Kent County Council

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

and

Review of the effectiveness of the Local Safeguarding Children Board[1]

Inspection dates: 6 March to 30 March 2017

Report published: 13 June 2017

Children's services in Kent are good		
1. Children who need help and protection		Requires improvement
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.

Executive summary

Kent County Council is delivering a good service to children and families. Leaders and senior managers have responded purposefully and methodically to service weaknesses, resulting in strengthened services and improved outcomes for children. Through his effective leadership, the director of children's services (DCS) sets clear priorities, demonstrating a firm resolve to improve outcomes for children and young people. This is in the context of a significant increase in the number of unaccompanied asylum-seeking children arriving in Kent during 2015–16. The local authority tackled the increased demand on children's services effectively, along with work it was already doing. Senior managers have responded swiftly to these changing needs through considered restructuring of services for care leavers. Political leaders have been responsive to budget pressures, supporting increased financial investment.

Following an inspection of safeguarding and children looked after in 2010, which found services for children inadequate, the local authority has engaged with partners in a substantial improvement journey. By 2013, inspections of child protection and children looked after found services had improved to adequate. Building on these foundations, managers have systematically tackled weaknesses across the service, using a comprehensive quality-assurance framework and regular case-auditing to identify areas for practice improvement. However, the help and protection that children receive continue to require improvement. Some aspects of practice have improved, but more work is required to ensure consistently effective decision-making when children first come to the attention of the service, as well as to improve the quality of assessment for those children living in private fostering arrangements.

Services are well targeted and coordinated to meet the specific needs of communities of Kent. Children and their families have access to a wide range of early help services from the earliest point of need. When need becomes more complex, children are referred to the Central Referral Unit (CRU) and most receive a prompt response that ensures their needs are met at the earliest opportunity. However, some referrals closed prematurely, before all relevant information had been gathered and analysed to ensure safe and appropriate decision-making. Once alerted to this by inspectors, senior managers took decisive action to review recent referrals, reopening some for further scrutiny, and revising working practices, structure and management oversight in this part of the service.

Social workers develop strong and constructive relationships with children. They see them regularly and use creative direct work to ensure that they understand children's experiences and views. The majority of assessments are analytical and result in high-quality plans that focus on the needs of children and lead to effective interventions, with positive outcomes. When child protection referrals lead to strategy discussions, they involve relevant professionals, are mainly timely, and, when appropriate, result in initial child protection conferences. However, for a small number of children open to the district social work teams, there are delays in recognising escalating risk. This is particularly evident for children living in neglectful circumstances or affected by

domestic violence. The local authority appropriately identifies children who are at risk of sexual exploitation and has developed strong working relationships through the multi-agency child sexual exploitation team. Adolescent risk management (ARM) panels are in place, but vary in their effectiveness. The local authority identifies and responds to children who go missing from home or care, but the quality and timeliness of return home interviews is too variable.

Effective services, including adolescent support teams and family group conferences, support children on the edge of care. This ensures that when possible children remain with their families. Children looked after by the local authority receive a good service. The vast majority become looked after at the right time and benefit from comprehensive assessments of their needs, and the majority live in stable placements. Assessments for foster carers, connected persons and special guardians are comprehensive. However, for a small number of children there is a lack of clarity about the steps required to formalise living arrangements with family and friends.

Children who have a care plan for adoption benefit from the effective service that the adoption team provides. Services for care leavers are good. Personal advisers remain in touch with large numbers of young people and most live in suitable accommodation. More work is required to ensure that young people in custody have regular visits and focused planning for their discharge.

Performance management systems provide detailed data and helpful analysis to monitor and develop services effectively. However, some data relating to care leavers is not accurate or reliable enough to enable proper scrutiny and oversight. Management oversight and case supervision and direction have significantly improved. Inspectors saw some examples of analytical case supervision, but the quality is not always good enough, and managers do not always sufficiently identify risks or challenge lack of progress.

