

Inspection of local authority arrangements for the protection of children

Royal Borough of Greenwich

Inspection dates: 3 – 12 December 2012

Lead inspector Chris Sands HMI

Age group: All

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Inspection of local authority arrangements for the protection of children

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 the Royal Borough of Greenwich is judged to be **good**.

Areas for improvement

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

Immediately:

- clarify the arrangements for transferring cases from children's social care services to local service support (the 'step down' process) to ensure that these are undertaken appropriately taking into account the needs of the child and family and the prospects for sustained progress through these arrangements
- ensure the outcomes of assessments are routinely translated into plans which are specific, measurable and outcome focused
- ensure case supervision clearly evidences rigorous oversight of child protection plans and their progress
- ensure decisions are firmly based on sufficient information and that these decisions are clearly recorded.

Within three months:

- ensure a work force development plan is prepared which supports the improvement plan
- ensure chronologies are consistent in their timely completion and are clear and fit for purpose
- ensure that the individual needs of siblings are clearly included within assessments

- review the high use of police protection powers with the police to ensure an appropriate and proportionate response to children deemed to be at risk
- review the inconsistent provision of agency reports to child protection conferences to ensure timely receipt of reports and that these can be made available to parents before conferences
- strengthen management oversight of statutory visits by enabling regular system reports to be available
- ensure the good quality of the risk analysis form is replicated within initial and core assessments.

Within six months:

- ensure the domestic abuse and violence against women and girls strategy is delivered within the set timescale
- ensure work is progressed to enable children and young people to access advocacy services which supports them to attend child protection conferences.

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 four of Her Majesty's Inspectors (HMI) and one local authority secondee.
8. This inspection was carried out under section 136 of the Education and Inspections Act 2006.

Service information

9. The Royal Borough of Greenwich has approximately 65,519 children and young people under the age of 19 years. This is 27.2% of the total population. The proportion entitled to free school meals (31% in primary schools and 29% in secondary schools) is considerably higher than the national average of 19% and 16% respectively. Children and young people from minority ethnic groups account for 33% of the total population, compared with 23.9% in the country as a whole. The largest minority ethnic groups are African (13.2%) with the next largest group being Indian (4.7%). The proportion of pupils with English as an additional language (37%) is above the national figure of 14.5%.
10. At the time of the inspection, 425 children were subject to a child protection plan. Children's social care services were providing support to 2017 children and young people.
11. Early help and support is provided through a range of targeted services including an integrated support service for children and families and 24 children's centres (organised in 16 federations), an integrated support

service for disabled children and services commissioned from the third sector. For young people aged 11 and above, the family solutions team provides support to prevent escalation of need to children's social care statutory services. For young people presenting as homeless, The Point provides multi-agency assessment and support.

12. Children's social care services which undertake child protection work include a contact and referral team, pre-birth assessment and support team, four assessment teams, a family solutions team, a dedicated children's services out hours' service, five care planning and protection teams and one children with disabilities team. A social worker is also based within the police public protection desk with responsibility to oversee and prioritise police notifications concerning children and young people.

Overall effectiveness

13. Overall effectiveness of child protection services is **good**. Inspectors found no evidence of a systemic failure to protect children. The contact and referral team is making appropriate and timely decisions and cases are transferred promptly onto the initial response and assessment teams. Good use is being made of the recently introduced risk analysis tool and this is having a positive impact on identification of risks and understanding the child's situation which subsequently informs decision making and case planning. This positive improvement in risk analysis now needs to be translated into initial and core assessments.
14. The strong focus on specific age range targeted services supported by multi-agency panels and parenting support programmes is ensuring that a good range of services are available and accessible to the most vulnerable children and families with the local area. The impact of this is seen through the reach of children's centres, timely pre-birth assessments and support and the family solutions team. Successful interventions are contributing to a high percentage of children and young people's cases being supported appropriately and safely below the threshold for statutory service provision.
15. The views of children and young people are being used effectively to inform service delivery and planning. For example, feedback from a consultation with children and disabilities has been incorporated into the short breaks service specification. However, to strengthen feedback arrangements, there is a need for a dynamic approach to be introduced whereby the views of children and families can be captured at significant stages of intervention. For example, by seeking the views of children, young people and carers after a child protection conference, after a child has ceased to be subject to a child protection plan and at the point of stepping down a case.

