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Inspection of local authority arrangements for the protection of children

Royal Borough of Kingston upon Thames

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Lead inspector	**Sarah Urding**

Age group: All

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Inspection of local authority arrangements for the protection of children

The inspection judgements and what they mean

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

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

Overall effectiveness

2. The overall effectiveness of the arrangements to protect children in Kingston upon Thames is judged to be **inadequate**.

Areas for improvement

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

Immediately:

- implement the local authority's action plan for the single point of access (SPA) as a matter of priority, to ensure that children receive timely assessments of needs and risks
- ensure that children are seen and seen alone when carrying out social work assessments
- ensure a more timely response, better communication and cohesive joint working relationships with the police when children are suffering, or at risk of suffering harm, in particular from domestic abuse, child sexual exploitation and missing from home
- develop and implement a procedure for the management of child protection concerns in cases open to the disabled children's team (DCT) also making clear co-working arrangements between the DCT and safeguarding teams.

Within three months:

- ensure that all children in need have an allocated social worker, a clear assessment of their needs and an outcome focused plan to address those needs
- ensure that missing children procedures are fully compliant with statutory guidance and that their development and effectiveness is subject to multi-agency planning and scrutiny
- ensure effective arrangements are in place to recruit a more permanent and stable workforce of qualified social workers
- ensure casework supervision is reflective, challenging and is used to monitor progress effectively on child protection and children in need plans
- ensure that assessments of potential private fostering arrangements are carried out in a timely manner and that training is provided to social workers and other agencies
- ensure that actions arising from case file audits are managed robustly and monitored through casework supervision
- ensure that the advocacy service is used to support the attendance of children and young people at CP conferences and when they do not attend, their views are independently represented
- provide middle managers with clear performance targets and commentary so that they have a shared understanding of the story behind the data and can use this effectively to improve outcomes for children

Within six months:

- ensure that recently implemented arrangements for escalating and de-escalating child protection concerns become embedded and effective so that children receive an appropriate level of service at the right time
- ensure that early help services effectively measure the impact of interventions on families and that this information is monitored and used to improve the delivery of services
- ensure the systematic gathering of feedback from service users to routinely inform the planning of child protection services.

About this inspection

4. This inspection was unannounced.

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

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

7. The inspection team consisted of five of Her Majesty's Inspectors (HMI) and one local authority seconded inspector.

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

Service information

9. Kingston upon Thames has the third smallest population of any London Borough at 162,200. Approximately 39,200 are children and young people aged 0 to 19, representing 24.2% of total population of the area. The population is forecast to grow by up to 8% by 2028. This means that there will be 3,136 more residents aged 0 to 19 by 2028 (increasing to 42,336). The number of births per year in Kingston has generally increased since 2002. There was a particularly large rise between 2003 and 2004 of 9.8%, with a further large rise of 7.4% between 2006 and 2007. However the number of births has stabilised to approximately 2,300 since 2009.

10. Kingston has 50 schools, comprising one standalone Children's Centre, 35 primary schools, 10 secondary schools, three special schools and a pupil referral unit. Of the 50 schools, 11 are academies (nine secondaries and two primaries). In 2012, 33.2% of the school population was classified as belonging to an ethnic group other than White British compared to 25.4% in England overall. The largest minority ethnic groups in the borough are Indian, Sri Lankan and Korean: the Korean community is the largest in

England and Wales. Among the primary school population who do not speak English as a main language, the top five languages are Tamil (4.6%), Urdu (3.2%), Korean (3.0%), Arabic (2.5%) and Polish (1.9%).

11. A Children's Trust with a multi-agency membership has been in place in Kingston since 2005. The Children's Trust has responsibility for the Children and Young People's Plan and its progress. A new plan was published in April 2013. The Kingston Local Safeguarding Children Board (LSCB) is independently chaired. A new independent Chair was appointed in April 2013. The Board brings together the main organisations working with children, young people and families in the area that provides safeguarding services.

12. Early help for children and families in Kingston is provided through a range of directly provided and commissioned services. A new Family Support Service was launched in June 2013 to provide a coherent protection and early help service for families. The service provides: targeted support to families within the community and specifically through the Children's Centre network and primary schools; targeted youth support; a TASK team supporting children and young people at significant risk of family breakdown; and a Strengthening Families team supporting the 225 families eligible for the Government Troubled Families initiative. These teams are supported by a multi-disciplinary team providing services such as multi-systemic therapy and Family Group Conferencing. To support multi-agency working and provide core early help services, the local authority and its partner agencies has reorganised the workforce into four multi-agency locality teams.

