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London Borough of Richmond upon Thames

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 dates: 25 September 2017 to 19 October 2017

Report published: 8 December 2017

Children's services in the Borough of Richmond upon Thames are good		
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 Inspections 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.

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Executive summary

Services to children and families in Richmond upon Thames are good. Senior leaders understand the needs of children and young people in the area well and demonstrate a relentless focus to meet these needs. The local authority has maintained good-quality services since the last inspection in 2012, and some aspects of services for children in need of help and protection have further improved.

Senior leaders have created an environment in which good-quality social work practice can flourish. This means that almost all vulnerable children and young people receive the help that they need in a timely manner. Practice is child-centred throughout the workforce. A number of social work services for children and young people are particularly strong, although this strength is less evident as the journey of the child moves towards permanence in care.

The decision to deliver services in partnership with two other local authorities through a community interest company has added value to the services that children and their families receive. However, some stakeholders spoken with during the inspection said that not enough has been done to engage them in meaningful consultation about the effects of changes on the way that services are provided.

Multi-agency statutory partnerships generally work well together, from a strategic level down to the provision of individual casework. Relationships between agencies are highly positive and this means that children and their families receive well-organised services, in the main. This is particularly true of services that offer help to families at the earliest stage to avoid their needs escalating.

Comprehensive and detailed assessments of need appropriately articulate risk and protective factors, with most leading to a suitable level of analysis. Social workers carefully take into account family history and the child's unique identity. However, chronologies do not always provide a clear and concise record of key events in children’s lives. This means that it is difficult to use them to understand the journey of the child, and how decisions to inform the provision of services have been reached.

Social work interventions for children in need of help and protection are well coordinated through the cluster model of service delivery; co-located services work together well through this model, and in a timely manner. In almost all cases, children benefit from the help and protection provided, including out of hours support. When change is not achieved and risks increase, cases are escalated appropriately. Inter-agency support to children and families is well organised, and good multi-agency dedication to child protection and child in need is demonstrated by partners’ evident commitment to attending all relevant meetings.

Frontline managers appropriately focus on the provision of high-quality services to children and families. However, recording of management supervision sessions is not consistently good. This means that some social workers are not receiving the level of reflective management oversight that supports good social work practice. Supervision sessions can be poorly recorded, and they do not always clearly detail

the rationale for key decisions made about the lives of individual children and young people.

Decisions enabling children and young people to become looked after are timely and appropriate. Effective, focused support to vulnerable families prevents children coming into care unnecessarily. Most children are helped to return home in a planned way, with support identified to help maintain progress. Social workers know their children well, visit them regularly and ensure that the voice of the child is captured in case records. Effective, collaborative therapeutic work with partner agencies, undertaken both with children and carers, successfully reduces risk and improves outcomes for children looked after.

Children looked after live in good-quality placements that meet their needs, although too many of them live out of area due to the shortage of local foster placements. Plans for permanence are subject to regular scrutiny. However, the endorsement of long-term foster placements is not always timely, nor is the rationale for the plan clearly expressed by independent reviewing officers (IROs) in their recommendations. Contingency planning needs to be more specific and measurable and the rationale for care planning decisions more clearly recorded.

In the small number of cases where adoption is the plan for permanence for children looked after, the local authority takes swift action to ensure that plans progress quickly. Children are helped to live with their adopted family at the earliest opportunity. Family finding and matching arrangements are highly effective, and this leads to stable placements for children looked after. Adopters are well prepared throughout the process, and they receive help and support for as long as they need it. However, vulnerable birth parents are not always helped and supported through the process of adoption. This fails to reduce the likelihood of any further children becoming looked after.

Care leavers are well supported to live independent lives and achieve long-term stability. The local authority maintains good contact with care leavers and ensures that housing is appropriately matched to young people's individual needs. Health needs are quickly identified and met well. Pathway planning is generally effective. The leaving care team is well managed, and its members work together co-operatively. Social workers and personal advisers are diligent and responsive to young people and their needs. Despite recent improvements, further work is required to ensure that more care leavers secure long-term employment.

The Local Safeguarding Children Board has ambitious priorities for ensuring the effectiveness of local safeguarding services. Collaborative and effective partnership working demonstrates a culture of continuous learning and improvement. Improved coordination of services by the board has in turn improved the multi-agency identification and response to vulnerable children at risk, in particular heightening awareness about the risks to children who run away and those at risk of child sexual exploitation.

The local authority has not been sufficiently proactive in identifying and supporting children who are privately fostered.

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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 safeguarding arrangements/ arrangements for the protection of children was in May 2012. The local authority was judged to be good.
- The previous inspection of the local authority's services for children looked after was in May 2012. The local authority was judged to be good.

Local leadership

- The director of children's services (DCS), Robert Henderson, has been in post since October 2016.
- The London Borough of Richmond upon Thames (alongwith the Royal Borough of Kingston upon Thames and the Royal Borough of Windsor and Maidenhead) have delegated their children's services statutory functions to Achieving for children, a community interest company. The DCS in Richmond upon Thames is also the DCS in Kingston upon Thames. The local authority remains statutorily accountable for the range and quality of children's services and is therefore referred to throughout, even where day-to-day management arrangements lie with the company.
- The chief executive has been in post since October 2016 and is also the chief executive of the London Borough of Wandsworth.
- The chair of the LSCB, Deborah Lightfoot, has been in post since April 2013.
- The LSCB is shared with the Royal Borough of Kingston upon Thames.

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[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.

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Children living in this area

- Approximately 45,000 children and young people under the age of 18 years live in Richmond upon Thames. This is 23% of the total population in the area.
- Approximately 10% of the local authority's children aged under 16 are living in low income families.
- The proportion of children entitled to free school meals:
  - in primary schools is 7% (the national average is 15%)
  - in secondary schools is 10% (the national average is 13%).
- Children and young people from minority ethnic groups account for 19% of all children living in the area, compared with 21% in the country as a whole.
- The largest minority ethnic groups of children and young people in the area are the mixed group and Asian or Asian British.
- The proportion of children and young people who have English as an additional language:
  - in primary schools is 23% (the national average is 20%)
  - in secondary schools is 19% (the national average is 16%).

Child protection in this area

- At 31 August 2017, 785 children had been identified through assessment as being formally in need of a specialist children's service. This was a reduction from 836 at 31 March 2017.
- At 31 August 2017, 136 children and young people were the subject of a child protection plan (a rate of 30 per 10,000 children). This was an increase from 111 children (26 per 10,000 children) at 31 March 2017.
- At 31 August 2017, one child was living in a privately arranged fostering placement. This was the same number as at 31 March 2017.
- In the last two years prior to inspection, two serious incident notifications were submitted to Ofsted and one serious case review was completed.
- There was one serious case review ongoing at the time of the inspection.

Children looked after in this area

- At 31 August 2017, 103 children were being looked after by the local authority (a rate of 23 per 10,000 children). This was a reduction from 106 (24 per 10,000 children) at 31 March 2017. Of this number:
  - 81 (or 79%) currently live outside the local authority area

- 29 live in residential children's homes, of whom 93% live out of the authority area
  - two children live in a residential special school[1], and both live out of the authority area
  - 67 children live with foster families, of whom 72% live out of the authority area
  - one child lives with parents
  - 25 children are unaccompanied asylum-seeking children.
- In the last 12 months:
  - there have been five adoptions
  - 14 children previously looked after became the subject of special guardianship orders
  - 21 children ceased to be looked after, of whom none subsequently returned to be looked after
  - no children and young people ceased to be looked after and moved on to independent living
  - six young people ceased to be looked after and are now living in houses of multiple occupation.