16. Leadership and governance arrangements are strong with clear evidence of senior managers and elected members taking an active, keen and challenging interest in children's services. Corporate and partner responsibility for children's services is well embedded, championed by the Chief Executive and the senior management team. The strength of the leadership and governance arrangements in improving educational outcomes is well evidenced and these leadership attributes are now the subject of a strong focus on improving children's social care services.
17. Arrangements for oversight and challenge of child protection services and practice have been strengthened through the appointment of a new Chair of the Greenwich Safeguarding Children Board (GSCB), an additional Head of Service with specific responsibility for children's social care operations and the successful and full implementation of the peer review improvement plan. Good attention has been given to ensuring that the plan is subject to intense and regular scrutiny through council and elected member groups and panels with an additional feature of an external scrutineer. Early signs are evident of this scrutiny combined with a 'hands on' and assertive approach leading to improved practice being embedded within the service.
18. The council is knowledgeable about its strengths and weaknesses and has used this intelligence well to add value to the peer review specification. The subsequent improvement plan is ambitious in scope and timescales for delivery combined with a clear emphasis upon improving practice through a determined approach to changing culture using a 'what good looks like' approach and learning from other local authorities.
19. The council is data rich with comprehensive performance management reports and arrangements. Where performance has been identified as falling below expected standards, this is rigorously pursued leading to improved results. However, whilst being data rich, the council is not yet taking best advantage of this information to fully analyse performance.
20. Inspectors evidenced the impact of service and practice leading to some good and improved outcomes. Further work is required specifically in relation to the quality of practice and this is reflected within the identified areas for improvement. However, this inspection has confirmed that practice overall is adequate. Some good examples were evidenced in casework which was child focused with the views of children and young people and their carers being actively sought to inform assessments and child protection conferences.
21. The measures put in place to improve quality of practice demonstrate a clear determination by the council to ensure that services and outcomes improve through their diligent approach to the extension of the professional educator programme. However, where practice and standards

are not being met, capability procedures are being used appropriately to address these.

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

22. The effectiveness of the help and protection provided to children, young people, families and carers is **good**. In cases seen where children require statutory intervention and where there is a risk of significant harm, there is a prompt and appropriate response to referrals from a wide range of agencies. The recent introduction of a risk analysis tool ensures focused analysis based upon known history. The tool also enables good identification of risk and protective factors within the current and historical context to enable an understanding of the child's journey. During the inspection, through scrutiny of children's social care case files and the application of the common assessment framework (CAF), children were found to be appropriately protected.
23. The council's ambition for children to receive early help to improve outcomes and prevent the need for statutory intervention is a strength which is shared well with partners and settings as is the need to provide appropriate interventions for children and young people of different ages. There are clear procedures for establishing teams around the child (TAC) to respond to identified needs where referrals to children's social care are below the threshold for statutory service intervention.
24. The council provides a wide range of appropriately targeted and effective intervention services to support children and young people and their families. Location of family support workers in children's centres has strengthened the capacity of children's centres to support families, prepare assessments using the CAF and to lead TAC meetings. Management oversight of these workers is suitably provided by a qualified social worker. This supports close links between statutory and early help services which increases the opportunity to identify children at an earlier stage where a referral to children's social care services should be made.
25. Children's centres are increasingly engaging hard to reach families through improvements in working arrangements with health visitors who use consent forms completed by parents during after birth visits to refer to children's centres. A range of parenting support programmes which are tailored to different needs of families are available and include programmes which are viewed positively by parents who report they support an increase in their self-esteem, confidence and resilience.
26. The inclusion teams, special schools and alternative provision offer services on an outreach and targeted basis to address challenging behaviour which is rendering children and young people vulnerable to under achievement and exclusion. The multi-disciplinary primary and

secondary fair access panels are succeeding in implementing interventions which are reducing exclusions and preventing escalation of family tensions.