13. Contacts are received and assessed by the Single Point of Access (SPA). Services for children in need of protection or requiring a child in need plan are managed and delivered by teams with Children's Social Care. These comprise two Referral and Assessment teams, three Child Protection teams, a Looked After Children Team and a Leaving Care and Unaccompanied Asylum Seeking Children Team. Children with disabilities receive services from an Integrated Disabled Children's Team. There is a joint local authority out-of-hours service with three other neighbouring London boroughs. At the time of the inspection there were 161 children who were the subject of a child protection plan. These comprise 85 females, 75 males and one unborn child. Of these children, 40% are aged under five, 34% are aged 5 to 11 and 26% are aged 12 years or older. The highest categories of registration are neglect at 49%, emotional abuse at 27%, physical abuse at 17% and sexual abuse at 1%. Mixed categories of registration account for 6% of cases.

14. Achieving for Children (AfC) management team is working in shadow form until the formation of AfC as a legal entity in April 2014. This will formally combine children's services between Richmond and Kingston. The Director of Children's Services will retain statutory responsibilities alongside Heads

of Service for safeguarding in each Borough. This role is not currently subject to joint management arrangements and this is not proposed moving forward. Individual management arrangements are retained to ensure suitable focus and oversight of children's social care locally.

Overall effectiveness

15. The overall effectiveness of the arrangements to protect children in Kingston upon Thames is judged to be **inadequate**.

16. Following an inadequate judgement at an Ofsted inspection of safeguarding and looked after children in May 2012 this local authority is under a formal notice to improve from the DfE. The inspection last year identified significant failings in relation to the protection of children and a disturbing gap between inspection findings and managers' assessment of the quality of cases seen. Council leaders took immediate action prior to the publication of the inspection report in July 2012 and appointed an experienced interim Director of Children's Services (DCS) from the neighbouring borough of Richmond with a clear aim to improve the service. The restructure of children's social care services began in July 2012 alongside discussion with Richmond about a more permanent arrangement for jointly managed children's services across the two boroughs. This resulted in the permanent appointment of the DCS in December 2012. An Improvement Board was established in September 2012 led by an experienced Independent Chair and robust monitoring by the Board of the improvement plan began upon receipt of the DfE notice in October 2012.

17. Children's services are still at an early stage of the improvement journey but solid foundations for establishing the service are in place in relation to strategic planning, policy implementation and the restructure of services. A joint senior management team was appointed in December 2012, which is responsible for overseeing the protection and early help services in both Kingston and Richmond. The team incorporates heads of services for safeguarding social care in each borough. These posts are not subject to joint management arrangements reporting directly to the DCS and this has ensured a sustained and appropriate localised focus on the protection of children. Senior managers have prioritised the recruitment of high quality, experienced social workers and managers during the restructure as a means of addressing poor practice and improving outcomes for children. In May 2013, the Improvement Board chair submitted a 6 month review of improvement in services to date. In their response in June 2013 the DfE reported that the council are at an expected stage of improvement and further ahead in some areas than would be expected. This rapid action has improved safety for children and young people in Kingston overall. For example; a social work team manager now oversees all contacts coming in to children's services; a third team of child protection social workers have been recruited to ensure a timely response to child protection concerns; and the numbers of child protection conferences have doubled without loss of timeliness. The numbers of children subject to a child protection plan have more than doubled which is significantly higher than statistical neighbours. However, there remains significantly more to do to improve the quality of child protection practice and ensure that social workers

consistently deliver robust risk assessed interventions, and the provision of coordinated help for children.

18. A clear strategic vision is in place which is underpinned by a well-informed assessment of local need, incorporating the joint strategic needs assessment, child poverty strategy and young carers' strategy. The children and young people's plan has been recently revised and the delivery plan is currently being developed. The delivery plan will consolidate actions from the improvement plan; the Achieving for Children plan, action plans from Serious Case Reviews and the Domestic Homicide Review. This planning is currently in progress and demonstrates focus on securing continued improvement in the delivery of services and staff development. Scrutiny and oversight of children's services has been strengthened to facilitate improved challenge and elected members are active members of the Improvement Board. The corporate parenting panel is independent to the DCS, and is providing an additional layer of scrutiny and direct feedback from service users to members. An experienced Independent Chair of the LSCB was appointed in April 2013 alongside a new lead member, responsible for council oversight of children's services. Respective roles and responsibilities are currently embedding and therefore permanent arrangements for the oversight of children's services are only recently in place.