Recommendations

1. Ensure that plans to help individual children are specific, measurable and that they include contingencies.

2. Improve the quality and consistency of the recording of social work supervision sessions so that it is compliant with the local authority's policy, and can clearly evidence both the quality of individual casework and the impact, to support social workers' professional development and performance.

3. Improve the quality of chronologies to ensure that they provide a clear and concise record of key events in children's lives.

4. Ensure that a rationale for permanence plans for children looked after is clearly recorded on children's records. This should include the clear consideration of why adoption is not the preferred plan.

5. Strengthen the recording of IRO recommendations so that they are sufficiently clear and detailed about timescales to achieve permanence.

6. Ensure that vulnerable birth parents are helped and supported through the process of adoption to help them come to terms with the decision, and to reduce the likelihood of any subsequent children becoming looked after.

7. Develop, in conjunction with partners, a strategy to improve pathways into employment and training for care leavers.

8. Strengthen planning across children's services so that strategic, operational, and service planning captures the current position and the rate of progress against targets.

9. Effectively engage all key stakeholders in the management of change, including service reviews in the development of children's services.

10. Strengthen the response to the identification, the assessment and the monitoring of private fostering arrangements.

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Summary for children and young people

- When children and families need help and support, staff working across Richmond upon Thames provide the right sort of help at the earliest stage. This is helping more children to continue living safely at home.
- Services that support children and young people work together well, and managers check often to ensure that children and young people's needs are met, particularly during difficult times in their lives.
- Children and young people who are most at risk are protected by several agencies working well together. They get good support from social workers, who know them well, and who listen and take account of their views. Professionals talk to children and young people who have gone missing, after they return, but more needs to be done to find out why children run away, to help them stop.
- Children and young people are taken into care to support and protect them when all other options have been thought about, and at a time that is right for them Social workers listen to children's views carefully and help them to be involved in plans for their future. Foster carers provide good care but do not always feel listened to or valued by senior managers.
- Children and young people who are cared for by the council usually go to good schools and are making better progress in their education. Their personal education plans are starting to help to improve outcomes. Effective help is provided by the virtual school if they are not doing as well as expected.
- The Children in Care Council (CICC) has achieved a lot and is able to challenge senior managers effectively. It encourages all children looked after to take part and get involved in CICC activities. 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.
- Social workers try hard to make sure that children in care can live with a member of their birth family, and they quickly consider adoption for all children who might need it. As a result, most children know soon after they come into care where they will live until they are independent. They are well supported both to move when they are ready, and after they move.
- Young people who are leaving care are helped well and have a good choice of places to live that meet their different needs. Sixteen-year-old young people looked after are supported well and progress to education, training or employment. However, not enough young people have the opportunity to take up an apprenticeship or go to university.

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

Summary

Help and protection that children and young people receive in Richmond upon Thames is good and appropriately child-centred. Social workers and family support workers know their children very well, and the voice of the child is evident throughout the records of their work with children and young people.

Early help to families is well developed and highly effective. When problems occur, children and families receive a prompt offer of help and support. As needs and risks increase or decrease, cases are stepped up or down appropriately.

The single point of access to children's services is well managed and works effectively. Parental consent to referral is carefully considered. Information is appropriately shared between agencies to assess children's immediate needs. Social workers act swiftly when children are judged to be at risk of significant harm. There are good links with the children's out of hours service.

Children are seen, and seen alone. Assessments are comprehensive and detailed, and most include an appropriate level of analysis. Social workers carefully take into account the family history and the child's unique identity. Social workers and family support workers recognise the significance and importance of diversity and are responsive to children's and families' ethnic and cultural backgrounds. Risk and protective factors are clearly articulated. However, very few chronologies summarise clearly and concisely the key events in children's lives, and this limits their use in understanding the child's journey through services to their current point.

Child protection conferences and core group meetings are timely and well attended, as are child in need meetings. However, the quality of child in need and child protection plans is variable. They are not always outcome-focused, specific or measurable. Despite this, interventions by core groups of professionals are well coordinated. In most cases, children benefit from the help and protection provided. When change is not achieved and risks increase, cases are appropriately escalated to social workers. The cluster model of co-located services means that escalation happens swiftly, easily and effectively.

A proactive response to domestic abuse means that its detrimental impact on children and young people is minimised. The multi-agency risk assessment conference is an effective forum for sharing information, identifying and assessing risk and coordinating protective responses.

When 16- and 17-year-olds present as homeless, their needs and the risks are carefully assessed. The adolescent response team provides a timely and effective response to young people in crisis.

Inspection findings

11. The help and protection that children and young people receive in Richmond upon Thames is child-centred because social workers and family support workers know their children very well. The voice of the child is evident throughout the records kept by professionals, and children are routinely seen and regularly consulted about the services they receive to keep them safe.

12. Early help is well developed. A rich range of services are offered early when problems occur in vulnerable families. As a result, children and their families receive a prompt offer of suitable help and support, which is organised well to ensure its effectiveness. As needs and risks increase or decrease, children's cases are stepped up or down, to and from statutory services appropriately, and social workers can intervene to protect children where appropriate.

13. The single point of access (SPA) to children's services is well managed and run. The need for parental consent is carefully considered, and information is shared between agencies appropriately. Social workers act swiftly when children are judged to be at risk of significant harm. Good links with the children's out of hours service mean that protection is assured for children around the clock. The quality of referrals generated by partners is variable. In some cases, this is due to a lack of familiarity with the system for referral. Social workers in the SPA are therefore available to provide advice and guidance to other professionals wishing to refer. However, take-up of this consultation service is not well recorded, and this makes it difficult for senior leaders, such as the Local Safeguarding Children Board, to evaluate its effectiveness.

14. The response to contacts and referrals at the 'front door' is timely and effective, because the SPA is co-located with the multi-agency safeguarding hub (MASH). Managers, all of whom are qualified in social work, oversee all decisions. They make good use of weekly performance management reports to monitor the work of the SPA and MASH. Contacts are rated and prioritised appropriately. Decision-making is proportionate and timely.

15. Staff based in the SPA take full account of previous involvement with children's social care, and the issue of parental consent is routinely considered. The MASH process is used selectively and intelligently. Daily morning MASH meetings ensure a consistent approach to the application of thresholds criteria. Management oversight of the overall referral process is clear and well recorded. This means that children who are at immediate risk of significant harm can be fast-tracked to the appropriate team for suitably swift help and support.

16. The children's emergency duty team (CEDT) provides an effective out of hours service. The service is delivered under the terms of a long-standing and well-developed contract. It is well managed, and there is clear evidence of a commitment to continuous service improvement. Referrals from the CEDT are clear, concise and appropriately detailed. Good two-way communication with the SPA helps to ensure that there is a timely and effective response to risk and

needs. This includes children who go missing and those who are at risk of sexual exploitation.

17. Locality-based referral and assessment teams respond promptly to referrals from the SPA and MASH. Managers provide an appropriate level of oversight that prevents drift or delay. In most cases, children are seen quickly, and seen alone. When there is an immediate risk of harm, children are generally seen within 24 hours, and often on the same day. Children in need are also seen promptly, usually within three to five days of the referral, and this ensures that their views are taken into account in any assessment of their needs.

18. Strategy discussions consider background information from partner agencies and other professionals, and most are well recorded. However, the majority of strategy discussions involve a telephone conversation with only the police. The focus is on whether the threshold has been met and whether there needs to be a joint or single agency investigation. Other partner agencies are not directly involved, and this limits the quality and the richness of information sharing, for instance on a child's health.

19. Social workers know the children and families they are working with well. They are actively encouraged to undertake direct work with children. The quality of direct work seen is of a high standard and helps to ensure that the offer of support is informed by what children think and feel. Social workers and family support workers recognise the significance and importance of diversity. They are responsive to the ethnic and cultural background of children and their families.

