Royal Borough of Kingston upon Thames Council

Inspection of services for children in need of help and protection, children looked after and care leavers

and

Review of the effectiveness of the local safeguarding children board[1]

Inspection date: 22 May 2015 – 18 June 2015

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Children's services in the Royal Borough of Kingston upon Thames are good
Good leadership means that children and young people are protected, the risks to them are identified and managed through timely decisions and the help provided reduces the risk of, or actual, harm to them. Children and young people looked after, those returning home and those moving to or living in permanent placements outside their immediate birth family have their welfare safeguarded and promoted.

1. Children who need help and protection		Good
2. Children looked after and achieving permanence		Good
	2.1 Adoption performance	Good
	2.2 Experiences and progress of care leavers	Good
3. Leadership, management and governance		Good

[1] Ofsted produces this report under its power to combine reports in accordance with section 152 of the Education and Inspections Act 2006. This report includes the report of the inspection of local authority functions carried out under section 136 of the Education and Inspection Act 2006 and the report of the review of the Local Safeguarding Children Board carried out under the Local Safeguarding Children Boards (Review) Regulations 2013.

Contents

The local authority

Information about this local authority area[2]

Previous Ofsted inspections

- The local authority does not operate any children's homes.
- The previous inspection of the local authority's arrangements for the protection of children was in June 2013. Ofsted judged that services were inadequate.
- The previous inspection of the local authority's services for looked after children was in May 2012. Ofsted judged that services were adequate.

Local leadership

- The Director of Children's Services has been in post since July 2012. The Director of Children's Services is a shared post with the London Borough of Richmond upon Thames.
- The chair of the Local Safeguarding Children Board (LSCB) has been in post since May 2013.
- The LSCB shares an independent chair with Richmond upon Thames.
- Children's services are delivered through Achieving for Children (AfC), a community interest company established by Kingston upon Thames and Richmond local authorities. This means that AfC is commissioned to provide the services for children in need of help and protection, children looked after and care leavers evaluated by this inspection.

Children living in this area

- Approximately 36,000 children and young people under the age of 18 years live in Kingston upon Thames. This is 21.4% of the total population in the area.
- Approximately 14% of the local authority's children are living in poverty.
- The proportion of children entitled to free school meals:
  - in primary schools is 9.6% (the national average is 17%)
  - in secondary schools is 8.3% (the national average is 14.65%).
- Children and young people from minority ethnic groups account for 33.4% of all children living in the area, compared with 21.5% in the country as a whole.

[2] The local authority was given the opportunity to review this section of the report and has updated it with local unvalidated data where this was available.

- The largest minority ethnic groups of children and young people in the area are Asian/Asian British.
- The proportion of children and young people who speak English as an additional language:
  - in primary schools is 33.7% (the national average is 18.7%)
  - in secondary schools is 28.6% (the national average is 14.3%).
- The largest ethnic group in the borough is from Korea.

Child protection in this area

- At 31 May 2015, 906 children had been identified through assessment as being formally in need of a specialist children's service. This is a reduction from 916 at 31 March 2014.
- At 31 May 2015, 134 children and young people were the subject of a child protection plan. This is an increase from 100 at 31 March 2014, but it is lower than in March 2013 when 163 children were subject to a child protection plan.
- At 31 May 2015, five children lived in a privately arranged fostering placement. This is a reduction from seven at 31 March 2014.
- Since the last inspection, two serious incident notifications have been submitted to Ofsted and two serious case reviews have been completed or are ongoing at the time of the inspection.

Children looked after in this area

- At 31 May 2015, 118 children are being looked after by the local authority (a rate of 34 per 10,000 children). This is a slight increase from 115 (33 per 10,000 children) at 31 March 2015, and a significant reduction from 147 in November 2012. Of this number:
  - 77 (or 65%) live outside the local authority area
  - five live in residential children's homes, all of whom (100%) live out of the authority area
  - four live in residential special schools, all of whom (100%) live out of the authority area
  - 90 live with foster families, of whom 60% live out of the authority area
  - no children are placed with parents
  - 18 children are unaccompanied asylum-seeking children.
- In the last 12 months:
  - there have been 12 adoptions
  - five children became subject of special guardianship orders
  - 59 children ceased to be looked after, of whom five subsequently returned to be looked after

- no children and young people ceased to be looked after and moved on to independent living
- 14 children and young people ceased to be looked after and are now living in houses of multiple occupation.

Executive summary

Services to children and their families have been transformed since the last inspections of children looked after services and safeguarding. The 2012 safeguarding and looked after children inspection found services for looked after children to be adequate and safeguarding services to be inadequate. The 2013 inspection of local authority arrangements for the protection of children also found provision to be inadequate. Council leaders, together with Achieving for Children (AfC), the Local Safeguarding Children Board (LSCB) and the Children's Services Improvement Board (CSIB), have successfully delivered against an ambitious improvement plan. This has led to an impressive level of change in service delivery for children and families across Kingston upon Thames. Almost all areas identified for improvement in the previous inspections have been addressed in full and this is having a positive impact for children.

The local authority oversees effectively the work of AfC through robust commissioning and contract management arrangements. The integrated arrangement between the two local authorities is proving to be an effective one for Kingston upon Thames. The integrated service, delivered through AfC, is leading to greater efficiencies, for example through a single senior management team. It also encourages the sharing of best practice and processes between the two boroughs. The Director of Children's Services has a determined and innovative approach and, together with a highly skilled senior management team, this leads to a constant drive to deliver high quality services for children and their families.

Children and their families in Kingston upon Thames now receive coordinated, effective and timely early support from a wide range of universal and targeted services. If their needs or risks escalate, prompt referrals are made to children's services, which are progressed efficiently for statutory assessment. The large majority of children receive a good service from diligent and skilled social workers who take account of their views. Assessments are detailed and appropriately identify risk. Plans meet needs and reduce risk, and the regular review of progress ensures delays are usually avoided. For those children in need of protection, including those who become looked after, swift and robust action is taken to reduce risk and secure stability.

The vast majority of children who are looked after live with families within, or close to, the borough and rarely experience changes of placement. They have their physical and emotional health needs assessed and have prompt access to relevant services. Children, including those with complex needs, are adopted where it is in their best interests. Care leavers have a choice of a range of accommodation and the large majority benefit from meaningful and enduring relationships with their key workers.

Particularly strong areas of practice are the creative and thoughtful direct work undertaken with children to gain an understanding of their thoughts and feelings and ensure these inform their plans and the wide range of effective post-adoption

support services.

No children were identified in this inspection that were left at risk of significant harm; however, there are areas where the quality of work with children requires further improvement to ensure all children receive a good service. These include the sharing of reports before child protection conferences; timely intervention and support for children who are privately fostered; routine multi-agency attendance at strategy discussions; the quality and analysis of return home interviews for children who have been missing from home or care; take-up of advocacy and independent visitor services; and permanence planning, including the use of parallel planning.

Strong governance and commissioning arrangements have underpinned the swift improvements to services for children and their families. Effective recruitment and workforce development activities have achieved a more stable and permanent workforce with the skills to deliver good services. A strong and committed senior management and leadership team are providing constructive challenge and delivering against a demanding agenda. Comprehensive performance management information is used across all levels of hierarchy within the council and AfC to inform delivery and service development.

Aspects of leadership and management where improvements are still required include oversight within the children with disabilities team and of emergency placements, reducing delay in the assessment of prospective adopters and improving the content and use of the adoption panel chair's report. Other aspects include the range of post-16 options for care leavers, broadening oversight of issues affecting children looked after and care leavers by the corporate parenting panel, and the inclusion of children's safeguarding issues in the joint strategic needs assessment so that this can inform commissioning decisions.

Recommendations

1. Ensure child protection reports are shared with children and parents/carers, allowing sufficient time for them to understand and consider the report, and prepare for and participate fully in conferences (paragraph 24).

2. Ensure that assessments of potential private fostering arrangements, and visits to children in these placements, are carried out in a timely manner (paragraph 35).

3. Ensure that strategy discussions include social care, the police and health professionals, with other agencies as appropriate, to ensure decisions regarding the investigation and protection of children are fully informed by all key agencies (paragraph 23).

4. Improve the quality of return home interviews so that when children go missing the reasons are well understood and this learning informs plans to protect children, individually and collectively (paragraphs 29, 48).

5. Review independent visitor and advocacy arrangements to ensure that the service is accessible to all children who may benefit from it (paragraph 52).

6. Ensure that all permanence plans for children, including the use of parallel planning, are pursued with urgency and that progress is tracked robustly to avoid any unnecessary delay (paragraphs 43, 71).

7. Further strengthen management oversight in the children with disabilities team, particularly when plans change in response to children's emerging needs and risks (paragraph 20).

8. Ensure that all decisions to place children with family members and friends in an emergency are timely, made by an appropriately senior manager and clearly evidenced in case records (paragraph 39).

9. Ensure that the adoption panel chair's report to the local authority provides a detailed understanding of Kingston upon Thames' adoption work and supports the development of the panel and local services (paragraph 80).

10. Increase the range of post-16 employment and training options available for care leavers, including apprenticeships (paragraph 96).

11. Ensure that the corporate parenting panel provides effective oversight of the full range of issues affecting children looked after, including the work of the independent review service; the effectiveness of services to reduce the risk to children who go missing from care; and the effectiveness and uptake of employment and training opportunities for care leavers (paragraph 108).

12. Complete the joint strategic needs assessment to include issues relating to the safeguarding of children and ensure commissioning decisions are fully informed by this partnership needs assessment (paragraph 101).

Summary for children and young people

- Senior managers have improved support for children and young people in the areas found to be weak when the borough was last inspected. Services that support children and young people now work together well and managers are constantly checking to ensure children's and young people's needs are met, particularly during difficult times in their lives.
- When children and families need help and support they are provided with effective services quickly. Teams of staff working in the different localities across the borough, including children's centres, provide the right sort of help at an early stage. This is helping improve children's and families' circumstances.
- Children and young people who are most at risk are protected by different agencies working together. They get the support they need from social workers who listen and take account of their views. Professionals talk to children and young people who have gone missing when they return, but more needs to be done with the information to help keep children safe.
- Social workers care about the children and young people they work with and, if children and young people can only be supported and protected by being taken into care, they make the right decisions at the right time. Social workers listen to children's views carefully when planning for their futures. Foster carers are supported well by the borough.
- Children and young people who are cared for by the council usually go to good schools and make good progress in their education. Their personal education plans help in this respect. Their progress is followed carefully and support or one-to-one tuition is provided if they are not doing as well as expected. Children and young people are encouraged to develop their interests and take part in sport and after-school activities.
- The Children in Care Council has achieved a lot. It helps organise social events for young people and has established a youth club that has good facilities and activities for children and young people of all ages. The Children in Care Council is working hard to get young people involved as older members leave.
- Social workers are good at considering adoption for all children who might need it, including children with complex needs. As a result, older children, disabled children, brothers and sisters, and children from minority ethnic groups are being adopted.
- Young people who are leaving care are helped well and have a good choice of accommodation that meets their different needs. Sixteen-year-old young people are supported well and progress to education, training or employment and to university but not enough young people have the opportunity to take up an apprenticeship.