27. Good use is made of the CAF through the fair access panel process to assess needs, assess the effectiveness of prior interventions and to plan and implement support or managed moves agreed by the panel. The panel is diligent in ensuring that school based options including the involvement of parents through TAC and parenting support are explored fully before considering managed moves.
28. Young people aged 16 and 17 receive a good range of services through multi-agency working at The Point. This is particularly effective in targeting interventions to support young people who are homeless, at risk of being homeless or in financial difficulty. An age appropriate version of the CAF is used well to clarify the needs of the young person and secure their commitment to necessary action and mediation. Housing services are effective in resolving family conflicts, resulting in very few young people requiring section 20 accommodation for the reason of homelessness. Services at The Point are also very effective in reducing young people's levels of vulnerability, through enabling them to access education or training or gain employment, and in addressing drug and alcohol concerns. The Support Through Early Intervention Panel (STEIP) ensures an effective and proportionate multi-agency response to reports of youths perceived to be at risk or involved in crime/antisocial behaviour.
29. The council is working towards a more consistent use of the CAF as a common assessment tool across services. The TAC approach is well established and protocols for setting up teams and assembling expertise from different services are flexible, enabling prompt response to identified needs. The use of CAF and TAC procedures effectively supports the early identification of targeted support to vulnerable children in the Royal Borough. The number of children and young people receiving early help through the CAF and TAC processes are improving and there is now a greater commitment from health visitors to initiating CAFs and adopting the lead professional role.
30. Early years, portage and inclusion teams have doubled the number of TAC for these services in recent months. Family support and family engagement workers working from children's centres have had a significant impact on intervention from these settings. The number of CAFs and TAC initiated and led by primary schools remains relatively low although the council believes it is as a result of under recording of activity. The family solutions team leads the majority of TAC for children aged 11-15 and provides specialist intervention for those at the edge of care, support for children in need and support for step down. Through these services, the CAF and TAC is effective in reducing the need for higher level services with 80% of children and young people being supported

remaining below the threshold for statutory children's social care intervention.

31. Child protection plans and TAC plans seen by inspectors generally lead to improved outcomes for children. Parents spoken to clearly understand the intentions of child protection plans, the expectations made of them and other agencies in enabling their children to remain safely at home. Parents also understood that non-adherence to the plan which resulted in an increased risk to their children could lead to a legal planning meeting. Most cases seen take into account the views of parents and where appropriate the views of children which contribute to effective planning and communication of the help on offer. Conference and core groups observed were inclusive meetings that facilitated parental contribution and consideration to the formulation, development and monitoring of plans.
32. The process of police notifications is well coordinated between the police and the council by the co-location of a social worker within the police protection department. Early identification of risk and prioritising referrals is effectively undertaken through these arrangements. The impact is that the social worker oversees all police notifications supporting the early identification of risk. This reduces inappropriate referrals to children's social care services. Incidences which do not reach the threshold for social care intervention but where lower levels of intervention are required are referred appropriately, for example, to children's centres.
33. The pre-birth and assessment service enables effective early tracking and monitoring which results in close tracking, early information gathering, and timely identification of risk. Weekly, bi-agency meetings with a multi-disciplinary focus ensures well planned information sharing across agencies in the management of pre-birth assessments.
34. Access to interpreting services is readily available and meets the diverse language needs of the local community. Ethnicity is routinely recorded on case files and CAFs with evidence seen of this being considered appropriately in the majority of assessments.
35. There are some good examples of the views of parents and children being used to assess and develop early help and social care services. For example a children's centres survey that was completed by parents and carers showed a very high rate of parental satisfaction with the support they received. Parents were highly likely to recommend the children's centre to others and the Discover Me courses to help secure employment. In response to a survey of parents'/carers' experience of child protection case conferences which was undertaken in March 2012 a small group of parents agreed to an interview to further discuss their experiences, the findings of which were fed back to social workers, managers and child protection chairs to improve practice. Children with disabilities were consulted about their experiences of access to services and this directly

informed the detail of the service specification. However the views of children, young people and their families are not collected systematically following interventions, for example after a child ceases to be subject to a child protection plan or at the point where a case is being stepped down from children's social care to targeted services.