20. Assessing social workers make it their priority to understand the history of the child and family. They differentiate appropriately between the experiences of different children living in the same family. In most cases, risks and protective factors are clearly articulated and recommendations are coherent. This leads to appropriately targeted help and protection. However, chronologies are electronically generated without any obvious attempt to edit or revise them. Most are too long. They do not sufficiently differentiate between routine social work activity and significant events in children's lives. This makes them difficult to use to inform assessments. (Recommendation)

21. Initial and review child protection conferences are timely. In most cases, they are well attended by an appropriate range of professionals, and information is shared well. Child protection conference chairs provide effective challenge, and this helps to ensure that any decisions made are proportionate and appropriate. Minutes are clear and simple and circulated promptly, which helps to avoid confusion or delay.

22. The quality of written child protection plans is variable. Approximately half of those considered by inspectors were found to require some improvement. Some are too long and confuse risks with tasks. Others lack specificity, and tasks and actions are not measurable. This lack of clarity, about who needs to

do what by when, makes it difficult to use them to track progress against outcomes and challenge any deficits. Senior managers are aware of this and are revising the child protection plan template to make sure that it is compatible with the preferred model of working.

23. Partnership working at an operational level is strong, support is well coordinated and robust, and effective inter-agency working mitigates the shortcomings of written plans. Good multi-agency commitment to attending core groups and child in need meetings means that progress is closely monitored. When change is not achieved, and risks increase, cases are escalated appropriately. This is helping to improve outcomes for children and young people.

24. A cluster model of service delivery supports a fluid and dynamic response to risks, needs and changing circumstances. The model is facilitated by the co-location of teams along locality boundaries, and this leads to close and positive working relationships between staff. Children's cases are swiftly, easily and appropriately escalated from family support to child in need, and from child in need to child protection. The converse is equally true when this is appropriate. This ensures that children and young people get the right level of help and protection, suitable to their assessed needs.

25. A proactive response to domestic abuse demonstrates that the local authority is determined to reduce the impact of domestic abuse on children. The multi-agency risk assessment conference is an effective forum for sharing information, identifying and assessing risks and coordinating protective responses for the children of families experiencing domestic abuse. Having funded a domestic violence specialist for some time, the local authority has in the last 12 months developed an innovative group work programme for perpetrators. This is designed to break the cycle of serial abuse by men who have multiple or a series of partners, and early indications are very encouraging. . Of eight who started the 22-week programme, seven men have recently completed it, and the impact on families is now being monitored.

26. Children who have a disability are able to access a range of support services in line with their assessed needs. They and their families benefit from effective early intervention, including the provision of respite care. This helps to prevent safeguarding issues and concerns from escalating. The local authority is making steady progress in ensuring that every child who needs an education, health and care plan has one. The transition to adult services is well managed. A named link person in adult services gets involved in the planning process for young people aged 14 onwards.

27. Allegations against staff or persons of trust with children are well managed. The designated officer is knowledgeable and experienced and understands when and how to commence a child protection enquiry, if one is necessary. Cases are followed up in writing, including those that do not meet the threshold for a strategy meeting, and this is good practice. Systems in place to identify any

emerging patterns apply equally to individuals and settings and ensure that the offer of repeat offending is minimised.

28. Good awareness of, and a prompt response to, children who are at risk of sexual exploitation results in multi-agency planning meetings that are effective in safeguarding and protecting them. The multi-agency sexual exploitation group provides regular and effective oversight of this process. The number of children who go missing from home is relatively small. All are offered a return home interview and two thirds have one, most within 72 hours. However, senior managers recognise that the quality of recording return home interviews is variable, and this hinders a clear understanding of why children repeatedly go missing and the opportunity to help them to stop.

29. Children missing education (CME) are well reviewed and risk-assessed. Effective action has led to a reduction in the number of CME over the last two years. However, the local authority acknowledges that the oversight of the quality of education provided for children and young people who are being electively home educated is not sufficiently robust and has appropriate plans in place to address this.

30. The local authority has not been sufficiently proactive in relation to identifying children who are privately fostered. It cannot be confident in its ability to identify private fostering arrangements, and this has the potential to expose children who are living with unrelated adults to risk. (Recommendation)

31. The adolescent response team provides a timely and effective response to young people in crisis. When 16- and 17-year-olds present as homeless, their needs and the risks are carefully assessed. They are helped to make informed choices about their rights to care or accommodation. The level of help and support provided is appropriate, and bed and breakfast accommodation is not used, even as a short-term solution.

32. Older children are encouraged to participate in their child protection conferences. Relatively few of them choose to do so, and the take-up of advocacy support is low. However, more of them are using an online questionnaire to comment on their experiences of child protection. The local authority recognises that it needs to make better use of this feedback.

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

Summary

Outcomes for children looked after in Richmond upon Thames are good. Effective, focused support is provided to vulnerable families prior to children coming into care. Decisions to look after children are timely and appropriate, and helped by timely information sharing through the cluster model of working. Most children are helped to return home in a planned way, with support identified to help maintain progress.

Social workers know their children well, visit them regularly and ensure that the voice of the child is reflected in their case records. Assessments are clear, detailed and regularly updated to reflect the changing needs of children. Multi-agency working is a strength, and it is often collaborative with mental health services, including therapeutic work undertaken with both children and carers. This reduces risk and improves outcomes for some of the most vulnerable children.

Children have access to a wide range of cultural leisure opportunities. They live in good-quality placements that meet their needs, although too many of them live out of area due to the shortage of local foster placements. Plans for permanence are subject to regular scrutiny, although the matching of long-term foster placements is not always timely. Contingency planning needs to be more specific and measurable to ensure that the rationale for care planning decisions is clear.

Children's participation in the review of their care plan is extremely positive. Reviews are timely, and children engage well in the process. The CiCC is vocal, organised and represents a wide range of children's views, holding senior managers to account on a range of issues.

The virtual school offers effective support to ensure that the educational needs of children looked after are met and monitored effectively. The overall trajectory for attainment and attendance is positive.

The local authority is in touch with almost all of its care leavers, and young people receive effective support that is mostly responsive to their individual needs.

When adoption is the plan for children in Richmond upon Thames, the local authority takes swift action to ensure that plans progress quickly. Children live with their adopted family at the earliest opportunity. Family finding and matching arrangements are effective and result in stable placements for children. Adopters are well prepared through the process and receive help and support for as long as they need it.

Parents who have relinquished children to care are not always given sufficient ongoing support. This means that they are not enabled to learn from the experience and avoid repeating it.

Inspection findings

33. The majority of decisions to look after children are timely and appropriate. Good support is provided to children on the edge of care by effective family support services, including 'strengthening families plus' and 'better by design' programmes. Family group conferences, convened by a dedicated team, ensure that focused work identifies support within the wider family network when families' needs are escalating. Most children who return home from care do so in a planned way, with support identified, including for children who are subject to special guardianship orders. In a very small number of cases seen, the plans to return children home provided limited detail of how support will ensure the avoidance of future episodes of care.

34. The local authority has effective systems in place to monitor the timeliness of care proceedings, which have improved to an average of 27 weeks in the last six months. Court assessments are detailed and thorough and provide a clear rationale for care thresholds. A dedicated case progression officer maintains a public law outline tracker, attends legal planning meetings, and liaises closely with social workers to oversee progress at pre-proceedings stage through to the conclusion of proceedings. Managers also oversee the quality of support to children who are subject to a supervision order, in line with the revised supervision order policy. The children and family court advisory and support service (Cafcass) reports that there is effective liaison with the local authority, that social workers have a good relationship with families, and that they are positive about the quality of social work practice.