19. Strengthened strategic partnerships are in place in relation to schools and health through membership on the Improvement Board; work to prepare schools for the restructure of social care; and the appointment of a joint commissioner for health and social care. However, there has been a lack of continuity in police representation at a senior level on the improvement board and at a strategic partnership level. This has impacted on effective use of the escalation processes in relation to inappropriate delays in joint working between children's social care and the police and in the development of a strategic response to child sexual exploitation, domestic violence and children missing from home. Missing children procedures are not yet fully compliant with statutory guidance.

20. The restructuring of services for early help and protection coincided with the first day of inspection fieldwork. This follows the implementation of a single point of access (SPA) in January 2013 that replaced Advancing Services for Kingston Kids (ASKK). The SPA has improved service responsiveness for children at immediate risk of significant harm, as there is now social work scrutiny at the point of contact. However, effective signposting to lower level services is not yet embedded or effective, resulting in unacceptable delays in the transfer of cases to the referral and assessment teams. Inspectors examined cases which required a social work assessment being held in SPA for a number of weeks whilst further information was being gathered. Senior managers were not aware of the delays in managing these cases and therefore, they were not subject to any formal risk assessment process during this time. Social work tasks in

relation to 'information gathering' included undertaking a short assessment without the benefit of the child being seen, and/or brief intervention which inappropriately placed responsibility for children's safety on the non-abusing parent. This potentially places children at further risk. The local authority took responsive action to address this deficit during the inspection.

21. The pace of change to improve the quality of social work practice is being hindered by instability across the staffing structure. In spite of an appropriately focused recruitment and retention strategy as part of the workforce strategy, challenges remain to recruiting high quality, experienced social workers. There are high numbers of agency staff although some have been in post for over a year and numbers have decreased recently. Recent recruitment activity has yielded positive results but not all team manager posts are permanently appointed to and newly appointed team managers are currently undergoing induction. This is resulting in ineffective management oversight of current work and the overall quality of practice is not yet consistently adequate. Supervision of social workers is not sufficiently challenging or focused on case work and actions identified in audits of case work are not routinely implemented. Although an appropriate framework for the management of performance and quality assurance is in place, this is not yet embedded in managers' practice. Performance targets are being developed in conjunction with the service delivery plan.

22. There is insufficient involvement of children and their families in the strategic planning of services, or to support children and young people's attendance at child protection conferences. Consequently, their attendance is low. Early help services are not systematically measuring the impact of their interventions on families to improve the delivery of services.

The effectiveness of help and protection

Inadequate

23. The effectiveness of help and protection of children and young people in Kingston is **inadequate**. Too many children experience delay in steps taken to provide them with sufficient help and protection and they are not supported by clear plans based on rounded and analytical assessments. There are examples of sound, direct work which improves children's welfare but overall quality is too variable, thereby reducing the effectiveness of help and protection.

24. Early help services have recently undergone significant and necessary restructuring in order to provide a response for children and families with additional needs that is planned to be more coherent and effective. Previously separate family support teams, including Targeted Youth Support, the Strengthening Families team (Kingston's name for the

Troubled Families initiative) and the Adolescent Response Team have been brought together under one strategic manager and will, from June 2013, provide services as part of four multi-agency locality teams. These teams can access dedicated support from a wide range of disciplines, such as Child and Adolescent Mental Health and adult social work services. Senior managers with social care expertise continue to rapidly progress implementation plans and have begun to ensure swift identification of need, delivery of safe and effective early help, and where possible, prevention of escalating need or provision of a safe 'step down' for those families no longer in need of social work intervention. This is supported by clear step up and step down processes, but the local authority acknowledge that these are not yet consistently well understood by practitioners.

25. There are early signs that the changes already implemented are leading to more coherent service delivery for families, as indicated through recent team around the family meetings and improving communication and information sharing between children's social care teams and early help services. However, arrangements are very new and there remains a legacy of work with families where services have not been delivered in a coordinated way. Overall there is, as yet, limited evidence that recent early intervention has prevented the need for statutory social work intervention. Some good family support work was seen by inspectors in individual cases, which has made a difference to children and families. For example, in avoiding homelessness and school exclusion and providing positive activities for children outside of their home environments, such as through the young carers group. Systems, including the use of the new 'distance travelled' tool, are being introduced to ensure that the impact of future interventions is measured and monitored effectively.