36. The number of children subject to private fostering arrangements is acknowledged as being relatively low in Greenwich. The Greenwich Safeguarding Children Board has undertaken an awareness raising activity within the borough. The council identified that initial visits and assessment of private fostering arrangements had not been satisfactory. Performance is monitored closely and has, as a result, improved. The council's own data currently shows that the percentage of children who receive a visit within seven working days of notification and the visiting of these arrangements at least six weekly is better than statistical neighbours and national indicators. However, visits undertaken to these arrangements every 12 weeks in the second year show the council is performing less well.

The quality of practice

37. The quality of practice is judged to be **adequate**. Locally agreed thresholds for services are known and understood across the partnership and used appropriately. When professionals have concerns about a child, information is generally shared without delay. The inter-agency referral form is an effective tool for key partners to refer matters of concern and is commonly used by professionals seeking access to services.
38. The council has experienced a significant increase in the number of referrals over the past three years to children's social care services with a high proportion of these progressing appropriately to initial assessment. In the vast majority of contact and referrals sampled, inspectors found that these were made appropriately. Effective action has been taken to reduce the number of inappropriate referrals to the service. This has been well supported by the creation of two early help practice advisors who are located within the contact and referral team and who support partner agencies to progress CAF assessments and TAC meetings. Social work expertise and advice is readily available to partner agencies in determining the appropriateness of referrals and to offer guidance to signposting to other agencies.
39. The dedicated contact and referral team functions efficiently and processes the vast majority of contact and referrals within statutory timescales. Management oversight is generally good. Effective and timely decision making identifies cases promptly that need a rapid response from the initial response and assessment service (IRAS). Most contacts examined by inspectors which did not progress on to a referral gave a clear explanation and rationale for decisions made. One example was seen

where risks had not been fully assessed, with insufficient checks being made resulting in the case being closed prematurely. All the contacts sampled evidenced that ethnicity of children and their families were suitably recorded.

40. The contact and referral service benefits considerably by the co-location of a social worker within the police public protection desk. A key role of the social worker is to provide social work expertise and advice to the police, enabling contacts which feature domestic violence and pose a potential risk to children to be prioritised and allocated to a social worker in a timely manner. Additionally, the social worker also undertakes joint visits with the police.
41. The quality of assessments is improving but is variable across the teams with the majority signifying adequate practice. Most current cases benefit from a commonly used risk analysis tool which takes into account both risk and protective factors alongside historical concerns. Social workers confirm that this is an effective tool which supports them to focus contextually on the risks to children. However, despite this more recent positive development, there were still notable weaknesses in the quality of analysis within some assessments.
42. Some cases lacked management rigour with examples such as poor action planning and insufficient rationale within assessments that were signed off. Several cases seen by inspectors demonstrated good examples of thorough consideration being given to the family's culture and presenting family dynamics. Assessments undertaken under the CAF are of a generally good quality and take into account the child's and family's needs.
43. The quality of pre-birth assessments seen by inspectors is good. Assessments are comprehensive, child focused and address both protective and risk factors. Pregnancy in high risk cases is managed well through the pre-birth assessment and support team supported by rigorous tracking and monitoring by robust multi-agency maternity weekly meetings.
44. The majority of core assessments seen by inspectors are not supported by robust planning. This limits the ability to monitor and track progress and implement appropriate support mechanisms and interventions. In some cases seen, step down planning from children's social care to local services was not sufficiently graduated or too early with some closed too quickly after intensive social work intervention.
45. Case recording is generally timely. When case recording is not always up to date, social workers report that this is a result of high case loads. However, the quality of recording varies significantly across teams. In most cases seen, recording reflects the work that has been undertaken and is clearly outcome focused. Overall, chronologies are not well

embedded or sufficiently focused on significant events. In some cases significant gaps were noted and impede capturing a coherent picture of significant events.

