Inspection of local authority arrangements for the protection of children

London Borough of Brent

Inspection dates: **22 October to 31 October 2012**
Lead inspector **Pietro Battista**

Age group: All

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The inspection judgements and what they mean

1. All inspection judgements are made using the following four point scale.

Outstanding	a service that significantly exceeds minimum requirements
Good	a service that exceeds minimum requirements
Adequate	a service that meets minimum requirements
Inadequate	a service that does not meet minimum requirements

Overall effectiveness

2. The overall effectiveness of the arrangements to protect children in Brent is judged to be **adequate**.

Areas for improvement

3. In order to improve the quality of help and protection given to children and young people in Brent, the local authority and its partners should take the following action.

Immediately:

- review all referrals in one of the locality teams identified by inspectors that have resulted in no further action or a children in need plan in the past six months, to ensure that children are safe and that any actions or plans have been implemented
- the Brent Safeguarding Children Board should ensure that the police public protection department promptly exchanges appropriate information with partner agencies and promptly participates in child protection strategy discussions or meetings
- ensure that child protection plans in relation to children with disabilities aged over 14 years are robust and are fully implemented.
- ensure that strategy discussions are clearly recorded and contain actions agreed, individual responsibilities and timescales
- ensure that the outcome of referrals is routinely notified to referring agencies
- ensure that assessments contain sufficient analysis of information to inform risk and to understand the impact of the situation from the

child's perspective, and that the outcome of assessments, plans and key documents are explained and given to parents

- ensure that all decisions to remove children from child protection plans are robustly risk assessed.

Within three months:

- ensure that child protection conferences are consistently well managed and chaired
- ensure that children in need and child protection plans are of a consistently high quality, that they contain specific targeted outcomes and contain a case specific statement of risk and contingency plans
- ensure that all core groups rigorously monitor, review and develop the child protection plan and that the meetings are recorded
- ensure that risk management plans are developed as part of domestic violence risk assessments
- ensure that social work managers confirm that social workers have undertaken actions assigned to them within child protection plans and record this in case supervision.

About this inspection

4. This inspection was unannounced.

5. This inspection considered key aspects of a child's journey through the child protection system, focusing on the experiences of the child or young person, and the effectiveness of the help and protection that they are offered. Inspectors have scrutinised case files, observed practice and discussed the help and protection given to these children and young people with social workers, managers and other professionals including members of the Local Safeguarding Children Board. Wherever possible, they have talked to children, young people and their families. In addition the inspectors have analysed performance data, reports and management information that the local authority holds to inform its work with children and young people.

6. This inspection focused on the effectiveness of multi-agency arrangements for identifying children who are suffering, or likely to suffer, harm from abuse or neglect; and for the provision of early help where it is needed. It also considered the effectiveness of the local authority and its partners in protecting these children if the risk remains or intensifies.

7. The inspection team consisted of three of Her Majesty's Inspectors (HMI), an Additional Inspector and an Inspector seconded from another local authority.

8. This inspection was carried out under section 136 of the Education and Inspections Act 2006.

Service information

9. Approximately 311,200 people live in Brent, 77,500 of whom are children. There is an increasing population of younger children living in Brent. In the last eight years 4,545 extra school places have been created. Brent has one of the highest proportions of ethnic minority residents in London; they make up 92% of the Borough's school population. Approximately 60% of children and young people speak English as an additional language. Large and established communities of Indian, Black Caribbean and Irish people live in Brent. However, the proportion of children from these backgrounds is decreasing. The numbers of children from Somali and other Black African groups, Eastern European, Afghan, Iraqi and Hispanic backgrounds are increasing. Brent was ranked as the 35th most deprived local authority area in the 2010 Index of Multiple Deprivation, placing it amongst the top 15% most deprived areas. Over 33% of children in Brent currently live in a low-income household and 20% in a single-adult household.

10. There are high levels of child obesity, particularly affecting children living in Harlesden and Willesden and children of Black Caribbean and Black African backgrounds. Brent has more domestic violence offences per 1,000 head of child population than the London average. There has been a reduction in crime over the last four years with significant reductions in gun crime, knife crime, robberies and youth violence, although they remain at a higher rate (per capita) than Brent's statistical neighbours and the London average.