26. Until recently, the common assessment framework (CAF) has been used inappropriately as a referral into other services, rather than an effective assessment leading to multi-agency work. Those examined by inspectors were mainly inadequate. The local authority has already identified the need to ensure that common and effective ways of working, including whole family assessment, regular reviews and smart action planning are implemented consistently. The eCAF is now adopted as the common assessment tool across early help services and has been used in a few cases. Both universal and targeted services are undergoing a significant change in ways of integrated working, such as carrying out assessments of the 'whole family' and providing a multi-agency team around the family to support a range of needs. Training is being rolled out across the early help workforce which is beginning to build confidence in a developing culture of shared responsibility. A comprehensive workforce reform programme is in place.

27. The multi-agency locality teams are being built around quality schools and early years provision, alongside plans for collaborative working between

children's centres. Centres are increasing the engagement of target families with a developing role in targeted and protection work. Evidence based parenting programmes such as Webster Stratton and Triple P, including tailored programmes for parents of children on the autistic spectrum are highly valued by parents. However, these are not yet coordinated across the borough and their impact is not being measured effectively.

28. There are sufficient, high quality early years places for all funded two-year-olds. Priority has been given to those with highest levels of need and every two-year-old who is the subject of a child protection or child in need plan is currently attending quality provision. The pupil referral unit has recently been judged as good by Ofsted and the Anstee Bridge Project is highly valued by both schools and the pupils that are being supported to remain in school. The authority's performance with regard to exclusions and absence from school is good and above comparators. There are effective policies and procedures in place regarding children missing education and elective home education. There are currently no children whose whereabouts are unknown.

29. When children are clearly identified as at risk of significant harm, the Single Point of Contact (SPA) is facilitating prompt identification and appropriate transfer of cases for assessment by the referral and assessment teams. However, for cases where concerns are not clear but needs are potentially above that referred on to early help services, inspectors have seen a number of cases which have been 'assigned' for further information gathering resulting in some children failing to receive a timely assessment of need, risk and provision of services. Following assignment, some children and young people's needs are in effect the subject of a brief assessment without them being seen. This is contrary to statutory requirements. Examples were seen by inspectors of these 'assessments' being followed up by meetings with non-abusing parents, which put them on trust that there would be no harm to the child and thus inappropriately left them responsible for their child's safety without the support of services.

30. Children in need are not yet receiving a consistent and responsive service. Although a Child In Need protocol was launched in January of this year, detailing expectations in relation to assessment and planning, this is not consistently followed by social workers. Whilst the majority of cases seen by inspectors had a child in need plan in place, some had no plan, an empty plan template or a plan in some other format and file location. This reduces the efficacy of intervention in both meeting and addressing children's developing needs and in effecting positive change. During the inspection period, there were25 children in need cases that were unallocated to a social worker for a 48 hour period and the council does not have in place any formal process for risk management of these cases. These cases are being assigned to the duty teams to complete tasks as

directed by the team manager, or in reaction to new events or information.

31. Procedures for joint working between safeguarding social work teams and the disabled children's team (DCT) are not clearly defined or well-coordinated which reduces the effectiveness of protection from harm and promotion of welfare experienced by children with disabilities. Some examples of good individual practice by social workers were seen, that supported timely and focused direct work. However, there is a lack of clarity between teams as to where the responsibility lies for carrying out child protection assessments. In some cases seen, risk and need was not identified or addressed in a consistent or timely manner and there is a lack of coordination between social workers where families with both disabled and non-disabled children require an intervention.

32. Private fostering arrangements are not yet consistently well understood or promptly recognised by social workers and agencies. Numbers of privately fostered children are low, and an awareness raising campaign has recently been undertaken targeting schools, libraries and doctors' surgeries. Assessments of privately fostered children have generally been robust but only one out of eight statutory assessments were completed within timescales in 2012/13. Measures have been introduced to improve the timeliness of assessment and ensure placements are suitable. The local authority has also identified the need to raise awareness amongst ethnic minority groups within the borough.

33. Clear and appropriate procedures in relation to children missing from home were issued in December 2012 but are not yet fully embedded in practice. The SPA are not yet routinely identifying all missing children in their electronic case recording and there is no system for monitoring the completion of interviews with children on their return, although inspectors saw evidence of children being visited on their return in case files. The provision of services for children at risk of child sexual exploitation is currently commissioned in relation to individual need. The council are aware of the need to develop a broader range of service provision but this is currently underdeveloped. At present there is no LSCB sub group monitoring or coordinating multi-agency work in this area and no independently commissioned service in place to conduct return interviews. This makes it difficult for the local authority to identify and understand trends, to exercise scrutiny, or to fully develop a coordinated response with partner agencies. This means that children suffering, or at risk of suffering, sexual exploitation are less likely to be identified and to have their practical and emotional needs effectively addressed.