46. Some key omissions in recording were evident with this often being attributed to the fact that it is common practice that case recording and assessments are often only completed on an individual child. This results in the individual needs of children in sibling groups not always being given sufficient consideration. In some cases, there was an absence of consideration of each individual child's needs within assessments due to the focus on only one child within a sibling group.
47. The views and experiences of the child are generally well documented and case notes often reflected positively the steps taken by the social worker to build up a trusting relationship. However in some of the cases seen the views and experiences of the child are not clearly documented consistently in assessments, child protection enquiries and case recording. However, in one child protection conference observed, the views of the child were clearly articulated enabling the child's voice to be heard clearly.
48. Child protection enquiries are undertaken promptly by suitably qualified social workers. Effective partnership working with the police ensures telephone strategy discussions routinely take place. However, they generally lack evidence of information from other professionals being included in the discussion. Inspectors observed some good examples of effective multi-agency strategy meetings during which key professionals met to share information to support effective planning and decision-making in the management of risk. However, the majority of these strategy meetings are not attended by the police and this prevents the fullest sharing of information and exploration of risk.
49. The use of police powers of protection is high with some evidence seen where these powers were being used without prior consultation with children's social care services. Evidence from a sample of cases revealed that these powers were not always proportionate to the risk being presented. Many are undertaken during the working day, were not proportionate to the risk and could have been managed without the need to use police protection powers. The council and the GSCB are aware of this issue. The council is in negotiation with the borough police, using a thorough analysis of data to inform a change in practice.
50. Child protection conferences are chaired by experienced and skilled managers with appropriate decisions being made in the conferences observed by inspectors although one conference was prolonged and lacked focus and rigour. Conference reports are prepared and submitted in advance and quality assured by team managers. However, in one case, the report had been given to parents before it had been quality assured and there was significant information missing which, after the quality

assurance process, had been rectified. Parents confirmed that they received conference reports prior to the meeting and valued the opportunity to discuss these with their social workers. Parents were largely well prepared and understand the purpose of the meeting and the implications and seriousness of the recommendations being considered and the decisions made. The quality of the contributions by partner agencies at conferences is variable. Written reports are not routinely available prior to the conference and verbal contributions lacked clarity and analysis.

51. The practice of children and young people routinely attending their own child protection conference is not well embedded. This is an area of practice the council is keen to develop and intends to model the service development on the current arrangements for looked after children including the availability of advocacy services to support children and young people to promote attendance at conferences.
52. The quality of care planning is variable. Core groups are generally held within timescales with appropriate attendance by key professionals in the majority of cases. Some child protection plans seen by inspectors were focused and facilitated timely provision of targeted services while others lacked focus on risk and the timely completion of agreed tasks. The council's own audit of 60 child protection cases revealed variability in recording with no evidence that reports were shared with core group members unable to attend. This inspection identified that positive progress is being made to improve the quality and recording of core groups. Supervision records lack evidence of rigour in management oversight of plans and progress against identified targets. Child protection plans are sufficiently detailed to ensure clarity about the consequences of not engaging. However, older child protection plans tend to use a general statement relating to seeking legal advice. In some more recent plans, contingency planning is more rigorous with a sharper focus on objectives, timescales and individual accountability. There is evidence of a good range of services to support the delivery of the plan supported by strong partnership arrangements.
53. Decision making within children's social care is undertaken by suitably qualified and experienced social work staff and managers. However, decisions are not always routinely recorded and some lack a clear rationale. Legal planning meetings are appropriately held and explore thresholds for care proceedings and appropriately consider the individual needs of each child. There is evidence of an emerging, more recent drive to take decisive action where children are, or are likely to become, subject to a second and subsequent child protection plan.
54. Management oversight and decision making is evident on all case files. However its overall effectiveness can be weak at times as decisions are not always followed through. Currently, there is no systematic mechanism

for the team manager to audit or monitor the decision making of the assistant team manager who is tasked with decision making on all contacts and referrals. This shortfall is acknowledged and the council's own improvement plan includes an audit process to evaluate decisions made on cases where they do not meet the thresholds for children's social care services.