The experiences and progress of children who need help and protection	Good

Summary

Children and families who need help and support receive effective and timely services. Locality teams and children's centres deliver a wide range of well-coordinated early help services, which are improving outcomes for children and families.

The single point of access (SPA) and the multi-agency safeguarding hub (MASH) provide a timely and effective response to contacts and referrals. Children and young people in need of protection are prioritised and their needs competently assessed by social workers.

Social workers are imaginative and resourceful in working with children. Children are listened to and understood, and their views are used to inform assessment and planning. Social work visits to children are regular, purposeful and child-centred.

Assessment in the vast majority of cases is robust, with risks well analysed. In most cases, plans are effective in reducing risks and improving outcomes for children and young people.

Strategy discussions make the right decisions about relevant actions when there are concerns about the safety of children and young people. However, the vast majority are undertaken only by the police and children's social care, which means that other professionals are not contributing to key planning and decision-making. Child protection conferences are timely, sensitively chaired and attended by relevant professionals. Social work reports are of good quality, but children and parents or carers do not always receive these in good time and this inhibits their full participation in conferences. Children and young people are supported to attend their child protection conferences when they wish to and this is appropriate; their views are sought, analysed and used to improve services.

Children who go missing are offered return interviews. The quality of recording of interviews completed when children return is not thorough enough and findings are not analysed to identify patterns and trends that can inform service delivery.

The multi-agency child sexual exploitation group (MASE) discusses all young people recognised as vulnerable to sexual exploitation. MASE meets monthly and reviews all children identified by any agency as potentially at risk of child sexual exploitation.

Arrangements to assess and support children in private fostering arrangements are not robust enough and a small number of privately fostered children are living in unassessed placements.

Managerial decision-making, supervision and oversight of casework are mostly good. However, management oversight and decision-making within the children with disabilities team, particularly where decisions change in relation to child protection and child in need plans, are areas requiring improvement.

Inspection findings

13. There is an effective and coordinated offer of early help across Kingston upon Thames. Early help services are now an integral part of the locality teams and family support and youth support workers work closely with schools, health professionals and voluntary organisations to provide timely support to children and their families. The role of children's centres in early help, in supporting parents and in preparing children for school is clearly defined and understood. Children's centre outreach workers target services to specific localities of high need to encourage participation in centre activities. Children's centres are successful in ensuring 80% of eligible parents take up the offer for two-year-olds, which is improving children's readiness for school.

14. Schools also work well with children, young people and their families to identify their needs early and to secure appropriate support. This includes making referrals to the locality teams for more targeted input and also routinely attending and being active partners with early help meetings and plans. Locality teams and children's centres provide a wide range of parenting courses and these are having a significant positive impact on parents' ability to care for their children. Parents who spoke to inspectors explained how these courses not only helped them improve their parenting skills but also helped them make friends and reduce isolation.

15. The local authority has been successful in surpassing its target of 225 families for helping those with the most complex needs as part of the troubled families' initiative. Data are used well to target families, assessments of need are thorough and expected outcomes are clear. Almost two thirds of the families worked with involve children and young people of school age who have significant behavioural problems, have undergone fixed-term exclusions or have been permanently excluded.

16. The SPA provides a clear and effective contact and referral service and ensures quick transfer of cases to the referral and assessment teams for further assessment and intervention. Partner agency referrals are appropriate and timely. Threshold application and management decision-making in the SPA are robust, and address risk and need. Records demonstrate a clear rationale for the decisions made in the large majority of cases. Timeliness of contacts and referrals is good. Partner agencies have the opportunity to consult with social workers before making a referral. Head teachers report positive improvements in the response to their referrals to the SPA. Social workers and partner agencies understand the need to seek parental consent. Referrers receive consistent feedback on referrals made.

17. The SPA developed as a MASH in June 2014. Child and adolescent mental health services (CAMHS) joined the SPA in October 2014 and provide a screening service for mental health referrals. The range of agencies involved in the MASH, including health, police and probation, ensures a coordinated multi-

agency response, so that children and young people receive support and protection at an early stage. Partner agencies share timely information about children and families to inform assessment. Domestic abuse notifications from the police are timely and effectively triaged in the MASH to ensure high-risk cases are immediately progressed to the referral and assessment teams. Almost all contacts that meet the threshold for a referral result in a single assessment and intervention. The local authority's data shows the re-referral rate for 2014-15 to be 19%. This is an improvement on the 21% of re-referrals in 2013-14, which was slightly higher than statistical neighbours (20%) and is lower than the national average (23%).

18. A strong emergency duty service, commissioned jointly with four neighbouring authorities, efficiently responds to concerns arising out of hours. An on-call manager from the local authority is available. Cases sampled by inspectors demonstrated timely decision-making, and communication with daytime services is prompt and effective, ensuring activity is followed up.

19. The strong interface between the multi-agency locality teams and the referral and assessment teams ensures children, young people and their families get the help and support they require at the right time. In the majority of cases sampled by inspectors there were clear and effective arrangements for step-up and step-down cases where risk and concern had either increased or decreased.

20. Case records are up to date and reflect managerial decision-making and oversight of casework. When assessments are not of an acceptable standard, managers send them back for further work before authorisation. However, evidence of management oversight and rationale for decision-making within the children with disabilities team, particularly where decisions change in relation to child protection and children in need (CIN) plans, remains an area requiring improvement. No children were found to have been at risk because of this.

21. The large majority of assessments and plans are of good quality, explore all presenting and historical concerns, consider the effects on the child or young person, and robustly evaluate risk and protective factors. When needs are identified, children and families do not have to wait for support until the assessment is completed. Managers regularly review CIN plans to track progress. Assessments thoroughly address issues of diversity. Inspectors saw many good examples of the use of translators and interpreters to help parents and carers understand and participate fully in meetings. Assessments where no further involvement is required as either child protection or CIN are appropriately stepped down using the team around the child process. This ensures continuity of support for children and their families and smooth transfer to locality team workers.

22. Social workers visit children and young people regularly and develop strong, trusting relationships. A particular strength of the local authority is its resourceful use of direct work with children and young people to enable them

to express their views and inform assessments and intervention plans. Inspectors saw many excellent examples of effective and creative work with children and young people, including the use of mobile technology to help young people understand the risks of child sexual exploitation.

23. Strategy discussions in the large majority of cases are timely but only involve police and social care. This means that other agencies are not fully involved in decision-making and the planning of child protection enquiries.

24. Child protection enquiries are swift, completed by experienced social workers, and overseen effectively by managers. Initial and review conferences are timely (94% in 2014–15) with good multi-agency attendance, although GP attendance is low and this limits the extent to which their information contributes to decision-making and planning. The LSCB is reviewing this and actions are in progress to ensure participation is improved. Child protection conference chairs provide effective scrutiny and challenge where child protection planning is not driving change to ensure alternative actions are progressed. Social work reports are of good quality but parents and carers do not always receive reports in time to enable them to prepare and participate fully in conferences.

25. The number of children who remain the subject of a child protection plan for 18 months or longer is low. However, the number of children who are subject to a child protection plan for a second or subsequent time has increased from 13% in 2013–14 to 22% in 2014–15. The local authority is aware of this and further analysis has shown that families with large groups of brothers and sisters have influenced the number of repeat plans. Inspectors saw no examples where children and young people were subject to unnecessary child protection processes.

26. Children and young people are encouraged to participate in child protection conferences. An advocacy service is in place to support children and young people who cannot present their views, wishes and feelings themselves. An 'opt-in model' is used for all children over the age of 11 years to ensure they contribute to or attend their child protection conference. To date, 60% of children and young people have attended with an advocate, their social worker or another trusted adult. Every child has the opportunity to complete individual questionnaires and an electronic survey supported by a participation officer. These are then used as a part of the individual's child protection process. Collated data are used more broadly for quality assurance, evaluation and service planning. A successful pilot of child-friendly child protection plans is helping children to understand concerns and these will now be implemented for all children.

27. The local authority has a good understanding of the factors leading to children needing protection. At the time of the inspection, 133 children were subject to child protection plans. Emotional abuse featured in 49% of plans, neglect 38%, physical abuse 6% and sexual abuse 5%. Multiple categories were used in 2% of cases. Domestic abuse and parental mental health (43%) are the most

commonly recorded risk factors, with substance misuse and alcohol misuse featured in 23%.

28. The multi-agency risk assessment conference (MARAC) considers children living in households where domestic abuse is a risk. Extensive awareness-raising, training, review and a process change have resulted in a significant and appropriate increase of referrals to MARAC. A domestic violence strategy and supporting work plan is in place. Progress to date has included the establishment of a domestic violence hub, access to a specialist domestic violence perpetrator programme, direct work with children and young people who have experienced domestic violence, and an increase in the number of independent domestic violence advisers from two to four. A young person's violence adviser based at the Basement One Stop Shop works with young people aged 16 to 18 years.

29. Effective arrangements are in place for identifying children and young people missing from home, care and education. The monthly multi-agency missing children (MISPER) group, chaired by the head of safeguarding, tracks and cross-references all children missing from home, care and education and identifies those at risk of child sexual exploitation. Children are offered return interviews with the advice and guidance service, their allocated social worker or an independent reviewing officer (IRO) following an episode of being missing. There were 99 missing from home episodes involving 77 children during 2014–15. Eighty-four percent of children were offered a return interview, of which 12% refused to participate. Where children had been missing only once, 15% received letters signposting to relevant support services. The quality of the recording of interviews is inconsistent; half sampled by inspectors did not contain sufficient detail. Nevertheless, where risks to children escalate, social workers and managers consistently recognise this and take appropriate action. The local authority does not collate information from return interviews to gather intelligence and identify themes. This is a missed opportunity to inform service delivery.