The local authority recognises the vulnerabilities of unaccompanied asylum-seeking children and works closely with the Home Office, immigration services, police and partners from adult services. They work effectively to reduce risks such as those related to trafficking, sexual exploitation, female genital mutilation and possible radicalisation. Arrangements for tracking missing unaccompanied asylum-seeking children are rigorous. A panel provides management oversight of those children who are missing, or at high risk of harm, to ensure that risks are understood and minimised when possible.

Young people aged 16 and 17 at risk of homelessness are supported by housing officers. There is a lack of consistent protocols with district housing departments. As a result, arrangements for support and accommodation are too variable. No young people were in bed and breakfast accommodation at the time of the inspection but this is used by district housing departments in some circumstances, which is not acceptable practice and leaves young people potentially vulnerable.

Contents

The local authority

Information about this local authority area[2]

Previous Ofsted inspections

- The local authority operates five children's homes. Four were judged to be good or outstanding in their most recent Ofsted inspections.
- The last inspection of the local authority's arrangements for the protection of children was in January 2013. The local authority was judged to be adequate.
- The last inspection of the local authority's services for children looked after was in August 2013. The local authority was judged to be adequate.

Local leadership

- The corporate director of Social Care, Health and Wellbeing is the DCS for Kent County Council and has been in post since November 2011.
- The DCS is also responsible for adult services and public health.
- Kent County Council does not have a chief executive. The DCS is currently responsible directly to the County Council. However, following a County Council decision in January 2017, the DCS will report to the head of Paid Service with effect from 3 April 2017.
- The chair of the Local Safeguarding Children Board (LSCB) has been in post since March 2014.
- The local authority uses the Signs of Safety model of social work.

Children living in this area

- Approximately 330,000 children and young people under the age of 18 live in Kent. This is 22% of the total population in the area.
- Approximately 17% 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 12% (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 9% of all children living in the area, compared with 21% in the country as a whole.

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

- The largest minority ethnic groups of children and young people in the area are Mixed and Asian/Asian British.
- The proportion of children and young people with English as an additional language:
  - in primary schools is 11% (the national average is 20%)
  - in secondary schools is 8% (the national average is 16%).
- Due to over 1,300 unaccompanied asylum-seeking children entering Kent since January 2015, the county (including the unitary Medway towns) continues to look after and accommodate disproportionately high numbers of children and young people from the Middle East and North Africa (MENA) region, Afghanistan and the Horn of Africa.

Child protection in this area

- At 6 March 2017, 9,193 children had been identified through assessment as being formally in need of a specialist children's service. This is a reduction from 9,290 at 31 March 2016.
- At 6 March 2017, 1,176 children and young people were the subject of a child protection plan (a rate of 36 per 10,000 children). This is an increase from 1,049 children (32 per 10,000 children) at 31 March 2016.
- At 6 March 2017, 40 children lived in a privately arranged fostering placement. This is an increase from 25 at 31 March 2015.
- In the last two years prior to inspection, 19 serious incident notifications had been submitted to Ofsted and one serious case review has been completed.
- There are four serious case reviews ongoing at the time of the inspection.

Children looked after in this area

- At 6 March 2017, 1,893 children were being looked after by the local authority (a rate of 57 per 10,000 children). This is a reduction from 2,310 (70 per 10,000 children) at 31 March 2016. Of this number:
  - 338 (18%) live outside the local authority area
  - 79 live in residential children's homes, of whom 33 (42%) live out of the authority area
  - 10 live in residential special schools[3], of whom two (20%) live out of the authority area
  - 1,353 live with foster families, of whom 160 (12%) live out of the authority area
  - 25 live with parents, of whom one (4%) lives out of the authority area

[3] These are residential special schools that look after children for 295 days or less per year.

- 500 are unaccompanied asylum-seeking children.

- In the last 12 months:
  - there have been 86 adoptions
  - 51 children became the subject of special guardianship orders
  - 1,316 children ceased to be looked after, of whom 37 (3%) subsequently returned to be looked after
  - 462 children and young people ceased to be looked after and moved on to independent living
  - 286 children and young people who ceased to be looked after are now care leavers living in houses in multiple occupation.