55. Individual supervision between managers and social workers takes place regularly. However the quality of supervision is variable with most cases failing to demonstrate reflection or challenge. Actions in case supervision are generally task centred with timescales for action not always evident or clear. Where supervision is better there were clear accounts of the discussion relating to training, personal development and support. Staff report that they benefit from reflective case conversations with and practice observations by professional educators. However, these conversations are not evidenced within either case recording or supervision files. Where individual performance is identified as an issue, managers take appropriate action to address this using the capability processes.
56. There is variability in the number of cases social workers are carrying across the service. The council has taken positive steps to seek to reduce high caseloads through increased staffing. Caseloads are reducing and staff confirm that workloads are becoming much more manageable. Regular reporting of individual team caseloads by middle and senior managers is in place for on-going oversight and challenge.

Leadership and governance

57. Leadership and governance are **good**. The council demonstrates a strong and determined commitment to maintaining and improving child protection and early help services. The council has a good understanding of its strengths and weakness and how these have impacted on service delivery such as realigning resources and children in need work to a more targeted approach. This has led to some effective services, particularly the pre-birth assessment service, the 0-5 service provision through children's centres, teenage support services through the family solutions service and the multi-agency support services to young people aged 16-17 years at The Point.
58. The creation of the contact and referral team in the initial response and assessment service in May 2010 has led to significant improvements in the way contacts and referrals are dealt with enabling the service to provide a more timely and consistent response. The reorganisation of the out of hours service provides an effective focus on children which is effectively integrated into the front line social care team. Plans to create a multi-agency safeguarding hub are well advanced and will further strengthen

the council's ambition to provide a more effective approach to partnership working and child protection.

59. The council's commitment to improving services is further demonstrated through their robust response to the recent peer review of their safeguarding services. The response is clearly articulated in an extensive action plan with tight timescales for delivery. The council's progress towards achieving their intentions is closely monitored by the senior management team and an external quality assurance challenger. The support to this improvement plan is commendable through the allocation of additional resources with oversight and monitoring by the Chief Executive, Cabinet, the Children's Trust and the Children and Young People's Scrutiny Panel.
60. The peer review and this inspection, independently of each other, have identified a need for more robust support and planning for vulnerable children especially where children who have ceased to be on a child protection plan require some on-going support to ensure sustained positive progress. The step down planning arrangements are generally considered too steep. This is an identified area for development by the council which is already the focus of a working group. In response to the inspection findings, the council confirmed immediate actions they were to take to address this issue in the short term, combined with appropriate plans for the medium term.
61. Learning from previous inspections to improve services especially in relation to the quality of practice and where sustained improvements have been a challenge remains a key priority area for the council. A team of professional educators is now well established, an initiative originally having been set up to support newly qualified social workers and which has now been expanded to all social workers. Social workers report positively that this initiative is helping them to sustain improvements in practice and there has been a demonstrable improvement in recent months which is evident in a number of case files seen by the inspectors.
62. The council and partners are well informed about the local demography and the needs of the local community. This is clearly evidenced through the comprehensive joint strategic needs assessment and the detailed profile of children and young people in Greenwich which is translated well into a tightly focused Children and young People's Plan. Appropriate priorities based upon the council's three key themes, resilience, prevention and protection, are now becoming well embedded in their ambitions for supporting children and families.
63. The local profile and plan has been used well to inform the commissioning of services and in particular the effective commissioning and decommissioning of services from the third sector. There is good evidence of the council working with partners to address specific areas of need and