11. Referrals to children's social care are managed through the five locality social work teams and the children with disabilities team. These teams retain responsibility for all cases where children remain at home, apart from those occasions where the work is passed to either the looked after children service, the early intervention service or are closed. The locality service is supported by early help services, much of which are delivered through the Borough's 17 children's centres.

Overall effectiveness

Adequate

12. The overall effectiveness of the arrangements to protect children in the London Borough of Brent is judged to be adequate. Clear strategic vision and leadership are in place that have secured improvements to practice and service delivery since the last inspection of safeguarding and looked after children services in 2011. No systemic failures that have resulted in children failing to be protected were identified during this inspection. In a few cases identified by inspectors where it was not clear that action to safeguard children were robust, the council took prompt action to address concerns. Practice is adequately child centred and is based on risk management that ensures children are safe. Inspectors found examples where practice and management oversight was of a good quality. However, this was not consistent and in many cases inspectors found aspects of poor practice and poor management oversight and direction.

13. Thresholds for access to children's services and for child protection are clear and are understood by partner agencies. Council strategies to develop early help services are ambitious and early intervention services are being systematically developed and targeted. The common assessment framework (CAF), team around the child (TAC), and family group conference (FGC) processes are used increasingly effectively.

14. Significant numbers of children live in families where domestic violence is an issue, and staff have developed skills and knowledge to support them. However, the council recognises the need to develop a wider range of services to support children involved in domestic violence.

15. Where children become subject to a child protection plan agencies across the partnership work well together to protect children. Information between agencies is appropriately communicated. However information exchange and involvement by the police public protection department is not sufficiently timely leading to delay in assessing risks to children. Partner agencies actively contribute to child protection conferences and core groups. However not all conferences or core groups effectively develop and implement child protection plans to ensure that children are safe.

16. The views and experiences of children and their families are increasingly being sought and used to develop aspects of the service, although this remains at an early stage of development. Children and young people involved in child protection processes are seen regularly by their social worker. However, they are not consistently offered the support of an advocate.

17. Elected members actively engage with, and support, senior managers, and provide effective scrutiny and challenge. Members regularly meet with

managers and attend the Brent Safeguarding Children Board (BSCB). The Board is meeting its core statutory duties, although it has made slow progress in implementing the key objectives detailed in its business plan. The Board and the council recognise the need to reinvigorate its work, and have appointed a new independent chair, established an Executive Board and implemented a new business plan.

18. Performance management within the children's social care services is well established, with robust analysis of information that enables managers to have a clear understanding of the key issues. Audits are undertaken by managers at all levels and are used to improve individual practice and to identify areas for development. However, this inspection found aspects of poor practice and insufficient management oversight and direction in a significant number of cases sampled.

The effectiveness of the help and protection provided to children, young people, families and carers

Adequate

19. The effectiveness of help and protection provided to children, young people and their families and carers is adequate. A range of early intervention services are being restructured to enable them to provide more effective help to the most vulnerable children and families. This restructuring is at an early stage of implementation.

20. Early help panels, established in September 2012, provide effective multi-agency advice to support workers undertaking early intervention work. Cases are robustly risk assessed to ensure that families receive the most effective help. They are in the early stage of implementation and it is too early to measure their impact.

21. Duty workers in the locality team provide a considered and well-informed initial response to professionals and members of the public who have concerns about children. Cases are promptly allocated where levels of concern or need require social work support. In most cases seen robust assessment of risks to children was undertaken which resulted in appropriate action to protect those children and to minimise risks. However, in a small number of cases seen by inspectors, actions to ensure children were safeguarded had not been fully followed through. The council took prompt action on these cases during the inspection. Where the reduction of risks to children could not be achieved through planned work timely action has been taken to ensure the safety of children through the courts.