35. Children have good relationships with their social workers, who know them well, visit them regularly and complete direct work with them to ensure that their wishes and feelings inform care planning. This is reflected well in most case records. Children have access to an advocacy service provided by an independent childcare organisation, and 23% of children looked after accessed the service during 2016–17. Independent visitors are engaged in consultation with children when required. Children looked after are made aware of their right to complain through the distribution of suitably child-friendly leaflets. A low number of individual children and young people complain; those who do are supported appropriately by the advocacy service.

36. Arrangements to support children missing from care are well coordinated by a multi-agency missing persons panel, which scrutinises each episode and ensures that actions are rigorously progressed and updated. Dedicated missing person's officers routinely offer return home interviews, and performance on take-up is analysed to understand trends. High-quality services support the identified needs of young people, such as those at risk of substance misuse or

involvement in gang activity. Services effectively inform risk reduction measures as part of care planning. The early identification and coordination of services to support children looked after who are at risk of sexual exploitation is effective. A monthly multi-agency sexual exploitation meeting ensures that the most vulnerable young people receive high levels of service to reduce their vulnerability.

37. Strong evidence of multi-agency working for the most vulnerable children at risk of offending behaviours, substance misuse, and mental health issues demonstrates that it is highly effective. In the very best examples, this work is child-centred, collaborative and has led to therapeutic interventions by the clinical psychologist for children looked after, youth offending service, and substance misuse services, to bring about significant reduction in risk and improve outcomes. Emotional health issues are taken seriously, and there is a clear commitment to work creatively and engage young people through therapeutic approaches, support to carers, staff training, and 'think space' reflective sessions. This ensures a good level of engagement with children and carers at home in their placement, prior to a formal escalation to child and adolescent mental health services.

38. Assessments are of good quality, are detailed and reflect the voice of the child. The child's social worker, in accordance with the child's changing circumstances and development, regularly updates them.

39. Care plans address the needs and experiences of children and young people sufficiently well. However, contingency planning could be more specific, timely and measurable, so that the rationale for permanence is clearly understood, and that parents and carers are clear about next steps if progress is not sustained within the child's timeframe. (Recommendation) Independent reviewing officers (IROs) could be more effective at recording this in the form of specific and measurable recommendations, so that plans for permanence do not drift. (Recommendation)

40. Health assessments are not always timely, although this is an improving picture and the local authority is making improvements through a multi-agency steering group and action plan which tracks progress. Good partnership working aims to improve notification processes, and the designated nurse is working more effectively with out-of-area providers to meet the needs of a significant cohort of children.

41. Professionals in the virtual school have taken recent and rapid steps to improve the educational experience and outcomes for children looked after. In terms of pupil attainment, the overall trajectory is positive. Those in primary education have improved over the last two years, and the gap between their performance and that of all pupils is narrowing. This is also the case for pupils at key stage 4. There is steady improvement in attendance but it is marginally below national comparators. The level of persistent absences has reduced well. There

has been a marked improvement in ensuring that children attend a school judged as good or better by Ofsted.

42. The professional team in the virtual school is able and enthusiastic. The headteacher has identified well the key actions needed to improve outcomes for children. The engagement of designated teachers is now good, and there are clear expectations of schools to ensure that the personal education plan (PEP) process supports children's learning. A well-received training programme and termly forum enable designated teachers to develop their practice. There is significant progress in the use of data to monitor pupils' performance. Professionals in the virtual school effectively assess input needed at PEP reviews and key transition points. Expectations in respect of children placed out of area are high and equivalent to those in the borough.

43. The extended reach of the virtual school now incorporates pupils up to the age of 18. This has enabled college managers and staff to benefit from the expertise and procedures that the virtual school has in place. However, too many young people fail to engage in sustained education, employment or training. A governing body provides informed support and challenge to the headteacher. Pupil-premium funding positively supports the education of children in care individually, or through borough-wide initiatives. Members of the CiCC work in conjunction with virtual school staff to run the purposeful and enjoyable 'Radio aspire youth' weekly broadcast.

44. Children have access to a range of child-focused activities after school, outlined in a clear and ambitious strategy. The 'Culture 4 Keeps' programme provides a comprehensive array of cultural leisure opportunities for children of all ages, including museum trips, art and theatre projects and encouragement to learn musical instruments. Youth clubs and celebration events ensure that there is a determined focus on the particular needs, experiences and achievements of children looked after.

45. Children are mostly cared for in safe, settled placements which meet their needs well. Brothers and sisters live together following the completion of detailed 'together or apart' assessments of attachment, which consider their views and inform care planning. Carefully considered delegated authority is reviewed on a regular basis to ensure that carers' responsibilities are understood and applied. This is particularly important in an environment in which a high proportion of children looked after are placed out of area.

46. Long-term placement stability for children looked after in Richmond upon Thames is 64% and is, in part, a reflection of the high number of older children who make up the children looked after population (41% are aged 16 plus). The local authority does not maintain in-house children's home provision. Young people are often placed at a distance from their home due to the absence of emergency provision, then brought back nearer the borough when the opportunity arises. In addition, the shortage of local foster placements means that too many children live away from their home area, and this increases the

potential for instability. However, the local authority works hard to promote contact for children with friends and family, including for those children who live more than 20 miles away from their home community.

47. The local authority is aware of the need to review its recruitment strategy in order to reduce its reliance on out-of-area foster placements. A recently appointed recruitment officer is developing the strategy and action plan to attract more local foster carers. A small number of recently approved foster carers have been recruited by the commissioned 'home for good' church-based charity, which aims to identify potential families who can be trained, assessed and approved by the fostering service. The local authority is also in the process of establishing an in-house children's home in recognition of the limited availability of local residential placements for those children who need a residential setting. This cohort often need a care placement in emergency circumstances, and the current absence of local, in-house provision means that they are initially placed at a distance from their home, then brought back nearer the borough as the opportunity arises. This is destabilising, for instance to their school placement, and can potentially lead to further disruption.

48. Support to a significant cohort of unaccompanied asylum seekers who constitute approximately one quarter of the total looked after population is well coordinated and child-centred. Suitable efforts are made to promote cultural and diversity issues within placements and ensure effective communication through interpreters. There is a determination by social workers to understand the child's journey to this country, take account of the emotional trauma experienced, and ensure that plans reflect the need for tailored support, which helps them settle and make progress in all areas. This includes encouraging children to participate in education, cultural activities, and skill-based workshops on budgeting and risk of sexual exploitation. Social workers also make timely referrals for therapeutic support for the most vulnerable children, when appropriate.

49. The majority of children looked after who have disabilities are supported effectively by a range of services that are well matched to their individual needs. There are a good variety of support services available, children are visited regularly in residential settings, and the transition to adult services is progressed in line with the child's care plan. Inspectors saw evidence of social workers and IROs communicating effectively, with non-verbal children using a range of methods.

50. A combination of temporary staff and the merger of two teams into one achieving for children fostering service over the last 12 months has led to some tensions within the fostering community. These are yet to be resolved. Some foster carers have reported difficulties, with changes of social worker, interim fostering managers and insufficient documentation provided prior to a child's placement. There are currently two fostering support groups and databases, which are yet to become one service. However, a new permanent fostering manager is now in place, and the local authority recognises the need to liaise

more proactively and effectively with foster carers to ensure that their views on the development of the newly merged service are understood and considered.

51. The fostering panel has played a key role in relation to quality assuring practice during this period of transition. Although the standard of written reports presented to panel is variable, the service is compliant with fostering standards and regulations. Fostering records, visits, training, and support to foster carers in those cases seen during the inspection is appropriate. Assessments of foster carers highlight strengths and training needs clearly, and are sufficiently detailed. An IRO, commissioned to ensure independence, chairs annual foster carer reviews.