concern which are delivering positive outcomes and results, such as serious youth violence, the focused work on gangs, missing children and the targeted approach to multi-agency service provision, for example, The Point. High priority is given by the council and partners through a multi-agency task group to identify and tackle child sexual exploitation through the development of a child sexual exploitation strategy, protocols, training and referral pathways. Appropriate links are established with the missing children group to share information and intelligence. However, there are some areas where the strategic approach has lacked continuity or requires further clarity. These areas include, for example, domestic violence, the gradient for step down services and the identified gap for children and young people aged 5-11 years.

64. Supported by joint commissioning groups, the Children's Trust Board is an effective forum for high level challenge and problem solving. This ensures there is political commitment and oversight for services to children, young people and their families. Whilst there is no combined action plan specifically connected to the Children and Young People's Plan, all services are expected to have delivery plans to meet the partnership's priorities and to achieve performance comparable with statistical neighbours at the very least. The partnership's 2011-12 evaluation of impact demonstrates clearly where progress has been made and where more still needs to be done.
65. Strong and clear lines of accountability exist between key elected members, senior officers and the more recently, newly appointed Chair of the Safeguarding Children Board. A robust corporate approach is adopted in considering wider issues of vulnerability and the impact of these on children's social care services. A good example of this is through the work currently being undertaken on assessing the number of families being affected by the welfare reform housing benefit cap and the relationship of these families to the work of the troubled families programme combined with the potential impact on children's services.
66. The Greenwich Safeguarding Children Board is meeting its statutory responsibilities and stated aims and objectives with board members from partner agencies including the voluntary sector at an appropriate senior level to ensure they are able to influence the safeguarding agenda in their respective organisations. A newly appointed, experienced independent Chair is eager to make a number of changes to the Board's current structure to ensure the work programme is streamlined and more effective in addressing core child protection business. Close links with the adults social care service have been established. Reciprocal arrangements for each service area to be represented at both Adults and Children Safeguarding Boards are well in place ensuring information is shared and more effective joint working takes. Improved attendance rates at board meetings are being achieved and are supporting a more strategic response to the safeguarding agenda.

67. Coordinating an effective multi-agency response to the most prevalent issue of domestic violence remains a critical key priority for the partnership. Hotspots have been identified through reported incidents and when mapped to the areas of most deprivation the council can see that the two issues are connected. Reporting levels are higher than the national average, and through effective auditing of child protection cases the council has established that 75% have a domestic violence element. Raising awareness, identifying victims at risk, reducing hospitalisation and establishing an effective range of preventative services with the support of all partner agencies remains pivotal to the work of the partnership in securing better outcomes for vulnerable children in high risk situations.
68. Using the learning from a very effective joined up approach between the police and council to address serious youth crime, the council is soon to embark in a similar way with the police to address serial perpetrators of domestic violence. A 'time limited' domestic violence strategy has been in place but has since lapsed. Whilst a range of services is being provided, these are fragmented and are not drawn together under an up to date overarching, coherent strategy nor have the services been evaluated as to their impact. This is an identified area for development and the council is working on a new strategy which includes violence against women and girls.
69. Key challenges for the service as a whole are known and understood by the board and across the partnership and are reported on in the annual safeguarding report. However the current annual safeguarding report, whilst detailed and informative, fails to explore any real impact the Board is having on service delivery and core child protection activity. Good governance arrangements between the GSCB and the Children's Trust are in place with the GSCB Chair attending Children's Trust meetings as a participant observer and the Lead Member for Children's Services attending the Safeguarding Children Board. The GSCB Chair provides an annual report to the Children's Trust Board and this ensures information sharing across both boards is effective with appropriate challenge.
70. Performance management arrangements are well established with appropriate reporting mechanisms to the Children's Trust, Children and the Young People's Scrutiny Panel, the GSCB and through the line management structure to individual teams. The council is data rich and this intelligence is supporting the council in improving practice and services for vulnerable children. Through weekly discussions with staff, quantitative and qualitative data is analysed to monitor key performance indicators. Where performance is seen to be slipping, measures are effectively put in place to deliver improvements. Whilst there is a richness of data, the council acknowledges a need now to use the data more effectively to fully understand some variations in the council's performance indicators and to measure any variability across individual social work

teams to ensure they achieve a greater consistency in practice and improvement.