30. Children assessed as being at risk of child sexual exploitation are presented to the monthly multi-agency child sexual exploitation (MASE) meeting chaired by the police. A risk matrix is used to identify children at risk and a MASE planning meeting is held as required. MASE has considered 19 children since January 2015 with strategy meetings held on all medium and high-risk cases. All children demonstrated reduced risk on exit from MASE. Children at risk of sexual exploitation are prioritised for immediate support from a commissioned service. Young people's feedback is that this service is helping them to make better decisions. Awareness-raising, coordinated by the police and LSCB, has taken place with taxi firms and licensed premises about the possible warning signs to look for with young people who may be at risk of sexual exploitation. Staff spoken to demonstrated awareness of the warning signs and associated risks of child sexual exploitation. The local authority acknowledges that a number of cases presented to the MASE do not have any risks of child sexual exploitation. They plan to do more work to distinguish between young people

who are at risk of and experiencing child sexual exploitation and those who present with multiple and complex needs who require specialist services, to ensure young people receive the correct service at the earliest opportunity.

31. The authority has clear policies and procedures for identifying children missing education and maintains an up-to-date register. The children missing education group, comprising the heads of all relevant services, reviews the register regularly to ensure responses to pupils' needs are appropriate and improving outcomes. Almost half of the 48 children on the register have medical conditions that preclude them from participating in 25 hours of education a week, although the hours provided are appropriate. Children and young people attending alternative provision receive full-time education with good levels of attendance. A lead service works with each child on the children missing education register. Four excluded pupils are tutored for less than 25 hours a week as part of a re-integration plan or while an appropriate educational placement is being identified for September 2015. A small number of pupils with significant additional needs are tutored for six to eight hours while awaiting an appropriate placement next academic year. The education welfare service works closely with schools where the attendance of pupils is of concern, and overall attendance in the borough is well above the national average. The education welfare service tracks any children who have left school whose destination is unknown and the number of such occurrences annually in Kingston upon Thames is low.

32. Education welfare officers contact families promptly when children and young people are withdrawn from school by parents who intend to educate their children at home, offering help, guidance and mediation with the school where appropriate. They engage well with parents, 95% of whom opt for a meeting with officers. Education welfare officers contact families every six months offering support, for example to enable children and young people to sit examinations or to explore post-16 options. All families are cross-referenced to early help and social care records.

33. Appropriate consideration and identification of female genital mutilation, trafficking and gang violence ensures children are protected. However, the majority of referrals in relation to female genital mutilation are from schools. The team manager of the SPA appropriately recognised the low number of referrals and has raised this with partner agencies to ensure referrals are made and children are protected.

34. Social workers and managers are alert to the potential for radicalisation. Inspectors saw appropriate actions and consideration through assessment and strategy meetings. Appropriate arrangements are in place for multi-agency 'Channel' meetings to be convened where appropriate and to consider and share information to inform risk assessment, planning and prevention.

35. Five children and young people are currently subject to private fostering arrangements and received prompt assessment and regular monitoring visits.

Inspectors identified a further two cases where private fostering arrangements had not been properly assessed, due to an over-reliance on the carers seeking legal orders. This leaves children and young people vulnerable to risk. The local authority has taken action to raise awareness of private fostering, for example with independent schools and the Korean community, to raise the profile of private fostering but this has not resulted in any new notifications.

36. There is a comprehensive joint protocol for the assessment and provision of help for homeless 16–17-year-olds, jointly operated with the housing department. The Children in Care Council (CiCC) was involved in developing leaflets that accompany the protocol to ensure young people have a good understanding about the difference between section 17 and section 20 accommodation. Assessments in these circumstances are of good quality, evidencing risk and resilience factors for the young people with timely management oversight and decision-making. A young person's multi-agency accommodation panel regularly reviews cases to ensure placements and planning meet the needs of individual young people.

37. Robust procedures are in place to ensure allegations against people working with children and young people are managed effectively. Extensive awareness-raising of the role of the local authority designated officer within the local authority and with partner agencies has resulted in a significant increase in the number of referrals to the local authority designated officer from 61 in 2013–14 to 121 in 2014–15.

The experiences and progress of children looked after and achieving permanence	Good

Summary

Decisions about whether children need to become looked after are timely, appropriate and based on sound assessments of need. Practice before and during care proceedings is consistently good. Placement decision-making for some children who enter care in an emergency needs to be more clearly evidenced, although no children were judged to be in inappropriate placements because of this.

The local authority is working in a focused manner to provide sufficient placement choice for children and young people, although ongoing challenges remain. Carers are carefully assessed and well supported in their role.

Children are visited regularly by their social workers, who work productively with carers and with colleagues from partner agencies to support children. Children and the key adults in their lives contribute well to plans for their futures.

The monitoring and reviews of children's plans are robust and timely and led by an effective independent reviewing service. Risks to children are well managed, but the quality of return home interviews with children who go missing needs to be more consistent.

Most children looked after are settled and live with caring and skilled foster families close to Kingston upon Thames. Some aspects of permanence planning are not consistently good for all children. This means that a small number of children experience some delay before living in their permanent home. The virtual school tracks the progress of children looked after carefully. Children are enrolled at good or better schools and the attainment gap with their local peers is narrowing. The very large majority of children and young people make good progress in their learning. Their attainment is improving at all key stages. The Children in Care Council (CiCC) is an active and effective group and is positively influencing change in the borough.

Adoption is considered for all children, including those with complex needs. This is a key strength and results in older children, disabled children, brothers and sisters, and children from ethnic minority groups being adopted. Good, wide-ranging support is provided to those affected by adoption.

Care leavers are effectively supported in their transitions to adulthood. They have a good choice of accommodation that meets a variety of individual needs. Young people leaving care are encouraged to live in permanent, independent accommodation at a time that suits them. They are supported into education, employment and training; however, the range of post-16 provision available to care leavers, including apprenticeships and mentoring programmes, requires development.

Inspection findings

38. At the time of the inspection, the Royal Borough of Kingston upon Thames looked after 122 children. This represents a slight increase over the last 12 months. The rate of children looked after is broadly in line with similar local authorities. Decisions to look after children are timely and appropriate to the level of need and the risk. In almost all cases seen, decisions were underpinned by robust and comprehensive assessments. Social workers understand the thresholds for care. Plans and support for children who return home from care are robust, with clear contingency plans and the appropriate level of continuing involvement.

39. In a small number of cases seen, there was a lack of clear evidence of the decision-making and legal status of emergency placements of children with connected persons. Viability assessments were carried out promptly, children seen and risks suitably addressed. However, senior management overview of these placements, to ensure that all children are suitably protected and their progress tracked closely as soon as they enter care, is not sufficiently robust.

40. The Public Law Outline is used effectively. Managers have a good overview of high-risk cases and track its use closely. Letters before proceedings clearly articulate concerns and possible actions. Legal planning meetings are constructive and lead to clear, timely actions. Care applications, court assessments and evidence provided during care proceedings are of consistently good quality. The productive relationships that Kingston upon Thames has with neighbouring local authorities, the Children and Family Court Advisory and Support Service (Cafcass) and the judiciary through the Public Law Performance Group and the London Family Justice Board have enabled it to identify emerging practice issues and plan further relevant improvements. The average length of time for care proceedings has reduced significantly and is close to the national target of 26 weeks. In quarter three of 2014–15 the average was 25 weeks while in quarter four it increased slightly to 29 weeks.

41. The right support is available at the right time to meet the needs of children placed outside the borough. Young people living at a distance from the borough and carers were positive when they spoke to inspectors about the care and support provided by the local authority. Local agencies are notified promptly when children move outside the area. Inspectors saw examples of flexible and effective work to support young people's educational progress, including good liaison with local schools. Appropriate plans were in place to address young people's wide-ranging health needs, including their emotional well-being. Previous delays in accessing CAMHS support in a small number of cases have been addressed. Social workers visit children placed at a distance from the borough placements regularly.

42. In most cases seen, permanence for children looked after was pursued promptly through a suitable range of options. Inspectors saw evidence of some determined and persistent practice to tackle historical delays for children. Early

planning for children includes the appropriate consideration of special guardianship, and this is reflected in increased take-up. During 2014–15, six special guardianships orders have been made with a further nine cases in process at the time of the inspection.

43. In some cases seen by inspectors, recent intervention, including escalation from IROs, had addressed previous shortfalls. Practice to secure permanence is not, however, consistently robust and this has contributed to varying levels of delay for a minority of children. Family finding was not always undertaken with the necessary swiftness. The regular multi-agency permanence planning meetings, although demonstrating a clear commitment to tracking progress for children, could be more consistently challenging and focused.

44. Most children looked after are benefiting from living in stable, settled placements. In recent years, only a few children have experienced multiple moves while in care and this has dropped further to a very small number of children (three out of 199) in during 2014-15. There has been a sustained improvement in long-term placement stability. This performance comfortably exceeds similar local authorities and the national data. There has also been a drop in the percentage of children looked after living more than 20 miles from Kingston upon Thames, and the figure compares favourably with comparators.

45. The matching of suitably skilled and experienced carers to children and young people is thoughtful, well recorded and appropriately focused on meeting their individual needs. Reasons for not pursuing possible placements are explained clearly. The local authority is committed to enabling brothers and sisters to live together when it is in their best interests, and this commitment is reflected in the priority given to recruiting carers who are able to look after brothers and sisters together.

46. Assessments are of good quality and routinely inform effective reviews of children's plans. A small number of care plans could be more specific but most seen were of a good standard. Children's, families' and carers' views are an integral part of planning, although a small number of parents felt that the sharing of information about their child's progress could be improved. The use of an online consultation tool has contributed to a good level of children's participation in planning.

47. Children who are looked after are seen alone, and visits by their allocated social workers are regular and often more frequent than statutory requirements. The visits are purposeful and social workers know children well.

48. In most cases seen, risks, including those associated with children going missing and sexual exploitation, are identified and managed effectively and help to keep children safe. In 2014–15, eight children went missing from care on a total of 23 occasions; in the year to date, three children have been missing from care seven times. There were no children missing from care at the time of this inspection. The child's IRO routinely provides return interviews, although

these are of variable quality and information arising from the interviews is not always shared appropriately. Specific risks to children and young people were recorded clearly and required actions understood and applied by all those involved in the care of children. Contingency plans were in place. Foster carers are able to access appropriate support and guidance from the emergency duty service outside office hours, including when children go missing.