22. Where concerns escalate for children receiving support through the CAF or children in need services, children's social care services take prompt action to reassess risks. Inspectors saw examples of such cases being 'stepped up' appropriately to the child protection or court system following multi-

agency enquiries and also 'stepped down' where risks had diminished in the course of on-going work. In some cases, the step down from child protection planning was not sufficiently secure and as a result children became subject to a child protection plan for a second time.

23. Appropriate arrangements are in place to protect children with disabilities aged less than 14 years within the children with disabilities team. However, arrangements for the very few disabled young people of 14-18 who are subject to child protection plans and held within the transitions team are less secure. In the small number of cases tracked by inspectors, where disabled young people in this age group were subject of child protection plans the assessment and intervention was not robust. Partner agencies and families had not been fully engaged in assessments and plans, and minutes of core groups and reviews of the child protection plan did not clearly identify risks and protective factors. Objectives of the work were unclear and records did not show evidence of effective impact from intervention.

24. The council has recently implemented the signs of safety model, which enables staff to capture the perceptions of children and young people and to be more focused on the experiences of the child. Social workers effectively use this to encourage younger children to express their experience through play and drawings and to help older young people to use their own words to describe the problems that they face. The work is used well to enable parents to recognise the impact of their behaviour on their children. For example inspectors observed creative use of this model to improve professionals' and parents' understanding of the experience of younger children who have complex needs resulting from their disability. As a result, risk assessments and child protection planning for these children were well informed and in some cases had resulted in strengthened measures to assure their safety.

25. Prompt action has been taken by managers to tackle some areas that are under performing. For example, children in need planning was identified to be below expected standards, in part due to lack of capacity. As a result, children in need visits are now being monitored to the same standard as child protection visits, to ensure that they are timely and to prevent drift. A children in need team has been temporarily established to reduce caseloads in the locality teams and to undertake work with children in need to enable the case to be closed or stepped down to early intervention services. This approach has been effective in reducing work pressures within the locality teams.

26. Feedback from children, young people and families has been more recently developed. This was an area for development from the safeguarding and looked after children inspection 2011. However, whilst there has been more recent activity to gain feedback from users, this has not yet included qualitative feedback from families with children on child

protection plans, with the exception of a small sample survey of parents on cessation of child protection plans. A consultation in May 2012 with families with children in need receiving services through locality teams resulted in a high level response that was predominately positive about the service they received. Parents acknowledged the importance, for them, of receiving written copies of assessments and plans. However case records seen by inspectors do not consistently demonstrate that learning from this survey has been routinely applied in social work practice. Case records did not clearly show that key documents including minutes of decision making meetings were always explained and provided to families. A consultation with a smaller number of families being supported by a CAF confirmed a positive view of the support that they received.

27. Those parents who met with inspectors stated that with hindsight they understood why concerns had been raised for their children's safety and valued the services provided to them. In core groups, observed by inspectors, family members spoke confidently and were able to challenge professionals and to be challenged. One young person now living out of the area as part of her child protection plan reported that the early and continuing responses of her school nurse, social worker and child and adolescent mental health service (CAMHS) worker had 'helped her turn her life around.'

28. A significant proportion of children and families who receive support do not speak English as a first language. Interpreters are readily accessible where required and some examples were seen of key documents, including working agreements, being translated appropriately. Workers are well informed, through training and research, about the challenges and needs of families within the diverse community. In a small number of cases the diverse needs of children and their families were not sufficiently considered and this reduced the impact of the assessment and the understanding of the child's experience. There are not sufficient culturally sensitive resources in the area for parents involved in domestic violence. Some social workers have developed specific skills in engaging with fathers from diverse cultural backgrounds, which have been used well to effect positive change on entrenched family dynamics. This work is at an early stage and the council is aware that an improved focus on fathers and their role in protecting children is required. The council is aware that more services are required for children who have experienced domestic violence and is currently funding the development of a pilot programme to work directly with such children.