34. The police report that social workers are not adequately prepared for multi-agency risk assessment conferences (MARAC meetings) and sometimes fail to follow up actions delegated to them. Both police and council staff are aware of the escalation procedure available to them but

have not used it consistently. Although social workers are not using a consistent risk assessment model in relation to domestic abuse, the SPA is referring to the pan-London domestic abuse procedures.

35. Children's and families' views are not yet contributing effectively to assessments of their needs and individual planning. Children and young people are not routinely attending child protection case conferences and social workers are expected to represent their views. There is some evidence of recent improvement with the commissioning of an advocacy service for children and young people from Voice. Inspectors found that families are mostly clear about the reasons for local authority involvement and, more often than not, feel both listened to and engaged in shaping plans and interventions. A family group conferencing service is now available but this is at an early stage of implementation. The Public Law Outline (PLO) is being used as part of case planning in respect of care proceedings and ensuring that parents are fully informed as early as possible of concerns and the possible implications. Although family members are not always positive about their engagement with social workers and other children's services staff, they generally report being treated respectfully and believing that interventions have had a positive impact.

36. Basic information relating to ethnicity, race, religion, culture and language is recorded on case files. However, the impact of interventions to support children's welfare is reduced because assessments and plans are not consistently tailored to the specific needs of children and their families. Interpreters are used with families whose first language is not English and managers are focusing on developing social workers' understanding of the diverse communities that live in Kingston.

The quality of practice

Inadequate

37. The quality of practice is **inadequate.** Children are not sufficiently or consistently well protected. Professionals' understanding of the current thresholds of need is improving but this is not yet sufficiently embedded across all agencies. Partner agencies making referrals to Children's Services do not consistently use the multi-agency referral form (MARF) and consequently comprehensive information is not always available at the point of referral. Partner agencies are able to access social work advice through the Single Point of Access (SPA) in supporting them to determine whether a referral to children's social care is appropriate. However, some agencies report an inconsistent response from the SPA to the application of thresholds.

38. The SPA is having a positive impact on how contacts and referrals are managed. Where child protection concerns are clearly identifiable, there is a timely and effective response, with prompt decision making by a

qualified team manager, which results in timely transfers to the referral and assessment teams. However, where the level of risk or need is unclear, cases are held in SPA to undertake further screening. This screening involves assigning the case to a case coordinator to gather further information and undertake telephone contact with other agencies. The team manager oversees this and makes contact with parents/carers and conducts office visits with families. This is, in part an assessment without seeing or speaking with the child within the family home, resulting in decisions being based on parental response, rather than a robust assessment of need and any risk of the likelihood of further harm. The team manager monitors the progress of these cases through the IT system. However, they are potentially unallocated cases which are not tracked in the weekly performance report due to the outcome of the contact being completed as 'provision of advice and information'. Inspectors identified a small number of cases which had been held in SPA for an unacceptable length of time. This delay is potentially unsafe as risks are not identified in a timely manner. The council have accepted this as a significant weakness and taken responsive action to improve management oversight within the SPA and are undertaking a themed audit.

39. An effective transfer system between the SPA and the referral and assessment teams ensure that strategy discussions and section 47 child protection enquires are timely. Section 47 enquires are undertaken by experienced social workers, with evidence of clear management rationale for decisions made. However, inspectors identified a very small number of cases where managers had recorded actions for social workers to follow up and these had not been completed. In these cases, inspectors were unable to confirm whether safeguarding issues had been addressed. For example, in one case seen, a section 47 enquiry was initiated and a strategy discussion was held but no further work was undertaken for a four week period despite established systems in place to ensure this does not happen. This is contrary to statutory guidance set out in Working Together to Safeguard Children March 2013, which outlines the immediate and short term requirements to protect children and to undertake a multi-agency assessment. Strategy discussions are routinely held by team managers and the police. However, other professionals are not being routinely included in the discussion, and as a result, full consideration of background information held by partner agencies is not always available to inform decisions and actions. In a number of cases seen where the outcome of the strategy discussion was to undertake joint section 47 enquiries with the police, delays were evident in carrying out joint visits to children and young people due to a lack of police availability. This is despite attempts by the local authority to resolve these issues through the police commissioner and this leaves children and young people at risk of continued harm. Further delays were identified in the conducting of some joint interviews of children by the police and social worker, Achieving Best Evidence (ABE) interviews.