52. A permanence policy outlines clear expectations for staff. Permanence planning meetings are regular for individual children, from the point that they are looked after until a plan of permanence is agreed. A number of other panels also monitor plans for permanence, which can sometimes lead to confusion for staff in relation to matching processes. (Recommendation)

53. Inspectors saw evidence of comprehensive viability assessments of connected carers as part of parallel planning processes; however, in a very small number of cases, this was not sufficiently recognised or assessed in a timely way in accordance with the permanence policy. Support is provided to special guardians and connected carers, who access foster care training, therapeutic support and support groups as appropriate.

54. A high percentage of children participate in the review of their care plan (94%), and this is a strength. Their views are presented clearly through effective consultation, using a range of electronic communication methods. The participating children include disabled children and very young children over four years of age (60% completion rate). A dedicated officer supports them in the process, while collating and reporting on key themes for the corporate parenting board. Reviews are very timely, children sometimes chair their own reviews, and inspectors saw evidence of IROs providing challenge and escalating issues when appropriate, such as an overdue health assessment or the need to consider a vulnerable young person as a care leaver. IROs consistently meet with children prior to their review, and there is evidence of an IRO footprint on the case record. IROs attend permanence planning meetings and provide training to new staff to ensure clear expectations in relation to care planning standards and review participation. However, review recommendations are not always sufficiently clear and detailed about timescales to achieve permanence. (Recommendation)

55. The CiCC is a committed, organised and articulate group of young people, who are able to challenge senior managers effectively. A youth engagement officer provides support to the CiCC in its activities, and young people looked after are enabled to reflect on its remit, effectiveness and engagement with the local authority with determination and a clear sense of purpose. A well-written CiCC action plan and pledge identifies key issues and progress to date. It was

developed following a number of stakeholder events and a residential weekend. Representatives of the CiCC have regular meetings with managers, routinely attend corporate parenting panel, engage in peer research and facilitate a well-attended two-day 'Choices, voices and rights' training course for managers, social workers and elected members. Young people are actively involved in staff recruitment and recognise the need to engage with the wider looked after population through newsletters, celebration events, and birthday and Christmas cards for every child looked after.

The graded judgement for adoption performance is that it is good

56. Adoption is considered for children who are unable to live with their birth parents, or to be cared for within their extended birth families. Children live in placements that meet their needs. Five children were adopted in the 12-month period prior to the inspection. In all five cases, swift action ensured that adoption was secured as quickly as possible. The local authority has a proven record in placing babies for adoption. At the time of the inspection, there were no plans for adoption or family finding taking place for any sibling groups, older children or children who have a disability.

57. Plans progress in a timely way, and children are able to live with their adopters at the earliest opportunity. This includes appropriately placing babies with their adoptive parents under foster to adopt arrangements soon after their birth, resulting in earliest stability and permanence arrangements for these children. This effective use of concurrent planning could benefit more children. In a very small number of cases seen during the inspection, foster to adopt arrangements, considered sooner, could have reduced the number of avoidable moves for these very young babies.

58. Staff and managers in the service know individual children well and understand where children are in the process of adoption. Effective tracking arrangements are in place to ensure that children's plans for adoption do not drift.

59. The agency decision maker (ADM) appropriately challenges the quality and timeliness of submissions if they are not completed on time or to a good enough standard. The ADM has regular meetings with the independent chair and observes the adoption panel twice each year. The independent adoption panel chair has brought new ideas to the role. She is suitably qualified and experienced and brings a focused, analytical, and organised approach. Business support and legal advice to panel is effective in supporting the decisions of members.

60. The quality of work brought to panel is mostly of a good standard, although child permanence reports are not always detailed enough. The panel chair has identified this as a training need for staff. Additionally, reports recommending a match need to contain more information about the reasons why a particular

match is the best option for a specific child, and how this match will meet their individual needs. The panel chair recognises this as an area for improved practice. Panel minutes demonstrate that panel members are well prepared for panel. They ask relevant questions and offer suitable challenge, which contributes effectively to the consideration of issues to inform the ADM.

61. Richmond upon Thames is part of the South West London Adoption Consortium (SWLAC). Arrangements for responding to prospective adopters' enquiries in a timely way, delivering preparation sessions and coordinating training, are generally working well. The local authority is aware of the need to attract more adopters. The number of people who make enquiries about adoption is reducing, and the number who attend initial information sessions who then decide to progress for initial assessment has also fallen. These issues are clearly identified in the SWLAC manager's meeting minutes. However, the absence of a clear action plan to understand and address them is a deficit. The consortium recruitment strategy is not fully implemented in Richmond upon Thames, and, while this is a missed opportunity, there is not a high demand for adoptive placements and no children are waiting.

62. Adopters report to inspectors that they value the support they receive through the process of adoption. Social workers help them to be realistic about the outcomes and explain clearly the potential challenges that they could face in the future. They receive information about the benefits and possible risks when considering foster to adopt placements. Those adopters who are involved in these arrangements feel well supported through the process. Prospective adopter reports are of good quality. They describe strengths and vulnerabilities and are sufficiently analytical.

63. Family finding is effective and timely, aided by a specific family finding worker allocated to a child prior to granting of a placement order. Family finding visits to children, carers, prospective adopters, and birth families where appropriate take place early to prepare a profile and so matching needs can be considered. This means that plans can progress quickly once an order is in place. A range of local and national networks successfully identifies families for children. Children's social workers and family finding workers consider prospective adopter reports together. They visit families and prepare a shortlist of suitable matches to discuss and agree with managers at the permanency panel, before formal presentation at adoption panel.

64. Introductions between children and adopters are thoughtfully considered and lead to placements that last. There are opportunities for birth parents to have one meeting with adopters when appropriate. Children's social workers visit regularly during the settling in period to discuss and help solve any emerging issues early. Children and adoptive parents receive support up until the adoption order is made. There have been no pre-order disruptions in the past year.

65. Adopted children are provided with life-story books. These provide adequate information and detail about children's birth families and early history. However, given the small numbers and the very young age of the children involved, life-story work could be completed sooner. Some children who have had their adoption celebration event are still waiting for their life-story book to be completed. Later life letters are produced in a timelier manner and are appropriately included on children's files.

66. Adopters do not usually have to wait a long time for a child to be placed with them. There are currently two approved adopters waiting for a child. One of these is matched with a child from another borough, and details of the other approved adopter have been shared across the consortium. Approved adopters are encouraged to look for potential matches themselves on the national database. There are no children waiting for a match.

67. Some birth parents do not consistently receive sensitive support through the process of adoption. Help for them to understand and explore issues of loss and separation and come to terms with what has happened does not routinely take place. For example, inspectors saw a very small number of care leavers who have had babies removed from their care, not having their needs sufficiently considered in their own right. Additionally, a small number of vulnerable parents who have complex needs are not engaged in work to break the cycle to prevent further babies being removed from their care. (Recommendation)

68. The adoption service relies on paper records. This means that there is no central place to hold case records information. There is risk of important information about children being lost, and it is difficult to access important documents and information easily or quickly. Staff in the service are frustrated because it takes them longer to complete tasks. The local authority has plans in place to address this.

69. A wide range of post-adoption support is helping children and their parents effectively to manage behaviour and work through their thoughts and feelings about adoption. Bespoke packages of support, including group work, counselling and play therapy, are readily available to families.

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

70. Care leavers receive a good and responsive support in their moves to independent living. Pathway planning is effective, with the vast majority of plans completed in a timely manner and used well by social workers and personal advisers to help care leavers measure their progress and prepare for their futures. Pathway planning includes appropriate consideration of risks,

protective factors, legal issues, and access to financial entitlements to support care leavers' needs.

71. The local authority maintains good contact with care leavers. At the time of the inspection, it was in touch with almost all 19- to 21-year-olds. The care leaving team judge well the extent to which a young person wants and needs contact. In some cases, this is daily, but in others, every few weeks. Contact is appropriately maintained with those young people who are in custody or secure settings.