29. The CAF is used increasingly effectively within council services and across partner agencies to identify those children at risk of harm and to target early support in a timely way. Agencies appropriately prioritise the most vulnerable children and families to enable them to promptly access early assessment and support. TAC meetings are used appropriately to coordinate multi-agency work to identify needs and risks for children with

disabilities. Plans and minutes of meetings show a shared understanding and increasingly confident use of the 'signs of safety' toolkit to seek out the views of children. Children's centres are well developed and are linked to locality teams to focus early support to children and families at risk, often through multi-agency work. Seven of the 16 children centres in the areas have been subject to Ofsted inspections. Of these six were assessed as good and one was satisfactory for the extent to which children are safe and protected, their welfare concerns are identified and appropriate steps taken to address them. Case studies and discussions with professionals and parents demonstrate a wide range of practical interventions, support and care provided through the children's centres. This is the result of a significant restructure and refocus of the core work of centres as part of the council's strategy to reconfigure and target early intervention services. The extensive reconfiguration is at an early stage of implementation and it is too early to evidence the overall impact.

30. The FGC service is well established and was used effectively in cases seen by the inspectors to promote safe care for children within the wider family as part of child protection and children in need plans. Feedback from parents and children is undertaken after each conference and the service is highly regarded by families and social workers.

31. A range of parenting programmes support children and families at risk. Courses such as the freedom programme and one children's centre's own programme 'parent power' contribute effectively to increasing parents' capacity to develop positive relationships with their children and to build parent's self-esteem. The Freeman family centre, commissioned from third sector partners by the council, provides support to children and families, including those who are subject of child protection plans. Its staff and its work are highly regarded by partners and children and their families. Inspectors observed cases and meetings where the centre's support workers had developed high quality relationships with the family and a range of targeted help, advice and support which had enabled the parents to reduce risks to the children.

32. The violence against women and girls project provides a good focus on preventing violence by challenging attitudes and behaviours that foster this. However it is too early to assess the impact of this project. Young people aged 16 and 17 experiencing sexual violence and exploitation have access to a range of support services, although not all social work staff were aware of the availability of these resources. The council has yet to implement strategic and operational groups to monitor and oversee missing children and child sexual exploitation. A task and finish group has been developed to take forward this work which links sexual exploitation, gangs and missing children. However this group has made slow progress as a result of lack of engagement by key professionals.

The quality of practice

Adequate

33. The quality of practice is adequate. Thresholds for accessing children's services and for referring concerns about children are appropriately applied by partner agencies and professionals. Almost all referrals were prompt, contained sufficient information and were appropriately risk assessed by social care managers. Staff from partner agencies are able to access advice from advanced practitioners and from locality duty social workers. Locality managers and advanced practitioners attend regular threshold meetings to ensure that thresholds are consistently applied across the five locality teams. However, inspectors saw a few cases where the planning and purpose of intervention following referrals was not sufficiently clear.

34. All contacts and referrals are overseen by managers within each locality team and these are progressed in a timely fashion. However, in a number of cases sampled, particularly within one locality team, inspectors saw cases which had been closed prematurely, lacked clarity and had poor recording regarding the decisions and actions taken. As a result it was not always clear that children and young people were safeguarded appropriately. During the inspection the council reviewed these cases to ensure those children and young people were appropriately safeguarded. In some cases seen by inspectors, management decisions were made in the absence of significant information and as a result were not robust. This issue was similarly identified in audits undertaken by the council in March 2012.

35. In the majority of cases, telephone strategy discussions are routinely held between team managers and the police child abuse investigation team, although other agencies are rarely involved. As a result, relevant background information held by partner agencies is not available in some cases to inform decisions and actions. The record of strategy discussions, actions agreed, individual responsibilities and timescales are not always clearly recorded. In some cases strategy discussions should have been held as meetings and should have involved other relevant professionals. In a small number of cases, delays in undertaking strategy meetings resulted in undue delays in section 47 enquiries and safeguarding action being taken. The council acknowledged that there has been delay in arranging strategy meetings as a result of changes and structures within the police public protection department and has taken action to resolve this. A strategy meeting observed by inspectors was well chaired with the chair challenging members and identifying missed opportunities to protect the child.

36. The majority of section 47 enquires are timely and all are undertaken by suitably qualified social workers. In the majority of cases seen appropriate

decisions on risk were made. However, inspectors identified a small number of cases where actions had not been followed through and where inspectors were unable to confirm whether safeguarding issues had been sufficiently addressed. The council recognised this and took prompt action to ensure that those children were safe.