40. In the majority of more recent cases examined by inspectors, recording was timely and up to date. However, the council are still actively addressing a legacy of past poor social work practice, where records did not reflect the child's journey, the consequences of which are still apparent in some cases. The quality of case recording is variable. Inspectors saw some good examples which included detailed observations of children's presentation and development with clear evidence of the progress of the case. However, some case recording was too brief and lacked detail. For example, evidence of challenge to parents or the presenting risk was not always sufficiently recorded and the rationale for the visit was not always evident. The quality of chronologies and their use in terms of an assessment tool is variable: they are not always up to date or focused on significant events; others record the activity rather than the actual concern.

41. Children and young people who are the subject of assessments and other interventions are, in the majority of cases, routinely seen, including alone where appropriate. However, inspectors examined a number of cases where children had not been seen within acceptable time frames, resulting in some risk factors not being considered. Inspectors saw some good examples of direct work with children and families by social workers and family support workers which had been sensitively undertaken such as; keep safe work, parenting work, education in respect of alcohol and drug misuse which had led to identifiable improvements in the child's situation and reduced risks.

42. The quality of assessments, including initial and core assessments as well as CAF is variable. In some cases examined, the purpose of the assessment was not clear, with needs and risk not always identified. Overall, the quality of assessments is an improving picture with good examples of effective communication with a range of professionals to ensure assessments are holistic. However, some older assessments in particular are too descriptive, do not consider or identify all the risks, lack analysis, lack appropriate challenge to adults and do not reflect the views of the child. These deficits are not always identified or challenged by managers when they are authorising assessments and cases are being closed before key issues have been addressed. Timeliness of initial assessments remains low at 39% (2012/13). However, this is reflective of the work undertaken by the council following the SLAC inspection in May 2012 when a high number of assessments were reopened and reassessed to ensure children were not at risk. Early signs of improvement are evident with timeliness of initial assessments reaching 66% in April 2013. Timeliness of core assessments has improved and is now slightly above statistical neighbours at 77%.

43. The quality of child in need plans is variable. Whilst some plans are detailed and outcome focused, with evidence of effective monitoring, others do not have clearly set out timescales, measurable goals or

contingency plans to support children and young people. Some children do not have a child in need plan in place. Recent examples examined by inspectors confirm an improving picture in relation to the provision of continuity of support when children are no longer subject to child protection plans. Child in need plans are now being appropriately developed at the point of the final child protection conference.

44. Social work reports to child protection conferences generally do not reflect the child's voice and vary in quality. However, there are some good recent examples. Child protection case conference chairs meet parents prior to the meeting and are supported by the chair in order to help express their views. Child protection conferences observed by inspectors were not attended by children and young people. However, they were well chaired with good multi-agency attendance and appropriate information sharing. In some cases, children and young people were provided with good support as part of their plan. Few children attend their case conferences, and although an advocacy service has recently been commissioned from Voice, there is little evidence of its impact to date. Consequently children's views are not consistently well represented.

45. Child protection plans are generally adequate and outcome focused with clear evidence that child protection chairs are providing improved challenge and oversight of plans in between conferences. However, contingency arrangements are inconsistently planned for and do not state how the case should be managed if the plan is not progressing, or if risk escalates. In some cases, there was no stated alternative course of action whilst in other cases, contingency planning was not well considered and records lacked detail. Most core groups are timely and are well attended by partner agencies with an improving picture with regards to the impact core groups are making to children and young people's outcomes.

46. In some cases, where little progress was evident, legal planning meetings took place in a timely way. However, actions from the meetings are not always undertaken in a timely manner resulting in children and young people being left in unsatisfactory and risky circumstances for too long. Quality assurance audits are undertaken by Child Protection chairs three months after the initial child protection conference to track progress against decisions taken and actions agreed. However, where shortfalls in practice are identified, effective remedial action is not always taken by team managers. This is being monitored and addressed through monthly performance management meetings.

47. Referrals made out of hours receive a service from the emergency duty team (EDT), which is jointly commissioned with neighbouring authorities to provide emergency child protection services. There are good links between EDT and day time services as well as partner agencies such as the police. Case information sharing with EDT is effective and ensures informed responses to issues occurring out of hours. Cases seen by

inspectors highlighted timely communication between services and detailed records of the nature of EDT's involvement.