Recommendations

1. Ensure that prompt consideration is given to convening strategy discussions and, when appropriate, that strategy discussions are held for all children when risk increases.

2. Ensure that private fostering assessments are robust and include all required safeguarding checks, and that visits to children are timely.

3. Ensure that homeless young people aged 16 and 17 years are aware of their right to become looked after, assessments of risk are completed and there is adequate accommodation to meet their needs.

4. Improve the response to all children at risk of sexual exploitation, ensuring that assessments and safety plans are of a consistently good quality.

5. Improve the timeliness and quality of return home interviews for children who go missing, to ensure that they are an effective tool to safeguard individual children and inform strategic response.

6. Ensure that all care leavers in prison or secure training centres have purposeful visits and an up-to-date pathway plan.

7. Review the data routinely provided to the Kent Safeguarding Children Board (KSCB), and in conjunction with the board take steps to ensure that this is sufficiently comprehensive to enable the partnership to scrutinise the local authority's safeguarding performance.

8. Evaluate the quality of case and staff supervision across teams and districts and take steps to ensure that managers pay sufficient attention to social workers' performance, and to their development needs.

9. Ensure that data relating to care leavers is accurate, and that it provides leaders, managers and corporate parents with a clear view of the performance of the service.

10. In partnership with the KSCB, launch the multi-agency neglect strategy and ensure that early help and specialist children's services and professionals who work with families at all levels of need are equipped to identify, assess and address neglect within families.

Summary for children and young people

- In 2013, inspectors found that children in Kent did not get good enough services. Since that time, senior leaders, managers and social workers have worked hard to make changes to ensure that children get the help and support they need. In this inspection in March 2017, inspectors found that nearly all services in Kent are good.
- Political leaders have a real commitment to improving the lives of children. They have made sure that there is enough money available so that children get the help they need.
- When professionals are worried about children, they know who to contact to ensure that children get the help and support they need to keep them safe. However, social workers do not always find out enough information to make the right decisions. Managers know what they need to do and plans are already in place to make improvements.
- Social workers are good at working with other professionals, such as police officers, health visitors and teachers, to keep children safe. They meet children regularly, listen to what they have to say, and work hard to improve things for them.
- Social workers have a good understanding of what support children need to help them to lead fulfilling lives. Social workers ensure that children get the support they need to live with their families when possible.
- When children cannot live safely with their families, social workers work hard to ensure that children live with families that take good care of them.
- Social workers are good at ensuring that children are adopted quickly when this is the right decision for them.
- Nearly all children looked after go to good schools. Most have good attendance and are helped to do their best in their studies.
- When young people leave care, staff visit them regularly and provide the right support to help them live independently. Young people spoken to by inspectors said they feel safe where they live.
- The well-established Children in Care Council ensures that children are involved in helping to develop services. They regularly attend council meetings, sit on interview panels, and help to arrange interesting events, such as activity days, where they have fun and meet new friends.

The experiences and progress of children who need help and protection	Requires improvement

Summary

A comprehensive range of early help services provide good support to children and their families from the earliest point of need. Services are well targeted and coordinated to meet the specific needs of the communities of Kent. When need becomes more complex, step-up to statutory social work services is timely.

Decision-making in the CRU for children requiring statutory intervention is not yet consistently good. As a result, some children do not receive intervention as early as required. When immediate risks to children are identified, the response is timely and proportionate. Strategy discussions involve relevant agencies, and make the right decisions about the next steps. Initial child protection and review conferences are timely and well attended by agencies. However, in a small number of children's cases open to the district social work teams, action is not consistently timely in response to escalating concerns. Consequently, inspectors saw a small minority of children who had remained in situations of unassessed risk for too long.