37. Information sharing between agencies is timely in the majority of cases where an assessment or section 47 enquiry is being undertaken. However, case files did not evidence that referring agencies are routinely informed of the outcome of referrals or section 47 enquiries. Whilst information sharing with the police child abuse investigation team is responsive and timely, this is not the case with the police public protection department (PPD). In a number of cases the PPD have not promptly shared information with the council and have not promptly engaged in strategy meetings and this has resulted in avoidable delay in undertaking child protection assessments or enquiries being commenced that are not fully informed with information known to partner agencies. The council and the police have acknowledged this and have taken steps to address the issue through meetings between senior managers and practitioners in the police and children's services.

38. The volume of police notifications of domestic abuse is high and incidents assessed to be of high risk by the police are promptly referred to children's services. The domestic violence risk assessment format used within the children's social care team enables specific focus on domestic abuse and associated risks. However, the effectiveness of the risk assessment is reduced as it is not accompanied by a formal risk management plan and this results in an inconsistent approach in the management of domestic violence incidents across locality teams.

39. In almost all cases seen case recording by social workers is timely and is sufficiently up to date. Chronologies were not often up to date and those seen varied extensively in quality and in content. In a few cases historical information within chronologies was used well to assess risks to children. The council recognised the need to improve how chronologies are used in an audit report in June 2012, but have not yet ensured that these are improved.

40. Most assessments seen contain appropriately detailed information. However, in too many cases insufficient analysis is provided on the significance of the information in order to securely inform the risk assessment and to understand the impact of the situation from the child's perspective. In some cases core assessments are not sufficiently up to date or have not been undertaken despite management direction. Assessments seen did appropriately identify services required to meet the needs of children and those of parents. All cases appropriately recorded diversity issues within families, although not all sufficiently focused on the

implications of ethnic and cultural diversity issues on risks to the child to inform case planning.

41. The council is aware that the quality of practice and management oversight within the one of the five locality teams has not been sufficiently robust and has taken appropriate action to tackle the issues. A significant proportion of cases from this team, and a few cases from other localities sampled by inspectors, had significant shortfalls including poor recording of decisions and actions being taken, insufficiently robust assessments and actions required by managers not being completed. As a result, it was not sufficiently clear that those children and young people had been appropriately safeguarded. During the inspection the council reviewed these cases and were able to satisfy inspectors that those children and young people are safe. The council has audited open cases within the locality team referred to above. However, the council has not systematically reviewed all cases where no further action or children in need planning was recommended, following assessments within this team, to ensure that decisions and intervention was appropriate and that children are safe.

42. In almost all cases children and young people are seen regularly by social workers and are seen alone, where appropriate, with due consideration of the children's presentation and the home environment. In almost all cases, children subject to child protection plans are seen regularly on both an announced and unannounced basis. Most social workers demonstrate skill and confidence in direct work with children and young people to enable their voice and views to be heard and taken into account in case planning.

43. Social workers use a variety of approaches to engage children, young people and their parents and carers. In particular, the council has invested in implementing the 'signs of safety' model and have trained staff who use it well and enthusiastically within their practice. Where children are of an appropriate age to express a view, these are recorded within most assessments. However, few children or young people attend child protection conferences. Whilst there are examples of children and young people's views being presented to conference, this is not consistent. Advocates are available to children involved in child protection processes, but this is dependent on the knowledge of individual social workers of the availability of local advocacy services. The council acknowledges this and is tendering to commission advocacy services.

44. Parents seen by inspectors report that they felt fully informed why an assessment was undertaken or why their child was subject to a child protection plan and that they were engaged in the assessment and plan. This confirmed feedback in surveys of parents undertaken by the council. However, case file recording does not consistently demonstrate that parents are informed of the outcome of assessments or that fathers are always engaged in the assessment. In a small number of cases seen,

there was a noticeable absence of a focus on the father and the impact of their behaviour on the children, in particular where domestic violence was an issue.