48. Social workers spoken to by inspectors positively report that senior managers are visible, approachable and available. Senior managers are contributing to their good morale by holding monthly open door 'drop ins' and updating them about the improvement journey through regular newsletters. Social workers report they receive regular supervision and feel supported by recent improvements in supervision practice. However, case supervision records do not clearly demonstrate rigorous scrutiny and challenge of case planning or that supervision is reflective. In a small number of cases examined, there was an inconsistent focus on risk and protection of children and there was a delay in actions arising out of case supervision being completed by social workers. For example; assessments being undertaken, children being visited and conducting joint visits with the police.

49. A monthly multi-agency scrutiny panel provides oversight of cases where children and young people have more complex needs. The scrutiny panel is a good conduit for information sharing and is providing direction in these cases to avoid drift. Since the SLAC inspection in 2012 the council have undertaken a large number of case audits. However, there is no embedded process to ensure that the findings and actions from audits are routinely reviewed in supervision. This lack of challenge results in risk factors being overlooked and poor practice continuing in some cases. The council recognise this and are adjusting the quality assurance framework to ensure that learning from audits is embedded in social work practice. The lack of permanent staff has resulted in a high number of agency workers being employed within front line services. This has impeded improvement and consistency of service delivery and the ability of workers to forge effective and sustained relationships with families and other agencies.

Leadership and governance

Inadequate

50. Leadership and governance arrangements are **inadequate**.

51. Following the Safeguarding and Looked After Children's (SLAC) inspection in May 2012, a range of management strategies have been developed by an experienced and outward looking senior management team who can demonstrate a relentless focus on securing an improved service for children and families in Kingston. However, it is too early to measure the impact of these strategies in terms of sustained improvement in outcomes for children and young people.

52. Oversight and scrutiny of children's services has been strengthened since the SLAC inspection and a rigorous and well considered review of previous

failings in relation to protecting children has taken place to improve the corporate overview. However, owing to the very recent implementation of these structures, policies and procedures, they have yet to result in improved practice that is sufficiently consistent or embedded to ensure robust protection of children. Immediate action was taken in response to the SLAC inspection by the establishment of an Improvement Board to monitor the local authority response to the inspection and subsequent DfE Improvement Notice. The Board has provided appropriate and robust challenge and monitoring of the improvement agenda. Membership has been sufficiently senior to affect change and maintain momentum in relation to the pace of change. For example, in relation to securing funding for an additional team of social workers and ensuring prioritisation of the improvement agenda alongside arrangements for the joint management of children's services in Kingston and Richmond. The Improvement Board chair's six monthly report to DfE in May 2013, clearly and appropriately identifies that the pace of change has been substantial and rapid, with 83 out of the 96 actions outlined in the improvement plan in response to the SLAC inspection being met. The report demonstrates a realistic and shared understanding of key strengths, areas for development and risks, and includes an acknowledgement that challenges remain in relation to the recruitment of key staff, the development of the early help agenda, and ensuring a period of consolidation to embed fragile service improvements.

53. Elected members, including shadow portfolio holders, are members of the Improvement Board and have played a consistent role in the improvement agenda. A well-established meetings framework is in place to promote accountability between the leader of the council, lead member and the DCS and monthly meetings take place between the Chief Executive and the Independent Chair of the LSCB. The newly appointed lead member has been in post for one month at the time of the inspection and displays a strong commitment to ensuring continued and robust challenge. Networks are established with lead members nationally to facilitate learning and understanding of the role. However, owing to the recentcy of a number of these appointments, an understanding of respective roles and responsibilities is not yet fully embedded.

54. Joint management arrangements for protection and early help have recently been introduced across Richmond and Kingston boroughs, with a distinct offer of local services. The local authority is aware of the need to ensure that a balance is achieved to avoid an over reliance on the Richmond model of service delivery which, despite its proximity, is a borough with very different demographics to Kingston. The DCS is engaged in a series of well attended briefings with staff to address this. Partners interviewed by inspectors describe the newly appointed leadership team as modelling an open and responsive approach to partnership working at a senior level, which is appropriately inclusive of a culture of constructive challenge. Recent management appointments have

led to an increase in transparency, openness to constructive criticism, and a sense of shared responsibility for the partnership agenda. However, tensions still exist in strategic relationships with the police. Frequent changes in senior police personnel have resulted in a lack of consistency in partnership working at a strategic level, for example, in police attendance at the improvement board, and have hindered the development of effective joint working arrangements, including work with families experiencing domestic abuse, children missing from home and children at risk of sexual exploitation.