72. Care leavers spoke highly of their workers and the consistent support that they receive. In most instances, workers have developed good relationships with the care leavers whom they support, often over a number of years. Workers have high expectations of the young people and challenge them to achieve their best. A small minority of young people feel that they sometimes wait too long for a response from their worker, or that communication is rushed.

73. Accommodation for care leavers is suitable, with plans well advanced to commission further housing provision on a local basis. Care leavers spoken with said that they have accessible and encouraging workers who support them to live in semi-independent accommodation. The 'staying put' policy, after some initial caution on the part of foster carers, is increasingly effective. There are regular activities and social events, and staff are very good at marking special occasions such as birthdays. Young people are able to undertake national accredited modules within the setting on topics such as cookery. Staff use these opportunities to nurture care leavers' interests in further education. In order to prepare young people to face the realities of living independently, managers require them to undertake a tenancy information course. There are good arrangements for term-time and holiday housing needs of care leavers who attend university. All care leavers with whom inspectors met said that they felt safe in their accommodation.

74. Leaving care staff and team managers are responsive to, and well informed about, young people's health needs. They are proactive in ensuring that unaccompanied asylum-seeking children are health screened, with prompt action taken if there is a need for medical intervention. Regular health workshops target particular groups. Well-attended sexual health workshops for unaccompanied asylum-seeking children help young people learn about pertinent issues, such as consent and cultural norms in relationships. For example, they are then able to take personal responsibility by having informed access to a contraception service. Managers express concern that their careful monitoring shows that white British young women engage less well in health workshops. Through consultation, they have established that these young women would benefit from increased self-awareness on issues such as domestic violence, and managers are taking action accordingly to ensure that this happens. Pathway plans routinely cover health issues with care leavers who are well aware of their health history and of where to seek help if needed.

75. Not all of the care leavers spoken with by inspectors felt sufficiently prepared in their transition from being a child in care to receiving adult services. While there is much good practice, this is not consistently the case. However, the transition needs of disabled children are progressed in a timely way. More broadly, care leavers develop knowledge and skills from attending courses in money management and in cookery.

76. Care leavers are aware of their entitlements to financial support, such as their leaving care grant. They also have good access to funds through local charities to help them set up home. Workers deal with individual care leavers' financial matters sensitively on a case-by-case basis to meet need.

77. Team managers' actions enable care leavers to achieve long-term stability and independence. Managers are well informed about care leavers' needs when taking decisions. They seek, with some success, to match the allocation of social workers and personal advisers to the wishes and cultural backgrounds of care leavers. They work effectively with partners, such as housing associations, council departments, health authorities, and charities. Staff feel supported and able to exercise their discretion. Following a period of relativity high turnover of social workers, staffing has now stabilised.

78. There are some areas for further development in practice and this leads to a small minority of care leavers not benefiting from the effective and persistent support that is characteristic of the service. In particular, this may occur when care leavers become pregnant or become new parents. Team managers' quality assurance of pathway plans is not sufficiently robust to ensure that the written record does justice to the quality of the service being delivered.

79. The 1419 team, which works with the education business partnership directly, supports care leavers through the 'Way2Work' scheme. This provides internships, traineeships and apprenticeships. Improved coordination, including the virtual school, combined with better strategic involvement of colleges and employers, is beginning to have a positive impact, with the result that a greater proportion of care leavers than previously are finding sustained employment, training or education. Nevertheless, the number of those not in education, employment or training (NEET) across the total care leaver group is too high at 29%. The figure is better than in previous years and in other areas but remains a concern. (Recommendation) Older care leavers, aged 1921, fare less well than their younger counterparts. Overall, the way forward is good, but there is an insufficiently sharp focus on actions that may support care leavers to better engage in education, employment and training. The proportion of care leavers accessing higher education is lower than the national average.

80. Success is celebrated by an annual awards ceremony highlighting care leavers' achievements. The leaving care pledge sets out young people's entitlements clearly, in a positive manner, and guides the local authority's actions.

Leadership, management and governance	Good

Summary

Leadership, management and governance of services to children in Richmond upon Thames is good. Senior leaders ensure a relentless focus on the needs of children and young people. Child-centred practice comes from the top of the organisation and extends throughout the workforce.

Senior leaders have created an environment in which good-quality social work practice can flourish. Consistently good practice means that almost all vulnerable children and young people receive the help they need in a timely manner. Workforce planning and development has delivered major successes through supported professional development for social workers. This means that children can form secure relationships with their social worker. Supervision of social workers could be recorded in a more consistent manner by frontline managers.

Partnership working is a significant strength. Relationships between agencies are highly positive, and this means that children and their families receive, in the main, well-coordinated services. A culture of prioritisation and planning is not embedded. This results in care planning, most particularly planning for permanence, that is insufficiently timely or focused on achieving positive outcomes for children looked after.

The decision to deliver children's services as part of a community interest company has added value to the delivery of services to children. However, implementation of this change has been uneven, and not all stakeholders feel sufficiently engaged.

Senior leaders know the community that they serve, and they understand the services they provide to children well. Access to the community interest company's dedicated specialist teams leads to effective implementation of a range of detailed management strategies. However, more could be done to measure and monitor progress of any areas for improvement identified by quality assurance activity, so that senior leaders are aware of what improvement is being achieved, and at what rate.

Senior leaders understand well what needs to change to improve the local authority's arrangements for commissioning services, specifically for children looked after. They have invested significant time and resources in establishing the company as a provider as well as a commissioner of services, so that it can operate effectively within the placements market. This strategy is in its early stages of implementation and it is too early yet for it to demonstrate impact.

Inspection findings

81. Senior leaders have created an environment in which good-quality social work practice can flourish and services to children and young people are therefore strong and improving. Inspectors identified a number of areas in which social work practice to children and young people is particularly strong; principally where vulnerable children and their families are helped and protected. These include the cluster model of service delivery, the approach taken to families experiencing domestic violence, help to children who go missing and are at risk of sexual exploitation, and needs assessment by social workers generally. Improvement in the educational attainment of children looked after is also a significant success story. These positive aspects of social work practice are being further enhanced by the current roll-out of the local authority's preferred model of risk management. This supports the introduction of practice hubs, including embedded family therapists, as part of the government's partners in practice initiative.

82. Child-centredness is at the heart of the approach taken by Richmond's senior leaders to delivering good services to children and young people. Their relentless focus on the needs of the child permeates the workforce. In almost all children and young people's cases, this results in them receiving timely services of a high quality.

83. Most children receive services from social workers who are permanent and committed members of the workforce. Successful workforce planning and development is based on a recognised model of professional development. Social workers, including newly qualified workers, are offered career progression by a small, dedicated team of practice development consultants. This is delivered through both action learning sets and one-to-one sessions. An active staff council that advises on learning needs supports the programme. Staff retention has increased and vacancies have more than halved over time, from 25% of the workforce to 12% currently. This means that children can form secure and meaningful relationships with their allocated social worker.

84. Partnership working is a significant strength and means that children and young people receive mostly well-coordinated services, delivered jointly and effectively across the partnership. An evident commitment by senior leaders of children's services to effective multi-agency working is mirrored by that of senior leaders in partner agencies, including health services, the police, and the voluntary sector. The judiciary, and the children and family court advisory and support service (Cafcass) report satisfaction with the standard of social work practice seen in cases of individual children and young people brought before the courts. Governance forums effectively prioritise the provision of high-quality integrated services to children, such as the Health and Wellbeing Board (HWB) and the children and young people's partnership, which produces and publishes the shared children and young people's plan.