45. Social workers reported to inspectors that they receive regular supervision and feel well supported by their managers, who are visible and make themselves available for informal supervision or advice. This was confirmed in the majority of supervision and case files seen by inspectors. Staff report that they value the reflective supervision provided to them by advanced practitioners and this was clearly demonstrated in sessions observed by inspectors. Staff supervision records include a focus on individual performance, training and practice. However, case supervision is predominantly task orientated and does not clearly evidence challenge to improved outcomes for children. Case supervision records do not clearly demonstrate that managers rigorously scrutinise and challenge social workers to ensure that actions within child protection plans are progressed. In a small number of cases, this has led to delay in actions being completed that resulted in insufficient safeguarding arrangements. For example in one case a referral to the multi-agency risk assessment conference had not been actioned by the worker and had not been identified within supervision.

46. The council and the BSCB has introduced a structured process for child protection conferences. Senior managers have observed practice within child protection conferences and report that they are well chaired and are effective and that this is supported by feedback from partner agencies and parents. However observation of conferences and analysis of conference plans and records by inspectors does not support this. Three conferences observed in whole or part were not effectively chaired or managed and did not effectively engage parents. The conferences were too long as a result of which planning and decision making were rushed at the end as professionals and parents needed to leave. Partner agencies were well represented and their reports were provided. However those attending had not always seen each other's reports and the contents were not systematically or fully reported to the conference to inform decisions and plans. Parents are asked to complete a questionnaire about the conference, and those observed entered all positive responses, even though they had little opportunity to fully understand the areas that they were being asked to comment on, within a pressured environment.

47. The quality of both children in need and child protection plans is too variable. Outcomes are frequently too general and some of the plans seen were unnecessarily long, making it difficult for parents and professionals to focus on what key aspects need to change to reduce risks. Half of the child protection plans sampled by inspectors include a statement of risk with clear acknowledgement of concerns. However, contingency plans are not routinely included within child protection plans. Where contingency plans were evident, these were generalised rather than being case

specific. The number of children who are subject to a child protection plan for a second or subsequent time has increased in the past year.

48. Core groups are held regularly, and are well attended by partner agencies and by parents in most cases. However, it is not clear from core group review forms that core groups rigorously monitor and review the child protection plans to improve outcomes for children. In a small number of children in need cases, including some which have been stepped down from child protection, there was no evidence of a children in need plan being in place or being actively worked on during the period prior to the case being closed.

49. Out of hours services in Brent are commissioned to provide emergency safeguarding or looked after children intervention. Cases seen by inspectors' evidenced prompt communication of involvement in sufficient detail and this is facilitated by the out of hours service being able to access and input to the children's service electronic case systems. A review of the service by the council in July 2012 recommended an increase in social work and management resource to tackle pressures during weekends. This has yet to be implemented.

Leadership and governance

Adequate

50. Leadership and governance are adequate. The council has developed and updated a comprehensive joint strategic needs assessment that has been subject to wide ranging consultation across the partnership. Whilst the local profiling makes appropriate reference to domestic violence and includes reference to teenage relationships, there is a noticeable absence of reference to child protection issues.

51. Strategic planning through the Brent Plan for Children and Families, the Health and Wellbeing Board, the Safeguarding Children Board and the Child Poverty Strategy is joined up and ensures that the safety and health of children is the top priority. The aim to reduce children subject to a child protection plan is being achieved with a significant reduction from 260 children in April to June 2011 to 152 children in April to June 2012. However, there has been a recent increase in children subject to plans for a second or subsequent time and this is being closely monitored by the council. The draft Health and Wellbeing Strategy appropriately included the areas for development identified within the Safeguarding and Looked after Children inspection 2011. However, for better identification, assessment and robust safeguarding procedures, the strategy does not yet include timely or robust impact indicators and this makes it difficult to see how the impact of these activities will be effectively monitored.