49. Partnership working to support placements is well established. Plans for children are enhanced by the available support of co-located key professionals, such as the CAMHS therapist, a designated nurse for children looked after, and the virtual school. The CAMHS therapist provides one-to-one support to children as necessary (nine children at the time of the inspection) as well as advice and support to carers and social workers. The timeliness of health assessments and dental checks deteriorated recently for a five-month period, due to a vacancy for a children looked after nurse post. This post has now been filled and the local authority recognises the priority that needs to be given to this work in order to return to the previously very good performance.

50. Care and support for the large majority of children are sensitive to their diverse and individual needs. For example, interpreting and translation services are available when necessary. The communication needs of disabled children are addressed imaginatively and carefully. Inspectors saw several good examples of effective life story work to help children understand their earlier experiences, although this work is not always undertaken in a timely manner, especially for older children.

51. Children's contact with family and friends is actively and routinely promoted. Inspectors saw several examples of persistent, productive efforts by social workers and carers to help children keep in touch with family members despite many challenges, such as an ongoing fragility of relationships or the considerable geographical distance between children and their family members.

52. Children are well supported from a good quality externally commissioned advocacy service. IROs and social workers actively promote the service and initially low take-up by children and young people is increasing. However, only one child currently sees an independent visitor. During the inspection, the local authority acknowledged that it should review its arrangements to make sure that this important and distinct service for vulnerable children and young people is available to all who need it.

53. The very large majority of children looked after and young people make the expected educational progress against their individual targets and make good progress overall in their learning. The virtual school tracks the attainment and progress of children and young people carefully, including those in registered alternative provision, and challenges schools appropriately when pupils are not making expected progress to achieve their targets. Although the numbers of children and young people are small, attainment since 2012 has improved at Key Stage 2 and Key Stage 4, including their progress in reading, writing and

mathematics at Key Stage 2 and English and mathematics at Key Stage 4. The attainment gaps between children looked after and their peers are narrowing.

54. The virtual school provides tailored packages of support for children and young people with complex needs and challenging behaviour to re-integrate them into mainstream education wherever possible. Four children looked after were receiving 25 hours of education at the time of the inspection, including specialist one-to-one tuition, although one young person had not engaged with the service.

55. The school attendance of children who are looked after is good and improving. The virtual school receives regular attendance data and is alerted promptly when there are concerns about individual pupils. Personal education plans (PEPs) consistently address children's emotional well-being and behaviour where they present a barrier to learning and identify targets and actions for improvement. The specialist education psychologist prioritises work with those at risk of exclusion. Fixed-term exclusion rates are consequently low and there have been no recent permanent exclusions.

56. Children looked after are enrolled in good or better schools. At the time of the inspection, eight children and young people were attending schools requiring improvement as a result of their most recent Ofsted inspection. The virtual school is monitoring the attainment and progress of these pupils carefully and ensures that provision is appropriate to the needs of individual pupils.

57. All children and young people, including those in early years settings and those aged 16–18, have up-to-date PEPs, which are reviewed twice annually. Targets within the plans are mostly clear, measurable and relevant to children's needs. Although all PEPs provide information about the use of pupil premium funding, they are not always clear about the intended impact. Routine monitoring of all PEPs by the virtual school is improving quality, as is the training provided for social workers and designated teachers. Social workers and teachers are able to access advice surgeries prior to PEP meetings and this too is improving quality.

58. The involvement of the virtual school with older young people is increasing and virtual school staff and settings are successful in supporting most 16-year-olds in their education, training or employment. There are no young people undertaking apprenticeships, and the local authority has acknowledged the need to need to broaden young people's horizons and increase the opportunities they have post-16.

59. Children looked after, along with carers and carers' birth children, have access to local leisure facilities at a reduced cost, although this is not easily available to children living away from Kingston upon Thames. Overall, plans for children, including those living at a distance from their home area, pay good attention to leisure opportunities.

60. Case record-keeping is generally up-to-date and effective, giving a clear picture of professional practice and its impact. Line management oversight of casework is robust and considered, leading to clear expectations and specific actions for social workers and others involved in the care of children.

61. The IRO service is good overall. Manageable caseloads help IROs to undertake the full range of their responsibilities to monitor and review plans effectively. IROs see children between reviews if it is necessary and work well to make sure that children are able to participate in their reviews. A small number of young people have been supported to chair their meetings. IROs usually challenge weak practice effectively and promptly, although inspectors saw a small number of exceptions to this. Appropriate escalation by IROs to senior managers leads to early resolution of concerns.

62. IRO activity contributes to the organisation's understanding of strengths, weaknesses and plans for improvement, such as through effective case audits between review meetings, but there remains scope for IROs to develop further their role in driving overall improvement. For example, the annual IRO service report could be a more effective vehicle for helping corporate parents, children, carers and parents understand the service's impact on outcomes for children and for informing future priorities for the wider service.

63. Foster carers spoken to by inspectors were all positive about the support they receive from their supervising social workers. Some had specific concerns, echoed by some parents, about the varying quality of communication from children's social workers. Training that foster carers receive is suitably wide-ranging and challenging. The direct support to placements from specialist workers within services for children looked after is welcomed and productive, although delay in accessing support from the wider CAMHS service is an ongoing and particular concern. Foster carers' assessments and reviews are of consistently good quality. The voices of children, including birth children, and carers are well represented. The fostering panel's scrutiny of reviews is suitably challenging. Foster carers' records are uniformly clear and consistent with regulatory requirements.

64. Children are routinely informed of their entitlements and those spoken to by inspectors had a good understanding of the level of services that they should be receiving. The pledge to children looked after and care leavers incorporates references to significant entitlements and was developed in close partnership with an active and enthusiastic CiCC. The CiCC has begun a further consultation and review to evaluate the pledge's impact and continuing relevance.

65. CiCC members contribute effectively to corporate parenting panel (CPP) meetings and have also made confident presentations to Members of Parliament. The Director of Children's Services, his senior team and the lead member meet CiCC members regularly and know the children well. The CiCC's notable achievements include their involvement in organising a wide range of successful social events for groups of children looked after of all ages and the

establishment of a youth club at a well-equipped venue where care leavers provide support to young people. Each term the CiCC produces a newsletter. It has also produced two DVDs to help explain the challenges faced by children and young people in care. To build on these achievements, the CiCC has identified the need to extend its reach to a wider and more representative group of children who are looked after and who are care leavers. The CiCC therefore secured a budget of £10,000 from the CPP to support its work and this has provided a good opportunity for the young people to learn the importance of accountability through the targets they negotiated for continued funding.

66. Children and young people's achievements are celebrated at regular events and the local authority aims to include children living in distant placements whenever possible. Foster carers also welcome the celebration events, attended by senior leaders, which recognise the impact of the care they provide to children and young people.

The graded judgment for adoption performance is that it is good

67. The local authority is tenacious in its approach to securing permanence where adoption is identified as being in a child's best interest. This results in children, including older children, disabled children, brothers and sisters, and children from minority ethnic groups, securing legal permanence through adoption.

68. The local authority has improved performance in completing legal proceedings. This helps reduce the time for most children between coming into the care of the local authority and being placed with their adoptive family.

69. The adoption scorecard for 2011 to 2014 shows that children in Kingston upon Thames waited an average of 530 days between entering care and being placed for adoption. This is 17 days better than the national target of 547, 98 days better than the England average, and 101 days better than statistical neighbours. The average performance during 2014 and 2015 at 531 days is within threshold.

70. The average time that children with a placement order waited to be matched during 2011 to 2014 was 150 days. This was better than the England average at 217 days and statistical neighbours at 200 days. While a significant number of children with a placement order were matched within 150 days during 2014 to 2015, the average time children waited was 246 days. This is a deterioration on the previous three years' average performance. Children who waited longer were usually children with complex needs, including children with profound disabilities, children with severe health problems and sibling groups of up to three children. Notwithstanding the sustained efforts made to ensure timely

adoptions, the local authority recognises the need to reduce delay for these vulnerable groups of children.

71. At the time of the inspection, 16 children had an adoption plan. Of these, seven children are placed for adoption, including a sibling group of three children and two sibling groups of two children. Two children have been matched but not placed for adoption. Active family finding is taking place for the remaining children through child appreciation days, the use of the Adoption Consortium and Adoption Register. However, inspectors did find some instances where the use of parallel planning was not fully considered early enough in the planning for permanence. This is a missed opportunity to match and place children earlier with suitable adopters.

72. Adoption practice reflects a commitment to securing permanence for all children, ensuring that a child's ethnicity does not result in delay and that contact with birth parents is fully assessed and supported when it is safe and in the interest of the child. The complexity of children's needs does not act as a barrier to the local authority giving every child the opportunity to secure permanence through adoption. Appropriate use is made of 'together or apart' assessments when looking at the needs of brothers and sisters, and in the preparation and support for families taking sibling groups. This, coupled with rigorous family finding, has meant that a number of children with complex needs, and brothers and sisters placed together, secure legal permanence through adoption. This is a strength of the adoption service.

73. The detailed planning for children making the transition into their adoptive families helps ensure that children and families are supported to manage the changes. There have been no pre-order adoption disruptions during 2014 to 2015 and only one since 2011. This reflects sustained performance, demonstrates suitable matching and support arrangements and promotes good outcomes for children who settle well into their new homes. Between 2011 and 2014, no children had their adoption plan changed to another form of permanency. This is significantly better than statistical neighbours (20%) and the England average (12%) and reflects the local authority's success in securing adoption for all children who require it.

74. The adoption and permanency service works across Kingston upon Thames and Richmond local authority areas and joint working includes the recruitment, assessment and matching of children and adopters. This enables resources to be pooled effectively and increases the choice of approved adopters across the two boroughs.

75. The local authority has used the support of an independent consultancy to embed recent organisational changes around joint adoption practice in Kingston upon Thames and Richmond, including strengthening recruitment practices and strategies, but it is too early to demonstrate impact. During 2014–15 there were 147 adoption enquiries and 13 applications to become adopters. At the time of the inspection, there were nine approved adoptive parents and a further

15 adopters' assessments being progressed: seven at stage 1 and eight at stage 2.

76. Prospective adopters receive a prompt response to enquiries and preparation groups are accessible, support understanding of the adoption process and highlight the needs of children who are waiting to be matched. Inspectors found some delay in the progression of stage 1 of the assessment process. In a small number of cases, this was 'adopter led' but in other cases, the reasons were less clear. Stage 2 of the assessment process is timely and provides for a streamlined approval process in line with government timescales.