85. Senior leaders of the local authority, including elected members, engage well with children's services. They meet often with children through membership of forums such as the Local Safeguarding Children Board (LSCB). The corporate parenting panel, which is ably chaired by the local authority's chief executive, operates to an extensive work plan. This provides corporate parents, including elected members, with detailed knowledge of services to children looked after. An emphasis on hearing the voice of the child looked after means that corporate parents are well informed of their views and engage and include them at every opportunity. The chief executive holds the independent chair of the LSCB to account effectively, both through a cycle of formal and more informal meetings, such as at LSCB events. Senior leaders universally present as knowledgeable about children's services and are supportive of the commissioning arrangement in place for their provision. This level of commitment means that the service can go forward with confidence that its commissioning arrangements are both stable and effective.

86. The local authority has invested significantly in its services to children, and this means that a rich range of resources are available to support them. Children's services delivered by a community interest company in partnership with two other local authorities means that arrangements are subject to a detailed commissioning exercise. It is therefore particularly clear what the local authority is expecting to achieve for local children through its stake in the company.

87. Thorough commissioning practice means that accountabilities between different stakeholders are clear. This is because the relationship between the council and its children's services provider is highly structured, to enable effective management by the local authority of their contract with the company.

88. Senior leaders are enthusiastic about the development of high quality services to children and young people through the development of a community interest company. However, the change management process has left a small number of stakeholders feeling dissatisfied and left behind. Not enough has been done to engage these stakeholders in meaningful consultation about the positive effects of changes to the way that services are provided. (Recommendation)

89. Senior leaders are ambitious for children but their aspiration and vision are not fully supported by a culture of detailed prioritisation and planning across the service. As a result, at the level of individual children and young people's casework, care planning, most particularly planning for permanence, is not consistently strong. For example, the adoption strategy developed across the consortium clearly identifies all of the main issues for consideration. However, this strategy does not have an accompanying local action plan. No one nominated person is responsible for its implementation in the local authority, and many of required the actions are not yet implemented. (Recommendation)

90. Frontline managers appropriately focus on the delivery of high-quality services to children and families. Economies of scale allow the company to offer a more joined up and efficient business support service than each constituent small

local authority could potentially provide. For example, the learning and development plan is supported by a small, dedicated team that delivers a detailed training programme. The quality assurance framework is supported by designated intelligence officers who produce a suite of performance reports and use tools such as deep dive audits to help frontline managers understand any variance in performance. Because the company delivers these functions centrally, frontline managers can appropriately devote their time and energy directly to the provision of services to children and young people.

91. An evident commitment to continuous learning and improvement is supported by a sound quality assurance framework, in which arrangements to improve performance under the governance of a performance, quality and innovation (PQI) board are clearly set out. Intelligence on performance is suitably gathered from a wide range of activity and analysed. This includes lessons learned from serious case reviews, themes and trends from management reports on complaints, and variance from performance reports or practice audits. Targeted work streams are undertaken to understand and rectify dips in performance. This work has appropriately involved the principal social worker where wider organisational learning is required. In the main, arrangements to maintain improvement through being a learning organisation are sound.

92. It is not always clear what level or rate of improvement quality assurance work streams are trying to achieve for children and young people, or when they have been successful. It is not clear from the notes of the PQI board, to which work stream individual pieces of quality assurance activity belong. Aspirational targets are set to avoid compromise on quality. Further consideration of the criterion for achieving success and the milestones to be met along the way would further improve quality assurance work.

93. Senior leaders frequently report that they are aware of issues raised in this inspection, for instance through their recently initiated practice weeks, and they provided audits with action plans to support this. The progress of these action plans is tracked through a learning and improvement plan. This plan sets few success criteria beyond full compliance. Milestone targets are not routinely used. As a result, senior leaders were unable to describe with confidence what progress has been made to improve practice. For instance, practice week had identified management supervision as inconsistent, an audit was undertaken and an action plan was in progress at the time of the inspection. Inspectors established that practice management remains variable. Senior managers report that this situation is improving, but progress cannot be evidenced as there are no milestones to measure when it will reach tolerable levels.

94. Management supervision is not routinely recorded in line with the company’s own policy, in either frequency or content. A successful professional development approach means that the majority of social work practice recorded on individual case files and seen by inspectors was good, and included many significant strengths. Day-to-day management supervision plays a significant part in this success. However, the quality and consistency of recording on social

workers’ supervision files is inconsistent. This means that senior leaders and managers are not able to show effectively that social workers are receiving the level of reflective management oversight that supports good social work practice. It also means that clear decisions about the lives of individual children and young people are not always made during recorded supervisions sessions. (Recommendation)

95. The sufficiency strategy is a major investment of time and financial resources, and a major undertaking which is at an early stage of implementation. Information from a frequently refreshed joint strategic needs assessment is used appropriately to analyse actual and potential placement sufficiency to meet the needs of the care population’s specific communities. Improved corporate placement procurement is a strategic priority for the local authority. The former system of ad hoc spot purchasing is recognised as expensive and inefficient, as, previously, social workers rang round for individual placements, often for children and young people in urgent need. This approach left the local authority with a significant number of children and young people placed outside of the local area, sometimes at a considerable distance from its boundaries.

96. While there is some progress on developing commissioning relationships with local providers, the delivery of placement sufficiency is contingent on the company successfully entering the market as a provider as well as a commissioner of placements. To this end, an associate director for placements has been appointed. Plans are at an advanced stage for opening a new purpose-built children’s home, and for registering the fostering service with Ofsted as an independent fostering agency. These plans are sound as written plans, but it is too early to evaluate the effectiveness and impact of any revised arrangements on the sufficiency of placements for children looked after.

The Local Safeguarding Children Board is good

Executive summary

The Richmond upon Thames Local Safeguarding Children Board (LSCB) is good. It has ambitious priorities for ensuring the effectiveness of local safeguarding services. Richmond and Kingston Boards share one influential independent chair. Both boards function independently, but share some sub groups that provide increased opportunities for learning, and other efficiencies, through economies of scale.

The board meets its statutory responsibilities, and the governance arrangements are clear. The chair has successfully created a collaborative and effective partnership with a culture of continuous learning and improvement.

The board has successfully raised awareness about the risks to children who run away and to children at risk of child sexual exploitation. Improved coordination of services by the board has enabled increased identification of those children at risk, and effective information sharing reduces risk and informs successful prosecution of offenders.

Effective analysis of performance, observations, and a programme of audits have enabled the board to understand the quality of safeguarding practice across the partnership. While there is scrutiny of most key areas, this has led to improvements, specifically to timescales for initial health assessments. However, the board has not ensured the quality of partners' referrals to the SPA. It has lacked sufficient rigour in scrutinising private fostering arrangements, and in obtaining accurate data about attendance at child protection conferences. This means that the board is not yet assured of the effectiveness of practice in these areas.

The board scrutinises frontline practice through its established audit programme, and there is improvement in attendance of partners at the multi-agency risk assessment conference (MARAC). Multi-agency audits vary in rigour, and not all partners consistently engage with them. Action plans to improve practice are not sufficiently robust to ensure that changes in practice are fully embedded.

Engagement of young people is a strength. Under the banner 'Safe from', young people have undertaken two projects to raise awareness with their peers. Over 500 young people contributed to these events, and their work influenced the commissioning of child and adolescent mental health services (CAMHS).

Training provided by the board is of good quality, highly regarded by learners and evaluated for effectiveness. However, the board does not have a reliable system to be sure that all staff who need this training have received it.

Recommendations

97. Ensure that all board action plans are specific, measurable and time bound and that they are reviewed and updated regularly, so that the board can measure their effectiveness.

98. Improve the quality of agencies' referrals to the SPA so that information is expressed clearly and swift action taken where necessary.

