits may not be resolved.		required are completed and signed off within the agreed timescales. Given the current system this may mean managers reviewing their previous months audit checklists to ensure all actions have been addressed. **Management response:** A range of audits are undertaken, however managers should complete case file audits using the case file audit tool. The case file audit tool is currently under revision to capture the journey of the child and as part of the Liquid Logic implementation. Until an electronic system is implemented the service relies on self-reporting from managers. Discussion to take place		follow up identified actions: - If during the audit of a case file there are significant concerns that require immediate action, the auditor can email any member of the central Audit team, who will draw the individual audit down, convert it into a Word document and send it back for follow up and saving to the case file. - As standard practice, the Audit team draws down all the audits from the previous month, converts each into Word and sends them back to the relevant team managers, who then cascade the audits to the workers for saving to case files and following up actions. This process has been live for one full quarter now and the Audit team plan to dip-sample early submissions to ensure this process is effective in closing the loop.

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				between Heads of Service to determine responsibility for reporting outstanding and completed actions		
	Reports detailing the number of case file audits and the themes arising from the audits have previously been reported to the Safeguarding Steering Group which met on a quarterly basis during 2011. However, this group has not met in 2012 and the information previously reported to this group on case file audits has not been reported to another group. The Safeguarding Steering Group minutes from August 2011 state that quarterly reports on case file audits should be submitted to DLT with monthly reports being sent to the Director of Specialist Services and the Director of Targeted and Assessment Services. We have reviewed the DLT	There is a lack of reporting regarding the case file audit process and senior management may not be aware of the outstanding case file audits and any issues arising from them.	High	Summary reports should be provided to senior management on a regular basis detailing: a) cases audited; b) outstanding audits; and c) details of best practice and issues. **Management response:** System in place to provide summary report on quarterly basis	**Responsible officers**: Head of Safeguarding, Inspection and Audit. **Implementation date**: Completed	Reporting of audit counts, (including shortfalls), broken down into teams and services are now provided monthly to the Head of Safeguarding, Head of CSC and appropriate Directors. Additionally, there is a detailed monthly report plus a summary report done by the Senior Auditor which clearly identifies themes and trends at a very meticulous level. Month-on-month recurrent themes and findings are also reported along with suggestions and recommendations which are intended to identify and cascade good practice and also highlight areas where some adjustment to processes may facilitate progress and improve outcomes for the child. In addition to this, quarterly reporting is now regularly provided for DLT including themes and counts. The Senior Auditor submits reports

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	minutes for 2012 and cannot see any reports regarding case file audits. In addition the CYP Senior Auditor advised us that she had not been asked to submit any progress reports for a number of months. There has been no collation of the themes arising from the case file audits since a paper was prepared for DLT in Q4 2011. The number of case file audits completed is recorded on the quarterly safeguarding scorecards but no further details are provided.					and attends DLT to clarify and answer any questions and also to take away further actions as required. **Feb 2014:** A review of the File Audit Framework is now underway, alongside a joint review of the content of the audit tools. This work is intended to ensure that the right tools which ask the right questions are incorporated within the new LCS system and will therefore support all future case file audit work.
	The Safeguarding Peer Review from 2011 included the following recommendation regarding the case file audit process: *Ensure that key themes from casework audit are brought together in summative reports and linked into service plans/supervision/ and*	There is a risk that the best practice and issues identified from the case file audit process are not identified and communicated.	High	Management should ensure that the recommendations raised in the Safeguarding Peer Review are progressed. The status of these recommendations should also be included in any reports to senior management (see recommendation 4).	**Responsible officers**: Head of Safeguarding, Inspection and Audit and other appropriate Heads of Service. **Implementation date**: Completed	1. See above re: timetable and minimum requirements for case file audit for all services, now built into the QA framework for this area of work (and reviewed Feb / March 2014). 2. Manager Summaries are collated which capture additional QA / audit work taking place in teams and which have not been part of the central analysis process

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	learning and development ***Action:*** *1. Develop timetable for casework audits across all relevant services.* *2. Each Service Head to collate themes and learning from casework audits.* *3. Monthly report on audits carried out and the outcomes from them to be produced.* *4. Annual report summarising the issues coming out of casework audits across all services and the actions taken as a result.* ***Timescale:*** *1. September 2011* *2. April each year* As reported at recommendation 4 above some of these actions have not been implemented.			**Management response:** As above		e.g. using different audit tools not available online. The summary sheet also requests details of the case file audits undertaken and emerging themes, which are also fed into the reporting mechanisms. 3. See above – monthly reporting is now in place and outcomes are being cascaded back to all teams via senior managers / Heads of Service. 4. Reporting at this stage has been in place for a full quarter, with the cross DCYP audit process being undertaken monthly. Reviews are underway. Annual reporting is scheduled, but has not yet been undertaken. First annual report will be April 2014, although this will not include a full year, and will be a report on development of the work, processes established and emerging themes / findings since June 2013.
	The current case file audit process is managed outside of the social care system (ISSIS). The process requires high levels of manual	The case file audit process is not embedded in the current social care system. This increases	High	The CYP Audit Team should ensure that the case file audit requirements are fed into the design stage for the replacement social	**Responsible officers**: Head of Safeguarding, Inspection and Audit.	The case file audit requirements have been included within LCS system development, and are being kept under review in consultation with relevant

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	intervention and our audit findings have confirmed that the current process is not robust or embedded. The Directorate are currently looking to replace the current social care system (ISSIS) and should ensure that opportunities to embed the process in the replacement system are explored. The following features should be included in any discussions about the new social care system capabilities: - system selection of case file audits to prevent selection bias and to ensure full coverage; - automatic reporting of issues and statistics on completion of case file audits; - automated tracking of required actions and outstanding required actions;	the risk of managers not completing the audits and lessons learnt not being identified and communicated to the workforce.		care system. The design stage should ensure that the case file audit process becomes fully embedded in the system and is not seen as an additional task but part of the ongoing process. **Management response:** Currently in progress, discussions taking place between Senior Auditor and Liquid Logic project team outlining audit and reporting requirements to be integrated into Protocol. Awaiting confirmation from Liquid Logic project team as to how the audit process and reporting will be integrated	**Implementation date**: 25 March 2013	services. The partially-automated audit process within LCS is unlikely to become fully operational before September 2014. In the meantime, the interim arrangements using the online audit tools and analysis and reporting procedures will remain in effect. Whilst some self-sampling remains across services, a peer review process is being considered as part of the current review (March 2014). Additionally, a separate monthly audit cycle has been established via the central Audit team, which includes tracking the child's journey through a deep-dive and cross-service interrogation of different systems. Cases randomly selected centrally for deep-dive audit through CSC files are also cascaded to all services to gather data including Early Support, IDSS, WTWF, ACERS, Pupil Access, CME, Parent Partnership, YPS, Children's Centres, YOT, and Safeguarding input. This means that for 10 cases each

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	and - register of common themes to be used as a training tool for staff.					month there is an opportunity to evidence good practice across the CoN, highlight trigger points, and facilitate embedding chronology into future plans. Establishing this process also supports future inspection, as there is a clear process that is familiar to all services whereby collection and and collation of cross-cutting information on individual case files is now in place by interrogating different systems simultaneously. This process has been used successfully to support a mock inspection (Nov 2013) and a large themed audit on Missing Children. Workforce development can in future be reliably informed from findings and themes emerging month on month.