55. Following recent development activity, for example, a tighter business plan, which effectively prioritises core tasks, the LSCB now meets its statutory duties and the newly appointed Independent Chair has a firm foundation on which to build. However, it is too early for this development activity to evidence sustained positive impact on multi-agency practice. A period under the leadership of an effective interim chair has resulted in a smarter business agenda, focused on the core business of child protection, in line with the recommendation of the SLAC. According to senior partners who were part of the former structure, the Board previously lacked rigour, but now operates to a culture of appropriate challenge. For example, it has agreed a format for a dataset to monitor the effectiveness of interagency working and streamlined arrangements for the completion and publication of serious case reviews. However, the impact of these positive changes is still to be evidenced.

56. The overarching Children and Young People's Plan (CYPP) has recently been refreshed and now links clearly to the council's corporate priorities. The CYPP clearly sets out an ambitious and outcome focused vision for children and young people and this is monitored and reviewed by the multi-agency Children's Trust. It appropriately prioritises safeguarding and the provision of early help to children, young people and their families, and this is informed by a robust assessment of need, underpinned by a clear performance management framework with key performance measures outlined. However, it is too early to evidence the impact of the CYPP, as the delivery plan to support implementation is currently under development, and monitoring of the plan by senior managers which will take place quarterly, commences in July 2013. Although a few distinct examples have been seen by inspectors of efforts to gather feedback from service users to inform service planning, these examples are not coordinated and drawn together, and therefore little evidence was seen by inspectors of the systematic gathering of feedback from service users to routinely inform the planning of child protection services.

57. A recently introduced Quality Assurance Framework (QAF) sets down clear definitions and principles, and includes a wide range of QA processes, such as audits. However, whilst an extensive programme of casework audits was undertaken following the SLAC, there is currently no robust system in place to ensure that tasks arising from the findings of the audits

are consistently completed, resulting in continuing drift for some children. Some recent audits by middle managers also demonstrate the need for continued management development in relation to improving the quality of social work practice through robust challenge. Senior managers are currently heavily focused on delivery and embedding robust management oversight and challenge in order to embed practice standards for newly appointed middle managers. This is a necessary stage of the improvement journey and indicative of progress to date. The council is giving appropriate consideration to how a strategic and operational balance in managers' workloads will be achieved, in order to maintain the emphasis on improvement.

58. To deliver the QAF, a monthly performance board has been appropriately established in March 2013, chaired by the Head of Children's Social Care and attended by all departmental managers, including front line managers, and serviced by a dedicated quality assurance team. However, there have only been three Board meetings and these are not well recorded, with clear, timed actions being allocated to designated managers to support improvement. The quality assurance process is suitably supported by a monthly performance management dataset that appropriately assists leaders and managers to identify areas of practice that require management attention to achieve an acceptable standard of practice. Consideration of the report by inspectors indicates that a number of key performance indicators are demonstrating a positive trend. However, current performance often varies significantly from previous performance or that of statistical neighbours. The report is published as a series of tables and graphs without analysis, and although there is a plan in place to introduce them through the CYPP delivery plan, it is not yet inclusive of targets. It is therefore insufficiently clear how middle managers who attend the Board and receive performance reports could use the intelligence gained to clearly understand what is expected of them and ensure sustained performance improvement.

59. Areas from which organisational learning can potentially be drawn, such as learning from complaints, are currently underdeveloped. However, some progress has been seen by inspectors in the development of a learning culture, so that lessons learnt from the recent period of intensive service development can be consolidated and embedded. For example, the streamlined serious case review process was informed by a well-attended workshop organised by the LSCB and recent training has been delivered in relation to learning the lessons from national serious case reviews.

60. The social work service is heavily reliant on agency staff which does not lead to stability and continuity in the delivery of the service provided to children and young people. A detailed workforce strategy therefore incorporates an appropriate approach to the recruitment and retention of a competent and committed workforce that is of sufficiently high quality.

Additional strategies include; the provision of student placements; a 'grow your own' programme in which family support workers are offered social work training and 'bonded' to the department; a newly qualified social workers programme; and an attractive 'offer' of employment to encourage agency staff to stay permanently; including competitive pay, reasonable workloads, and a career pathway. All newly recruited staff are offered a comprehensive professional development package. Prior to the SLAC inspection, training opportunities were poorly attended and monitored, but these are now overseen by the performance board to ensure compliance. Social work staff interviewed by inspectors spoke of being well supported, and having ready access to training and supervision. Caseloads are reported by social workers to be manageable. Managers operate an 'open door' policy, and senior managers are described as being visible, approachable and supportive.

Record of main findings

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