77. Adopter assessment reports seen by inspectors were good, with a detailed view of applicants. They reflected good preparation and engagement with adopters. Adopters who spoke with inspectors were very positive about their experience of the adoption process, including the extensive range of training provided and the opportunity to meet with other adopters. The support provided by the assessing social worker was also highly valued by adopters. Ongoing support is provided to those adopters who have not yet been matched. This helps adopters update their skills and allows for the reviewing of matching considerations where appropriate.

78. Kingston upon Thames has a shared adoption panel with the London Borough of Richmond and this meets monthly. The administration of the panel is good and panel papers are distributed in advance, which supports the efficient running of panel work. Membership is established and the joint central list of panel members is regularly reviewed to ensure that panel members have the requisite knowledge and experience, including some personal experience of adoption. This helps panel members understand the users of the service.

79. Regular performance reports are completed by the panel adviser and provide for a detailed breakdown of adoption work in Kingston upon Thames. This enables effective monitoring of adoption activity. The quality of assessments presented to the panel, including child permanence and prospective adopter reports, are robustly scrutinised. This drives improvement by identifying good practice and learning.

80. The panel chair provides effective scrutiny of panel work. The independent chair's latest report to the local authority provides an overview of the joint adoption panel. However, the report lacks detail and does not provide sufficient qualitative analysis of the impact of the panel's work in Kingston upon Thames. For example, the adoption panel minutes appropriately highlight the variable quality of some child permanence reports. However, it is not clear, from the report, to what extent the prevalence of this practice relates to Kingston upon Thames child permanence reports. This means that the local authority cannot currently analyse Kingston upon Thames practice sufficiently.

81. The recommendations of the adoption panel are progressed promptly and are considered and endorsed as appropriate by the agency decision-maker (ADM).

The ADM proactively highlights issues early to inform learning and to ensure delay is avoided. The ADM scrutinises the functioning of the panel through observation of its meetings and holds regular meetings with the panel chair and legal adviser to ensure timely and effective decision-making.

82. The arrangements for the provision of adoption support services are well established. Between 2014 and 2015 there were 54 enquiries made to the Kingston upon Thames post-adoption support service and an offer of support was made in all cases. Support provided includes bespoke support to families, adults and children, an education drop-in facilitated by an educational psychologist, adoption counselling sessions offered by a child and adolescent psychotherapist and theraplay sessions. Importance is attached to this work and the range of activity available recognises the lifelong nature of adoption and the challenges faced by some adoptive families.

83. The council has used the adoption support fund well in helping adoptive families, in particular those who are under pressure and potentially at risk of breakdown. The local authority is also part of the South West London Post-Adoption Network, which provides a single point of contact to facilitate the effective exchange of information. South West London Adoption Counselling Services provide independent support to birth parents.

84. Inspectors saw a number of excellent examples of life story work completed with children, birth parents and carers. The presentation was attractive and the content sensitively set out the child's life experiences, explaining difficult and often painful histories. Life story work provides children with knowledge to help them understand their early lives. The quality of this work supports completion of the 'later life letter' and lays down a firm foundation and understanding for adoptive parents and children to build upon. This is a notable strength.

The graded judgment about the experience and progress of care leavers is that it is good

85. The local authority currently has 93 care leavers, the vast majority of whom receive a service from the leaving care and unaccompanied asylum-seeking children team. This dual-role team provides a good service to care leavers, which includes a specialist service to the 45 care leavers who are former unaccompanied asylum-seeking children.

86. Social workers and personal advisers work closely and flexibly together to ensure young people becoming care leavers receive a seamless service. The majority of pathway plans seen were of a good quality, clearly detailing the young person's assessed needs and describing how these will be met. Risk, including offending, drug or alcohol misuse and sexual exploitation, is identified and assessed appropriately in most cases. The need for appropriate housing is

addressed clearly in pathway plans. Young people are involved in developing and reviewing their pathway plans which are, in the majority of cases, up to date and reviewed on a six-monthly basis. This means that short-term progress is well documented but it can be difficult to see longer-term objectives for young people because goals are re-set every six months. Consequently, young people are not being guided to think clearly about their long-term aspirations or to put plans in place for their future.

87. Staff know young people well and understand their needs. They speak with pride about the achievements of the young people they work with and these are celebrated at an annual event, organised by the young people on the CiCC. The celebrations focus on a full range of achievements, including, for example, creative, sports and lifestyle achievements, as well as educational achievements.

88. Workers are persistent in their attempts to engage with young people and to re-establish contact with those who have lost touch with services. In one case, a worker had persevered in establishing and maintaining contact with a young person who refused contact with other professionals. This meant that when the young person encountered a recent crisis she had a stable person she could turn to for support. The local authority is in touch with 83% of care leavers. Some of those with whom it has lost contact are unaccompanied asylum-seekers who have exhausted their right of appeal and do not want to disclose their whereabouts. Cases where the local authority has lost touch are kept open and young people are encouraged to access the support of the team when they feel they need it. For some young people, the leaving care worker is their only familiar long-term contact so this 'open door' approach is important to offer them continuity when they need it. Care leavers are encouraged to take responsibility for their actions and understand the consequences of their choices.

89. The local authority meets the needs of the large proportion of care leavers who were unaccompanied asylum-seeking children well. Workers within the leaving care team have a wealth of knowledge about the needs and experiences of unaccompanied asylum-seekers, including those who have suffered traumatic experiences in their homeland and on their journey to the UK, and use this effectively in their work with young people. AfC have recently commissioned a specialist service offering counselling for unaccompanied asylum-seekers to focus on the loss and trauma they may have experienced to enable them to achieve their potential. This is a relatively new service and, although it is too early to evidence impact for young people, it is being well received by professionals.

90. Care leavers spoken to were positive about the support they are receiving. All said that they had a good relationship with their worker, with one describing her social worker as 'absolutely wonderful'. They said they felt safe and were pleased with their accommodation and the choices of accommodation they had been offered. Workers appropriately support young people into independence

through direct work, groups, training and workshops. The leaving care team designs workshops to meet the identified needs of different cohorts of young people. Topics covered include sexual exploitation, trafficking, female genital mutilation and maintaining healthy relationships. 'Cook and eat' courses help young people to manage on a budget and eat a healthy, balanced diet. The range of workshops has improved outcomes for many of the young people who have attended and is valued by care leavers who spoke to inspectors.

91. At the point of inspection, the local authority identified that 86% of care leavers were living in suitable accommodation. This is an improvement on 2013–14 when only 71.6% were living in suitable accommodation, which was below the national average (77.8%) and statistical neighbours (81.3%). Houses in multiple occupation are used when this is in the young person's best interests and suits their wishes. These include, for example, supported semi-independent accommodation, which is quality assured by the local authority, or halls of residence. The living arrangements of almost all care leavers are well known to the team and efforts are made to ensure that they live in accommodation that meets their needs. For example, the local authority is currently paying to reserve a bed in supported accommodation to ensure that one young person has suitable accommodation when he leaves custody. Young people are encouraged to live in permanent independent accommodation at a time that suits their needs. Supported living arrangements are used as a temporary measure, with tailored support to ensure that young people are prepared to live independently. Commissioned providers offer emergency accommodation; bed and breakfast is very rarely used, but when it is the only option, this is appropriately risk-assessed and an alternative housing solution is identified swiftly.

92. Close and flexible working with the housing department and other housing providers means that young people have a choice about their accommodation. Care leavers attend a tenancy workshop prior to taking on a permanent tenancy to ensure that they are prepared for the responsibility. The young people's accommodation panel oversees the allocation of accommodation and ensures that support is provided to young people who may be experiencing difficulties with their tenancy or where the tenancy is at risk of breakdown. The panel also ensures that young people in temporary accommodation (such as supported living or custody) have an exit strategy into permanent accommodation. The needs of future care leavers are analysed to ensure that there will be suitable accommodation available to them. The housing department is proactive in looking at flexible solutions to meet the needs of care leavers, such as redesigning an unused older person's supported housing scheme for use by care leavers.

93. There are currently eight care leavers who are benefiting from staying put arrangements. Young people are encouraged to stay in their placement after they reach the age of 18 where this is in their best interests. Inspectors saw flexible use of foster care allowances to ensure that young people have a stable home that supports them until a time when they were ready to move into

independent living. Foster placements have been maintained throughout a young person's time at university to enable stability even when this extends funding beyond the staying put requirement. Young people placed with independent fostering providers can also access the staying put scheme, as can those in kinship care arrangements where this will provide additional stability. However, some foster carers told inspectors that practice regarding staying put was not always clear or consistent.

94. Personal advisers and social workers appropriately identify and assess the health needs of young people through their pathway plan. They also undertake work with young people to ensure that they are healthy, such as support with their sexual health or encouraging them to access substance misuse or mental health services. Most of the cases seen demonstrated appropriate intervention from services such as CAMHS or adult community mental health teams where this was identified as a need. However, in a small number of cases there had been delay in accessing appropriate services. A transitions protocol with adult providers is soon to be introduced to assist joint working in this area.

95. Care leavers and children looked after on the CiCC have worked with health representatives to develop a health 'passport'. This is currently in paper format and is being piloted. Young people are keen to develop a mobile phone application so that they can have their health and other information in an easily accessible format. Currently, young people who wish to understand their health history have either to keep all their pathway plans or ask the local authority for a printout of their health information. This means that young people may not easily possess all their relevant health information when accessing health services.

96. Currently, 66% of care leavers are in education, employment or training, with 9% of care leavers attending university. This is an improvement since 2013–14, when only 48% of care leavers were in education, employment or training, which was similar to the national average (45%) but lower than statistical neighbours (50%). Young people are encouraged to access education that meets their identified needs, including pre-entry courses for unaccompanied asylum-seekers who have little or no understanding of written English. Although there are opportunities for vulnerable young people to access apprenticeships within the council and AfC, these are not routinely considered for care leavers. This is a missed opportunity to provide a route to employment and to develop their skills. Two care leavers have recently secured employment following apprenticeships within local businesses; however, there are no care leavers currently in apprenticeships.

97. Care leavers are provided with a useful folder containing information about their rights and entitlements, although this is generic and not specific to the local authority. Young people spoken to were not all aware of how they could give their views about service developments to the council, despite there being opportunities to do this, for example through the CiCC. The young people were, however, all aware of their entitlements, including the right to complain.