52. The council demonstrates commitment to sustaining child protection services through protected budgets and spend to save initiatives which are

designed to release savings that can be reinvested within children's services. The impact of these is yet to be assessed. Clear accountabilities and responsibilities exist between senior officers, the Lead Member and the chair of the BSCB. The Lead Member and Director of Children's Services both sit on the BSCB Board. The BSCB has demonstrated its ability to provide strong challenge to the Brent Children's Partnership to ensure that funding for the multi-agency risk assessment conference (MARAC) was sustained.

53. The BSCB meets its core statutory duties. The council recognised the need to improve the effectiveness of the BSCB following the Safeguarding and Looked After Children inspection 2011. This has resulted in a newly appointed chair for the Board; a review of the Board's business and focus; revised sub groups with a strengthened rationale and terms of reference; and streamlined oversight from a new Executive Board. The business plan for 2010-11 was too long and overambitious and as a result too many areas in the plan were not sufficiently progressed or sustained. The recently revised BSCB business plan clearly demonstrates high aspirations and ambitions, through five appropriate priorities. However, the plan is still long with a large number of actions. It is too early to measure the impact of the new BSCB arrangements.

54. Managers have access to a range of performance information which is used effectively to enable them to understand the strengths and areas that require development across the service. An audit protocol has been developed across social care and teams. Case audit activity is evident on case files which includes both quantitative and qualitative auditing. Audits undertaken have resulted in appropriate management action to improve practice in individual cases and wider themes are reported to and analysed by senior managers. However, cases reviewed by inspectors continue to show too much variability in practice and in the impact and focus of management oversight.

55. The quarterly performance report to the senior management team is comprehensive and covers a wide range of audit activity. Of particular note is the significant reduction in the numbers of children on a child protection plan, which the council attributes in part to the impact of the signs of safety approach. However, recent performance has seen an increase in child protection plans for a second or subsequent time the council recognises this and has commissioned an internal report to understand the causes of this, which exceeds the locally set performance target of 9%.

56. The council and partners demonstrate a well-informed knowledge of their area through their strategies and plans. Progress to address the areas for development identified within the Safeguarding and Looked after Children inspection is appropriately scrutinised within a range of meetings across the partnership. Many areas for development have been completed or are

on target for completion. However, other areas persist, for example, the high proportion of strategy discussions being held solely between children's social care and the police and the quality of child protection plans.

57. The borough has high levels of domestic violence and this is evident in the high number within children's social care cases. The council has clearly acknowledged the challenge to address domestic violence and recently agreed funding for three independent domestic adviser posts specifically to work with children, adults and within the Working with Families initiative. These posts are not yet established. The council acknowledges that more needs to be done to support children who have witnessed domestic violence in the home and are providing specific additional funding for a local children's centre to pilot a 10 week project to meet that need. The council is joining three other local authorities in an extended research project on domestic and sexual violence of young women to inform future service provision and support.

58. Staff speak positively about the support, supervision and professional development opportunities available to them. They are well supported through regular individual supervision. Where individual performance is below expected standards, this is clearly challenged by managers and positive action is taken. The advanced practitioner role within the children's social care teams is highly valued by social workers and focuses on practice improvement and reflective practice. However, the variability of social work practice indicates that more is required to improve the quality and consistency of practice. Experienced and newly qualified social workers, family support workers and children's centre staff report having access to a good range of training opportunities relevant to their roles and to council priorities. Staff are held to account appropriately through appraisals that include review of personal targets.

59. Learning from serious case reviews and the more recent domestic homicide reviews is effectively disseminated to staff, who are able to demonstrate how this impacts upon their practice.

60. The council's workforce development strategy is clearly set out with a combination of practical and aspirational objectives. The strategy does not have an associated action plan on which to robustly monitor progress and identify barriers to progress. However, recruitment and retention initiatives have been successful in sustaining a high level of permanent staff. Staff have enhanced opportunities for career development due to the team structures consisting of a deputy, advanced practitioner and team manager. Children and families benefit from more consistency and continuity of social worker support as a result of stability in the workforce.

Record of main findings

Local authority arrangements for the protection of children	
Overall effectiveness	Adequate
The effectiveness of the help and protection provided to children, young people, families and carers	Adequate
The quality of practice	Adequate
Leadership and governance	Adequate