71. Auditing activity is regular with quarterly reports being considered at meetings between the Director of Children's Services and the Cabinet Member. Through these meetings it was recognised that on too many occasions similar issues were being identified within audit activity which highlighted a disconnection between the audit process and improvements in practice. The Director of Children's Services is actively engaged in auditing activity especially in relation to being satisfied that appropriate progress is made on specific issues included within the improvement plan. For example, the recently introduced risk analysis tool and the direct oversight by the Director through random case auditing and feedback to individual staff.
72. Thematic audits are well established and although accurate they were not prompting sufficient progress in the quality of practice being provided to children and families. These findings contributed to the peer review specification and have led to accelerated plans to improve the quality of service and facilitate cultural change within the children's social care services. Progress to address the areas of development identified in the safeguarding and looked after children inspection in July 2010 has, in the main, been satisfactory with some areas fully addressed and operational. More rapid progress has been achieved since the beginning of this year supported by increased oversight by the Director of Children's Services.
73. The strong commitment to improving and achieving consistency in the quality of practice has resulted in the appointment of professional educators. The quality of supervision is variable with little evidence of challenge and smartness in timescales for completing actions. The provision of professional educators is a key feature in complementing the quality of supervisory conversations and in providing a focus on reflective practice. The quality of recording identified as an area for development in the unannounced inspection of contact, referral and assessment arrangements in April 2011 is an acknowledged challenge which has not seen sustained improvements. However, inspectors evidenced a significant difference in the quality of recording since the peer review improvement plan was implemented. The professional educators are tasked with driving forward and working to ensure sustained progress in this area.
74. The technology which supports the integrated children's system is generally fit for purpose, albeit with some system frustrations but requires some further fixing to enable full reporting of activity, for example, statutory child protection visits monitoring. This is work in progress with a trial having been completed and plans are now in place to enable all teams to run reports on visits.

75. Securing the views of children is not as well embedded as the council would aspire to and it has not moved on with sufficient speed since the safeguarding inspection in June 10. The council is keen to adopt a similar model to that used in the statutory looked after children reviews process, and establish an advocacy support service for children and young people to help them in either attending or being able to contribute in an effective and imaginative way to ensure their voice is central to the case discussion and final outcome.
76. The council uses learning effectively from other local authorities to inform their service developments and improvements. For example, the introduction of professional educators is a model from a neighbouring local authority which has been adapted and extended. Effective and responsive action has been taken to increase resources in the children with disabilities team following concerns being raised internally about the quality of practice in a particular case. Additionally, and most notably, the council's response to the peer review has been exceptionally robust. The drive to change culture in order to ensure sustained improvements through the 'what good looks like' principle is clearly articulated, supported by staff visiting other services and local authorities to assist in the learning and change process. Inspectors confirmed signs of improvement in the early stages of implementation of the plan.
77. The use of agency staff to cover vacancies is at its lowest for a number of years. This has been achieved through deliberate, successful targeted recruitment of newly qualified social workers (NQSW) and the recruitment of agency staff to permanent posts. Retention of NQSWs has been impressive with only one out of 22 starters over the past 18 months leaving the council. NQSWs are well supported by professional educators and peer support. The council's plan is now to target recruitment on experienced workers to achieve a balanced skill mix amongst its social care workforce. However, in terms of supporting the improvement plan to maximise its effectiveness and sustainability, there is currently an absence of a workforce plan specifically underpinning the improvement plan.

Record of main findings

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