Leadership, management and governance	Good

Summary

Political and local authority leaders, the Director of Children's Services, his senior management team and partner agencies have successfully worked together to transform services for children and their families in Kingston upon Thames since the last inspection in 2013.

Services for children and families are commissioned by the local authority through Achieving for Children (AfC), a community interest company owned by the Royal Borough of Kingston upon Thames and the London Borough of Richmond. Robust mechanisms have been implemented to monitor how effectively these are provided.

Clear governance arrangements are established between a wide range of strategic bodies, including the Local Safeguarding Children Board (LSCB), Children's Services Improvement Board (CSIB) and the council's Children, Youth and Leisure (CYL) Committee, which enable close communication and avoid duplication of work.

Almost all areas that required improvement, identified through Ofsted inspections in 2012 and 2013, have been tackled systematically. Some areas require further work, in particular strengthening children with disability services.

Strong performance management systems provide detailed data and analysis for staff, leaders and partners to monitor and develop services effectively. This includes those providing early help. In a few areas, monitoring needs to be strengthened.

Commissioning arrangements are now established and commissioned services are routinely monitored and are being systematically reviewed to ensure that they meet emerging needs. However, commissioning is not currently informed by a joint strategic needs assessment that includes issues relevant to safeguarding children.

The needs of children and families are clearly identified and used to inform individual case planning and the strategic development of services. Partners are well engaged, both operationally and strategically, in identifying needs and developing services. Relationships between agencies have significantly improved since the last inspection.

Management oversight, supervision and direction have significantly improved in the past year and staff are well engaged in service development. Staff recruitment and stability have improved over the past year, with social workers having manageable caseloads and reporting positively about working for AfC.

The corporate parenting panel (CPP) effectively engages with children looked after and care leavers, but panel members do not demonstrate a full knowledge of services and issues affecting these children and young people in Kingston upon Thames.

Inspection findings

98. Services for children and families in the Royal Borough of Kingston upon Thames have been commissioned through AfC, a community interest company jointly owned by Kingston upon Thames and Richmond councils. This has been undertaken systematically and robust mechanisms have been established to monitor the quality and impact of children's services. Extensive performance management information and analysis is routinely reported to Kingston upon Thames local authority, which has enabled it to monitor compliance, develop services commissioned through AfC and appropriately question and challenge. Economies of scale have been positively achieved by combining some services and roles across both councils, for example youth offending, adoption, a single senior leadership team and the local authority designated officer role.

99. The local authority requires AfC to report on its performance and the quality of its services to a monthly operational commissioning group and a quarterly strategic children's commissioning board. These two groups provide strong scrutiny and challenge about the quality of safeguarding practice and services to children looked after and care leavers. Clear performance targets have been agreed between the local authority and AfC. Where performance of services to children deviates from these, AfC are held to account and required to provide the local authority with a detailed explanation, identifying issues and plans to bring performance back in line with the agreed target.

100. The CSIB, established in 2012 following an Ofsted inspection of safeguarding and looked after children services, has driven sustained improvement effectively in services to children and their families, particularly since the last Ofsted inspection in 2013. It has secured ongoing commitment to improving services from senior managers, partners and political leaders, including cross-party support through the membership of the opposition's shadow lead member. Almost all issues from the last inspection have been tackled effectively, although a few areas require further input, such as return home interviews for children who go missing, private fostering assessments, take-up of advocacy and oversight by the CPP.

101. A clear and detailed children and young people's plan for 2013 to 2017 has been developed, which outlines key priority themes. These priorities are addressed in a specific and measurable AfC business plan for 2014 to 2017. Representatives on the children and young people's strategic partnership are sufficiently senior to represent their agencies and to exert oversight and challenge. Clear links and governance arrangements with other strategic boards are established. A detailed needs assessment was developed in mid-2014 and this provides a detailed synopsis of the needs of children and young people in Kingston upon Thames. However, the joint strategic needs assessment (JSNA), which was reviewed in January 2015, contains few areas related to children and the section on safeguarding has not been completed. This means that commissioning arrangements are not informed by the JSNA and therefore may

not fully reflect all partners' understanding of the key issues affecting children's safeguarding across Kingston upon Thames.

102. Strong and clear governance arrangements have been established between the leader of the council, the lead member, the DCS and Director of Children's Social Care (DCSC), the LSCB, the CPP, the CYL Committee and the CSIB. These arrangements ensure that the local authority, its partners and the LSCB chair are held effectively to account for the delivery and improvement of services for children and their families.

103. Senior leaders and managers have an effective range of routine meetings and established lines of communication that enable them to maintain an active oversight of the progress and quality of services to children and their families in Kingston upon Thames. The council's chief executive, leader of the council and lead member also make good use of independent expert advice from the chairs of the CSIB and LSCB. They value their access to this independent professional expertise and plan to continue this through commissioning an 'expert professional' when the CSIB is stood down, to ensure that they are supported to effectively oversee the work of AfC.

104. The chairs of the CSIB and LSCB liaise regularly to ensure that they do not duplicate the work of the individual boards, and to agree which board will take the lead on work areas. This working style has enabled the LSCB to develop partnerships and deliver against its statutory objectives while the CSIB remains in place. The two boards also have a clear plan for transition at the point the CSIB is stepped down by the Department for Education (DfE). However, the protocol for joint working between the LSCB and Health and Wellbeing Board (HWB) took many months to reach the point of sign off and it is too early to see its impact. Leaders and managers acknowledge that further work is required to ensure that children's issues are better represented at the HWB.

105. In almost all areas, strong performance management information is regularly collated and is available to managers and leaders at all levels. An extensive range of relevant information is gathered which contains detailed analysis of individual issues and trends. Managers routinely use performance information to oversee the work of their teams and individual staff. Robust performance information is regularly reported to senior managers, elected members and strategic and operational boards. This enables them to intensively monitor and analyse key issues and to take prompt action to address any shortfalls. As a result, managers have a clear self-awareness and realistic understanding of the strengths, areas requiring development and issues affecting children in the area. Although data regarding children missing from home, care and education is effectively drawn together and analysed, information on return interviews is not collated and analysed sufficiently.

106. Managers regularly undertake case file audits, and learning from these is effectively used to identify themes for development and to improve practice. Audits undertaken by managers on cases selected by inspectors were, overall,

robust and child-focused and appropriately identified good practice and areas requiring improvement. Kingston upon Thames joined with three other local authorities in 2014 to undertake a peer review of child sexual exploitation work. The review involved a range of agencies' senior managers and its findings and related multi-agency audits have been systematically addressed. This has resulted in robust monitoring, development of the child sexual exploitation strategy and benchmarking between boroughs.

107. Senior leaders and managers, through a range of approaches, ensure that they understand the views of children, young people and families and what is happening at the front line. The DCS and DCSC regularly meet with representatives from the CiCC; recently this included the DCSC attending the final day of a weekend residential for the CiCC to progress their application for a £10,000 grant. Inspectors observed that young people from the CiCC have established positive relationships and easy communication with the DCS and DCSC. The lead member sits on the CPP and also routinely visits front-line teams to gain the views of front line workers. She visits schools on a regular basis to promote partnership working and to secure feedback on the effectiveness of relationships between schools and children's services. Regular analysis of children's contributions via an electronic consultation tool has also increased senior managers' and corporate parents' overall understanding of some key issues in relation to vulnerable children.

108. The local authority has strengthened its role as corporate parent by providing training to all members. The council's chief executive chairs the CPP to ensure it has a heightened status with elected members and senior managers. This enables them to hear first-hand about the experiences and views of children looked after and young people. The CPP is appropriately constituted, with young people, political and local authority leaders, and partners. It also has a broad range of priorities to oversee and develop quality services for children looked after. A notable success of the CPP has been its partnership work with housing services to increase the availability of suitable accommodation for care leavers. However, panel members, who met with inspectors, were not able to demonstrate that the panel had sufficient oversight of the work of the IRO service; the effectiveness of services to reduce risk of children who go missing from care; or the availability of employment and training opportunities for care leavers, including apprenticeships and mentoring opportunities. Improving oversight and scrutiny of these areas would further strengthen the local authority as a champion of children's progress.

109. Relationships and collaborative working between key partner agencies that support children and their families have significantly improved since the Ofsted inspection of 2013. In particular, schools, health, police and voluntary sector partners report that relationships between staff operationally and strategically now work well. This has been enhanced through engagement with school staff in 'vulnerable children conversations' and also through engaging multi-agency colleagues in case-specific discussions in 'scrutiny panels'. Improved relationships are evidenced in the high attendance and engagement of staff in

strategic, operational and working groups. Escalation procedures have been established between AfC and partner agencies, which have progressively reduced in usage over the past year, as relationships, understanding of each other's roles and responsibilities, and collaborative practices have strengthened, for example through the work of the single point of access and the multi-agency safeguarding hub. Cafcass and the local judiciary also report improved working relationships and practices that have contributed to the significant improvement in the timeliness of cases that progress through the courts.

110. Effective action has been taken over the past year to strengthen the recruitment and retention of staff. As a result, the use of agency staff has significantly reduced (one team manager and seven social work staff at the time of inspection) and now makes up around 15% of overall social work staffing. Recruitment processes are now more robust to ensure that only staff who meet high quality standards are appointed. New staff, particularly those who are newly qualified, are well supported through an induction programme, detailed staff handbook and ready access to managers and peers for consultation and advice. Coaching and mentoring provision is being developed for staff to support them in their work. Action taken to recruit and retain home-grown social workers has resulted in eight workers being supported through training programmes and a further eight being identified for next year across both boroughs in AfC.

111. Workforce development strategies and programmes have been systematically developed and implemented over the past year. A wide range of core training has effectively been designed, delivered and reviewed, alongside training specifically tailored to services, teams and individual staff needs. Many programmes provided are delivered on a multi-agency basis, which enhances opportunities for shared learning and improved understanding of each other's roles and responsibilities. Overall, social workers have caseloads that are manageable, and are allocated work proportional to their experience. This enables staff to undertake good direct work with children and their families, examples of which were seen in many cases sampled by inspectors.

112. Effective action has been taken to engage staff, seek their views and to delegate authority appropriately. For example, in the past two months, a staff council has been established to develop consultation and feedback. Social workers have been involved in 'bureaucracy-busting workshops' and task groups to improve operational practices, such as case recording and looked after children and child protection processes. Staff surveys demonstrate an improving level of satisfaction among the workforce. Social workers spoken to by inspectors were positive about the changes in service structure and their roles. They reported that managers are readily accessible and that senior managers are visible and take direct interest in their work and in individual children and families. This reflects findings from the independent chair of the CSIB when seeking the views of staff over recent months. Social workers now have a budget for each family on their caseload and the delegated authority to

spend this to meet assessed needs. This is an innovative development, but it is too early to evidence impact.