99. Ensure that the LSCB annual report incorporates findings from the private fostering annual report, and the local authority reviewing officer annual report, and that it provides a rigorous assessment of the effectiveness of local services.

Inspection findings – the Local Safeguarding Children Board

100. The LSCB is ambitious and tackles complex issues, informed by local learning that identifies what actions are required to improve help and protection for local children. The board is well managed and chaired effectively; it fulfils its statutory responsibilities, and secure governance arrangements are in place. A suitable protocol between the LSCB, safeguarding adult board, HWB and community safety partnership ensures that relevant information is shared and that work of each board influences and complements, rather than duplicates. The LSCB chair attends each board at least annually, which enables children's priorities to be considered at all boards.

101. The experienced independent chair is highly regarded by board members and has successfully enabled collaborative partnerships with a culture of continuous learning and improvement. Tenacious enquiry and rigorous and respectful challenge between members has led to the board achieving a broad understanding and shared approach to safeguarding.

102. The chair, the board's professional adviser and board staff are knowledgeable, proactive and visible. They monitor and evaluate frontline practice through a range of activities, including observations of the SPA and MARAC, and visits to independent schools and sports facilities. The board has also meets with a range of frontline staff, for example IROs and health staff. By using audits and the multi-agency data set, the board assures its understanding of the effectiveness of safeguarding practice across the local partnership. However, this activity has not resulted in an improvement in the quality of the information presented to the SPA. Many agencies are not frequent referrers. This means that they require consultation on what they are referring and this can unnecessarily take up children's services time and resources.

103. Scrutiny of early help has enabled the board to challenge the achieving for children board about the effectiveness of services. For this reason, the common assessment framework format was changed to a more proportionate early help assessment, which is more accessible to partner agencies. Review of the early

help by the board has led to challenges to health service about low initiation of health assessments.

104. The section 11 self-audit process is highly effective. A wide range of agencies contribute, including those in the sports and voluntary sector. The board scrutinises, audits, and supports agencies in identifying learning and other actions. Voluntary organisations, GPs, health providers, and maintained and independent schools have engaged well with the process. Findings do not sit within a vacuum. Learning informs quarterly network meetings for GPs, and maintained and independent schools. The board is currently engaging pharmacists, dentists and opticians.

105. An established multi-agency audit programme provides information about the quality of frontline practice. Audits have focused on MARAC, section 47 and police powers of protection, disabled children, and child sexual exploitation. Audits vary in rigour, some include frontline practitioners, but a minority do not include full engagement of partners. Audit outcomes do not routinely include judgements about individual cases, and learning does not lead to consistently sharp action plans that can measure improvement in all cases. This reduces the effectiveness of the audit and the potential impact on improvement.

106. Oversight and scrutiny of single agency audits provide a helpful line of sight into practice in adult substance misuse services, and the board has been able to assure practice about safe storage of drugs. Regular scrutiny of single agency audits would further improve the board's understanding of practice.

107. The regularly reviewed multi-agency data set is broad and comprehensive. Appropriate curiosity and effective challenge by board members about variances in performance have resulted in improvement in initial health assessments for children looked after and the more accurate identification by adult services of parents who have mental health difficulties.

108. While creative solutions are found to a broad range of safeguarding needs, for example the 'was not brought' policy adopted by health to support children who do not attend health appointments, the board has not been robust enough in ensuring a focus on some critical areas. Although in very small numbers, data about private fostering was not provided to the board for over a year. This, and delay in achieving accurate information on parental, child, and professional attendance at case conferences has reduced the board's effectiveness in improving practice in these areas. (Recommendation)

109. The LSCB website is easy to navigate and is accessible to professionals, young people, and parents. It provides a wide range of useful information and access to up-to-date policies and procedures. The LSCB is currently reviewing the safeguarding online policy and has recently agreed policies for child protection medicals. However, it has not reviewed the local authority's policy on assessment as required by 'Working together to safeguard children 2015',

which means that the board is not up to date with current standards for assessment or how these standards interface between services.

110. Effective coordination by the LSCB has significantly strengthened the local response to children who go missing and those at risk of sexual exploitation. A comprehensive strategy and action plan support the work of the LSCB sub groups. This has led to improvements in a range of partnership activity, including prevention, identification support, protection and disruption. There have been awareness raising events for local businesses and budget hotels.

111. Regular audit and analysis of return home interviews of children who have been missing have led to an improved multi-agency response to children who go missing. For example, a high number of young people going missing from out of borough placements led to the commission of local provision. Schools where young people go missing receive preventative support. The board is aware of further improvements to timeliness and quality of return home interviews and strives to support practice in this area.

112. The LSCB effectively uses operational and strategic influence to improve practice following learning from an unpublished serious case review (SCR) which identified themes of emotional well-being and risky behaviour. Jointly with the Community Safety Partnership and HWB, the board has commissioned a review of services to address this and obtained the views of 1,500 young people about mental health through a survey undertaken by HealthWatch and the youth council. The findings from this survey influenced the commissioning of CAMHS services. Similarly, a review of domestic abuse services has influenced the new violence against women and girls strategy and delivery boards attended by the LSCB.

113. The learning and improvement framework draws on a range of learning, including from serious case and learning reviews, section 11 process and audits. A wide range of high-quality training provided by the LSCB is consistent with the London Safeguarding Children Board 'competence still matters' framework. There has been a 30% increase in training attendance and 80% increase in e-learning. Training courses are quality assured, and the effectiveness of training, evaluated by pre- and post-course questionnaires show that 66% of learners overwhelmingly report improvement in knowledge skills and confidence. However, the learning and development annual report does not sufficiently analyse the training needs by role or identify which roles have attended training. As result, the board cannot fully satisfy itself that suitable training reaches all staff. (Recommendation)

114. The independent chair of the board chairs the SCR sub group effectively. A well-embedded serious notification process has led to significant learning arising from examination of cases that do not meet the threshold for an SCR. Staff, trained in the Social Care Institute for Excellence (SCIE) methodology, effectively undertake learning reviews. The board is rigorous in ensuring extensive circulation of the learning from these reviews, for example through

the newsletter, training sessions and helpful briefings. SCRs have been undertaken appropriately, and healthy debate is evident regarding threshold. The LSCB carefully considered the findings of a learning and improvement case review; however, the action plan lacks the sharp clarity and detail to ensure full and effective implementation.

115. The LSCB annual report provides a comprehensive summary of work undertaken in accordance with the board's priorities. However, it is too descriptive and, while it has some evaluation of the impact of the board's work, the report does not sufficiently evaluate the work of the designated officer or private fostering, or provide a robust analysis about the effectiveness of safeguarding. The business plan has appropriate priorities to address local needs. However, the actions are not sufficiently clear or time bounded to enable the board to measure outcomes and impact. This limits its effectiveness. (Recommendation)

116. The joint Richmond and Kingston Child Death Overview Panel (CDOP) is highly effective. It reviews child deaths, identifying modifiable factors, and undertakes proactive work to reduce incidents of preventable child death. There has been considerable work to raise awareness of safe sleeping, water safety, and asthma and allergy management. Robust challenge of the chief coroner by the CDOP led to the development of national advice about signs of life.

117. Engagement with young people and online safety is a strength. Under the banner 'safe from', effective work with members of the youth parliament has enabled young people to raise awareness with their peers about abusive relationships. A 'flash mob' encouraged over 300 young people to attend a play. A separate project raising awareness about extremism and radicalisation resulted in 200 people taking part in a meeting, and 11 young people achieved formal qualifications as peer researchers. Children have benefited from 50 online safety sessions delivered through schools, and parents and professionals have attended. A high percentage (92%) of Richmond children report that they know how to keep safe online, compared with 82% nationally.

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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 differences that 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 whom 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 seven of Her Majesty’s Inspectors (HMI) from Ofsted.

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