113. The principal social worker maintains robust strategic oversight and challenge of the quality of practice, which has resulted in extensive work to develop and improve practice in areas such as reflective supervision, chronologies and use of theory. Inspectors saw that these are increasingly being used in social work practice. A practice adviser role, established in January 2015, is developing mentoring and coaching for staff, group reflective supervision and support to newly qualified workers in their assessed year of employment.

114. Robust action has been taken by senior managers to improve oversight, supervision and direction provided by operational managers and this has been well received by social workers. Supervision, including reflective supervision, is now regularly provided to staff and is well recorded on case files. Leadership training has been developed and delivered to around 30 managers across AfC in the past year. Alongside this, new leadership competencies for managers have been introduced and are being incorporated into a revised management-training programme for 2015–16.

115. A clear and detailed commissioning framework and code of practice have been developed by AfC over the past year and are being systematically implemented. All services previously commissioned by the local authority children's services have been reviewed since the establishment of AfC. Most have been maintained until the next related commissioning cycle, to enable stability in a period of transition and the establishment of the new commissioning and procurement framework. Those coming up for renewal have been redeveloped to meet emerging needs such as child sexual exploitation work to focus on prevention as well as intervention. Early help services have been extensively reviewed and expanded over the past two years, in collaboration with key agencies. A diverse range of early help provision has been developed, provided by AfC, by other statutory partners and through services commissioned through the private and voluntary sector.

116. Reviewing existing commissioned services identified some gaps in provision to meet emerging needs. Services have now been commissioned in response, for example domestic violence perpetrator programmes and bereavement support for children. The review of CAMHS has resulted in decommissioning the previous service and joint commissioning by the local authority and the clinical commissioning group through AfC for a single point of access to CAMHS and the redesign of tiers 2 and 3 provision. This has led to improved timeliness of CAMHS assessments and access to treatment.

117. There are ongoing challenges for the local authority in ensuring that there is an adequate range of placement provision available for children looked after. The council's commitment to enabling care leavers to remain with their foster carers whenever possible has placed an additional pressure on capacity. However, the strategy to meet the sufficiency duty is coherent and thoughtful and is allied to

focused and targeted recruitment activity that is informed by a careful analysis of need. AfC has secured innovation programme funding to develop a project to support young people both in and on the edge of care across both boroughs. The scheme will include the development of specialist fostering services for young people who would otherwise be likely to live in residential care. This is designed to reduce the already low reliance on residential care for children looked after. The commissioning of independent placement provision for children requires all providers to meet the quality standards set by the South-West London commissioning group.

118. Take-up of advocacy services remains low, despite significant efforts by social workers and IROs to promote the use of advocates. The reasons for this are not well understood. Where advocacy is used, it is of high quality and is valued by young people.

119. A high number (71) of complaints in relation to children's services were made in 2013–14. This has significantly reduced in the past year to 32, which is more in line with preceding years. Few complaints are received from children, although the complaints process is actively promoted to children and young people. A theme during the year was that confidential information had been inappropriately shared by social workers because of staff errors and IT problems. This has subsequently been addressed. In two cases, complaints in relation to the accuracy of social work assessments were upheld. These occurred after managers had introduced a policy that all assessments should be sent to parents, and are attributed to agency workers who were not familiar with the policy.

The Local Safeguarding Children Board (LSCB)

The Local Safeguarding Children Board is good

The arrangements in place to evaluate the effectiveness of what is done by the authority and board partners to safeguard and promote the welfare of children are good.

Executive summary

The last inspection of child protection services in 2013 found that there was a 'culture of appropriate challenge' within the Local Safeguarding Children Board (LSCB) but that rigour was lacking. Since then, through strong multi-agency commitment and robust partnership arrangements, the LSCB is now fulfilling its statutory duties and is demonstrating effectiveness in all key areas of its business.

Governance arrangements are effective. Key partner agencies are engaged and have membership at an appropriately senior level to ensure the influence and effectiveness of the LSCB. There is a culture of effective challenge and scrutiny. The relationship between the Children's Services Improvement Board (CSIB) and the LSCB is one of constructive challenge and support. Engagement with local young people is creative and purposeful.

The effectiveness of local practice to safeguard children is analysed and understood by using robust performance information, section 11 audits, serious case reviews and case audits. This leads to clear actions that have influenced leaders in partner agencies to improve services. However, further oversight of multi-agency strategy discussions is required to ensure all key professionals contribute to decision-making for children. The rigorous tracking of progress against actions gives a firm message about the need for sustained improvement. The learning and development framework supports the culture of improvement; this includes a systematic approach to the provision of high quality training. Almost all policies and procedures are up to date and accessible.

The LSCB's priorities are aligned with key local strategic plans and it routinely reviews these. Most of the areas identified for improvement through this inspection are already identified in the draft 2015–16 business plan.

Strategic oversight of arrangements to safeguard children who are at risk of sexual exploitation or who go missing is robust, with clear processes in place and comprehensive training and awareness-raising activities undertaken. The quality and analysis of data relating to return interviews needs greater attention. Specialist training for professionals who work with young people who go missing and those assessing risk within families where a child has a disability is yet to be commissioned.

E-safety awareness raising is comprehensive and highly valued by partners.

Recommendations

120. Analyse the effectiveness of multi-agency engagement in child protection strategy meetings (paragraph 132).

121. Update the missing from home and care protocol to reflect current practice and monitor its implementation (paragraph 143).

122. Further scrutinise the timeliness and quality of return interviews and ensure that strategic groups analyse intelligence and themes from these interviews to inform their ongoing understanding of local issues (paragraph 144).

123. Ensure that multi-agency practitioners have access to high quality training that is specifically focused on practice relating to children who go missing, and on identifying risk within families where a child has a disability (paragraphs 141, 144).

Inspection findings – the Local Safeguarding Children Board

124. Under the leadership of one chair, the Royal Borough of Kingston upon Thames and the London Borough of Richmond work together through separate safeguarding boards to fulfil their duty to coordinate and scrutinise local safeguarding arrangements. During 2013–14, the Kingston upon Thames LSCB underwent a review of its structure and governance. Sub-groups have been working under revised arrangements since March 2014. The board meets four times a year, with an additional two joint meetings. The roles and responsibilities of many partner agencies are common to both boroughs, with benefits in sharing some work streams, protocols and priorities. For instance, through the missing and child sexual exploitation sub-group the boroughs work together to understand the local prevalence of child sexual exploitation. The 2014–15 four London borough peer review of local child sexual exploitation and missing arrangements identified this joint approach as a strength. Separate quality assurance and serious case review sub-groups promote a sharp focus on practice and performance specific to Kingston upon Thames.

125. The relationship between the CSIB and the LSCB is one of constructive challenge and support. The boards are clear about their respective responsibilities. The chair of the LSCB is an active member of the CSIB, submitting monthly reports outlining progress towards priorities. Political and senior leaders engage well with the LSCB, and meet regularly between board meetings. The Director of Children's Services links well with LSCB chair. The chair is held to account by the Kingston upon Thames chief executive. This promotes independent scrutiny of the LSCB's performance. The LSCB has forged links with the Health and Wellbeing Board (HWB) and with the Safer Kingston Partnership, providing briefings about child sexual exploitation and

local serious case reviews. However, a formal partnership arrangement between the LSCB and the HWB took too long to finalise.

126. Good membership and engagement are in place, with robust follow-up from the chair where attendance needs to improve. Board members are sufficiently senior to represent their agencies and to exert challenge and influence. In 2014–15, all LSCB members signed a new membership agreement, laying out their roles and responsibilities. The voluntary sector is well represented and makes a helpful contribution. The board values the involvement of three lay members. They understand priorities and demonstrate a keen interest in improving the effectiveness of local safeguarding arrangements. The chair uses member appraisals to further scrutinise and strengthen engagement, considering partnership issues and analysing the board's effectiveness. Through appraisal and separate discussions with the clinical commissioning group (CCG) and HWB, the chair reviewed and obtained increased capacity for the designated doctor for safeguarding.

127. The culture of the board has changed considerably since the last inspection in 2013, which found that a 'culture of appropriate challenge' was evident, but that rigour was lacking. Partners see this as a significant improvement, and describe the current approach as 'questioning', 'challenging' and 'supportive, but won't let things go'. The chair leads the way in maintaining this culture, for example through undertaking challenge and improvement visits to senior leaders and partners.

128. The board's priorities are firmly linked to local need, with scrutiny focused on those areas that most need attention. The board identifies its priorities using a range of sources including section 11 audits, case audits, serious case reviews (SCRs) and detailed multi-agency performance data. The business plan flows from these priorities, and is consistent with the children and young people's plan, AfC business plan and the improvement board. The LSCB's influence is evident, for example in the sharper focus on improved engagement with the local Korean community. This is linked to the learning from a recent SCR.

129. The LSCB draft business plan 2015–16 includes appropriate actions relating to private fostering, young people who are not in education employment or training (including care leavers), advocacy arrangements, culture and diversity, children living with neglect, female genital mutilation and children who go missing. Sub-group work plans demonstrate attention to detail in delivering on these actions. The relationship between the board and Public Health colleagues is increasingly effective, with greater commonality in priorities. In response to a Public Health report on female genital mutilation (March 2015), the quality assurance sub-group now plans to work with Public Health and CCG colleagues to further analyse local prevalence and to consider how local partner agencies should identify and prevent female genital mutilation.

130. The board is fulfilling its duty to scrutinise and evaluate front line practice through a robust multi-agency audit programme that includes practitioners and

managers. Audit activity is planned using information from a wide range of sources. All key actions, once signed off, are passed to the quality assurance sub-group to analyse and test the impact of practice changes. This process works well. In May 2014, the quality assurance sub-group undertook a multi-agency audit on adolescent risky behaviour as a follow-up to actions from the SCR published in October 2013. The findings have informed ongoing improvements in practice targeted at this group, including a sharper focus on online safety as part of risky behaviour training.

131. The LSCB considers an appropriate level of information relating to the work of IROs. This includes an analysis of the effectiveness of IRO challenge and escalation of concerns about the progression of children's plans. The board also receives a good level of information relating to the work of the local authority designated officer and this is reflected well in the annual report. The board understands local challenges relating to the profile of private fostering and the relatively low number of local private fostering arrangements. As a result, a private fostering working group has been established to strengthen the board's scrutiny of work in this area.

132. An appropriate forward plan is in place and this includes re-visiting previous audits to re-evaluate practice. For instance, in 2013 the multi-agency dataset identified an increasing number of young people presenting to accident and emergency (A&E) at Kingston Hospital after a self-harm incident. In November 2013, this was scrutinised through a case audit, resulting in new responsibilities for GPs to contact these young people two weeks after presentation and invite them in for a consultation. A further audit in March 2015 re-evaluated the experiences of young people, with a particular focus on GP follow-up. This cycle of re-visiting practice evidences a strong commitment to sustained improvement. The board has not analysed the effectiveness of multi-agency engagement in child protection strategy meetings since 2013. Single agency audits are routinely presented to the quality assurance sub-group for analysis and consideration of learning, but the board acknowledges it needs to strengthen its oversight and influence on these audits through a more systematic approach.

133. Learning from SCRs is central to the board's learning and improvement framework. The SCR sub-group has developed into a well-functioning group from a low base. It considers all local serious incidents and appropriately applies the threshold laid down in statutory guidance when deciding on next steps. The group has considered the two ongoing and as yet unpublished SCRs in detail. A comprehensive and sensitive approach leads to appropriate identification and dissemination of learning, and early practice changes, such as reducing copying and pasting in social care records, which was leading to confusion between current and previous events. The board has already disseminated learning from the Child B SCR (unpublished at the time of this inspection) through closed sessions with local authority members, the HWB, Safer Kingston (Community Safety) and the Children, Youth and Leisure (CYL) Committee.

134. The LSCB collates its themes for local learning in one concise document, including all the key issues identified through SCRs and learning reviews, findings from peer reviews and multi-agency audits. Cross-agency themes, including the quality of professional supervision, recognition of risk, working with resistance, the value of gaining history and the voice of the child, assist the board in planning future multi-agency training and audit activity. Practitioners and managers are well aware of learning from local and national SCRs, with information disseminated via newsletters, team workshops and well-attended multi-agency briefings. The child's story is told and the voice of family members is heard. Improvements in practice were evidenced through this inspection, such as the consistent application of child protection thresholds. The serious incident notification protocol, introduced in December 2014, has led to greater discussion among partners about what constitutes a serious incident. Although professionals are now using the process, it is not yet fully embedded and it is therefore too soon to analyse impact.

135. The Joint Hounslow, Richmond and Kingston upon Thames child death overview panel reviewed the deaths of seven Kingston upon Thames children in 2013–14. In 2014–15, there were seven expected and 11 unexpected child deaths within the local authority, four of which are currently subject to serious case reviews. The panel reviewed eight child deaths from Kingston upon Thames during 2014–15. Learning is appropriately and swiftly shared with relevant agencies. National trends are considered alongside local learning.

136. Partners understand and prioritise the importance of the section 11 audit cycle because they see that the tool is used to identify strengths and weaknesses. Each audit is scrutinised and followed up with a letter from the chair, with feedback about audit quality and areas for further scrutiny. For instance, the Youth Offending Service audit prompted a request from the chair for more detailed feedback from young people exiting the service. An online tool for section 11 audits is accessible on the LSCB website. Agencies submitting audits in 2014–15 included Kingston Hospital, Fulham Football Club, 'Your Healthcare', Probation and CAMHS. There were 30 audits ongoing at the time of this inspection, including the CCG and the local library service.

137. The multi-agency data set is comprehensive and enables the board to scrutinise and evaluate performance. It includes robust performance information from the local authority alongside key data from other agencies. It includes numbers of drug users who live with children; offences relating to children including neglect and child sexual abuse; and children attending A&E following a self-harm incident. Helpful commentary enables partners to understand what the data means for local children. Where information is missing, follow-up is robust. The board has highlighted gaps in performance information relating to return interviews undertaken, but this has not yet been addressed.

138. The latest published annual report of the LSCB (2013–14) evaluates an appropriate range of multi-agency safeguarding issues. The style of writing is straightforward and is therefore accessible to the public. Levels of local need

are included alongside the progress of partners towards meeting these needs. The report analyses how well the board has discharged its statutory functions and delivered its priorities. There is an appropriate focus on vulnerable children, including those experiencing or at risk of child sexual exploitation, children affected by domestic abuse, children looked after placed away from their home area and privately fostered children. Areas for learning and improvement are clearly defined. The work of the local authority designated officer is summarised well.

139. The joint Kingston upon Thames and Richmond policy and procedures sub-group ensures that multi-agency policies and procedures are accessible and regularly reviewed. There is a clear cycle of need, design, implementation and analysis of impact. For instance, in October 2014 the quality assurance sub-group undertook a multi-agency review of neglect involving health visitors, schools, the voluntary sector and adult services. Incidence was explored, with a particular focus on parents who do not attend medical appointments. The policy and procedures sub-group then worked with another London borough to develop a new tool for practitioners. A multi-agency audit, planned for 2015–16, will test the effectiveness of this tool in assessing and responding to neglect within families.

140. The LSCB threshold document was comprehensively reviewed and published in 2014. It reflects current structures and processes including how to refer a child where there are concerns about risk or harm. It distinguishes between different levels of need and provides guidance about how these might present. Online links enable practitioners to access tools relating to domestic abuse, child sexual exploitation, trafficking, female genital mutilation, children who are missing, gangs and forced marriage. The application of thresholds is actively considered in all multi-agency audits, with appropriate scrutiny of relevant performance data. Findings from this inspection confirm that professionals from across the agencies are applying thresholds effectively in relation to children's needs and risks, resulting in appropriate and timely referrals being made.

141. The Kingston upon Thames and Richmond LSCB learning and development strategy includes appropriate priorities relating to single and multi-agency training. The multi-agency training programme is mostly comprehensive, although the board is yet to commission a course specifically focused on identifying risk within families where a child has a disability. This is a gap. The board has undertaken a thorough review of the local multi-agency training offer, linked to local priorities. The board also commissions additional courses according to emerging need, such as specific child sexual exploitation briefings for the children with disabilities service. Multi-agency attendance is good, with proactive challenge where attendance declines. Practitioners who attend training provide positive feedback on the quality of training events, but the board does not understand the longer-term impact on practice because of the poor response rate to follow-up evaluations. There are plans to review this process in 2015–16 so the board can gain a greater understanding of how training is influencing practice.

142. The LSCB effectively promotes the safeguarding of children online through an active and influential e-safety sub-group. A recent child sexual exploitation peer challenge audit recognised the work of this group as 'a real strength'. A wide range of educational and awareness-raising activity is undertaken, with a focus on risk groups such as disabled children, children looked after and care leavers. E-safety training has been delivered to domestic abuse victims and their children and to local schools in the past year, with 53 parents' sessions and 47 children's sessions across Kingston upon Thames and Richmond. Board members, AfC staff and foster carers have also received e-safety training.

143. The board has developed a good understanding of the local prevalence of child sexual exploitation and coordinates effective arrangements that reduce risk for individual children. Partner agencies, particularly the police, demonstrate considerable and sustained commitment to this area of work. The engagement of partners from health, sexual health, early help, police and domestic abuse services has been strong since the child sexual exploitation (CSE) and missing sub-group started in May 2013. Links between operational and strategic groups are well established, and representatives from the missing children and multi-agency child sexual exploitation groups regularly attend the sub-group. Comprehensive child-level tracking tools are used well. Partners use the child sexual exploitation data profile well to analyse local profile information and prevalence, which leads to the board prioritising and targeting specific areas for further input. The child sexual exploitation strategy (2013) underpins local partnership arrangements and is being updated. The child sexual exploitation action plan 2014–15 is up to date and comprehensive. The missing from home and care protocol 2014 has not been updated to reflect current practice.

144. In February 2015, the child sexual exploitation and missing sub-group undertook an audit of six return interviews relating to children who went missing during December 2014. The audit highlighted the variability in quality of return interviews. Local authority partners on the board took note of this weakness and took appropriate action to strengthen return home interview arrangements; they also acknowledge there is further work to do. However, ongoing board scrutiny of practice needs to be sharper and more persistent. Although training relating to child sexual exploitation is comprehensive, to date the board has not provided any multi-agency training with a specific focus on practice relating to children who go missing. Work is now underway to commission training in this area.

145. The child sexual exploitation awareness-raising working group effectively coordinates a comprehensive programme of activity. All local schools have received child sexual exploitation materials and key groups, such as council members, have attended relevant training. During March 2015, in a successful and wide-reaching police campaign, Operation Make Safe, visits were made to 200 organisations and premises such as fast-food outlets, bus stations, hotels and taxi firms with leaflets and posters. Awareness raising continues to be a key priority for the LSCB.

146. The LSCB is proactive in working with local young people to better understand and improve their ability to keep themselves safe. This is resulting in greater engagement, increased awareness and improved services. In 2014, the LSCB asked a group of local young people to undertake some peer research into awareness of child sexual exploitation, domestic abuse and online safety. This led to 12 Youth Council members working with LSCB on a high profile and successful campaign, Safe From, in which 170 local young people attended an awareness-raising event, hosted by the young people themselves. The wider campaign reached 380 young people via workshops and presentations. Young people said that the campaign increased their understanding about the signs of an abusive relationship and what child exploitation means. Following the campaign, the Basement One Stop Shop was launched, offering information, advice and guidance to young people who may be engaged in risk-taking behaviour.

Information about this inspection

Inspectors have looked closely at the experiences of children and young people who have needed or still need help and/or protection. This also includes children and young people who are looked after and young people who are leaving care and starting their lives as young adults.

Inspectors considered the quality of work and the difference adults make to the lives of children, young people and families. They read case files, watched how professional staff work with families and each other and discussed the effectiveness of help and care given to children and young people. Wherever possible, they talked to children, young people and their families. In addition the inspectors have tried to understand what the local authority knows about how well it is performing, how well it is doing and what difference it is making for the people who it is trying to help, protect and look after.

The inspection of the local authority was carried out under section 136 of the Education and Inspections Act 2006.

The review of the Local Safeguarding Children Board was carried out under section 15A of the Children Act 2004.

Ofsted produces this report of the inspection of local authority functions and the review of the local safeguarding children board under its power to combine reports in accordance with section 152 of the Education and Inspections Act 2006.

The inspection team consisted of nine of Her Majesty's Inspectors (HMI) from Ofsted.

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