Social workers see children regularly and know them well. Effective direct work enables social workers to gain a comprehensive understanding of children's wishes and views and to understand what life is really like for them. Assessments are analytical, and capture family histories, views and experiences and result in high-quality plans. Plans focus on the needs of children and lead to effective interventions, with positive outcomes. However, the quality of some assessments is not good, with some lacking analysis and not recognising all risk factors. Support for a small number of children subject to child protection plans ends too soon, before change has been sustained, resulting in children's circumstances deteriorating.

Inspectors saw appropriate action taken in the multi-agency child sexual exploitation team to monitor and reduce risks for children identified as being at risk of sexual exploitation. However, inconsistencies in the effectiveness of district ARM panels mean that intervention is not always successful in reducing risks for all children. Arrangements for children who go missing are variable, and improvement is required to ensure that all children have timely return home interviews and safety plans.

Children living in private fostering arrangements are identified but assessments are not rigorous enough to ensure that the arrangements are suitable. Services to homeless 16- and 17-year-olds are underdeveloped. District housing departments do not always refer homeless young people to specialist children's services for an assessment of their needs.

Inspection findings

11. Children and families benefit from a wide range of early help services, including commissioned services, children's centres and youth hubs that ensure that support is available as soon as need is identified. Intensive early help is delivered successfully through early help units across Kent, supporting 3,080 children and families in response to needs resulting from a variety of issues, including domestic abuse, parental substance misuse and behavioural issues.

12. Early help assessments are mostly good. Early help plans are well targeted, set clear expectations of parents and professionals and include specific timescales. Weekly step-down panels ensure that decisions to step support plans down from specialist children's services to early help are appropriate and that families experience a smooth transition between services. An effective quality-assurance process is informed by feedback from children, parents and carers, which evaluates the quality and impact of support provided and is used to inform service planning. Inspectors saw examples of early help preventing escalation to specialist children's services and making a tangible difference to children's lives.

13. The multi-agency CRU is the first point of contact for members of the public, professionals and families when there are concerns about children's welfare. This supports comprehensive information-sharing and provides immediate child protection responses. Partner agencies have the opportunity to consult with social workers to inform decision-making regarding next steps, which reduces the number of inappropriate referrals. Recent changes to the recording of these consultations have provided greater clarity about professional responsibility for subsequent actions. Consent to share information is appropriately sought from parents. In children's cases sampled by inspectors, the vast majority demonstrated partner agencies understanding the threshold criteria for access to children's social care.

14. Managers screen all contacts and referrals and swiftly determine whether they meet the criteria for statutory intervention or early help services. Although thresholds for referral are clear, they are not consistently applied in the CRU. Inspectors saw a small number of referrals closed prematurely before all relevant information had been gathered and analysed to ensure safe and appropriate decision-making. Senior managers accepted inspectors' findings and took immediate and appropriate action to address these shortfalls.

15. When child protection concerns arise, the response is timely in the majority of cases. When strategy discussions and meetings are held, they are effective, attended by relevant agencies, result in appropriate outcomes, and ensure that children are protected. Child protection enquiries are comprehensive, and when appropriate lead to initial child protection conferences.

16. Inspectors identified a small minority of children for whom progress of plans was poor, risk had escalated or there had been a lack of professional curiosity.

For these children, strategy discussions should have been held to consider whether a child protection enquiry was needed to further explore and understand risk. The local authority accepted inspectors' concerns and took action to strengthen children's plans or to arrange strategy discussions to consider whether child protection enquiries were necessary. (Recommendation)

17. The majority of children's assessments, including pre-birth assessments, are comprehensive, with sound analysis of risks, and result in coherent plans. However, the quality of practice in the district children's social work teams is too variable, with a small number of weaker assessments seen. Together with a lack of professional curiosity, these assessments did not fully explore the potential impact of cultural differences or consider the views of significant adults, including non-resident fathers. Consequently, these assessments are superficial and fail to provide the focus needed to help improve children's circumstances at a sufficient pace.

18. The local authority has completed a number of deep-dive audits to understand why the majority of children are subject to child protection plans under the category of neglect, and to address the increasing number of repeat child protection plans under this category. Despite the prevalence of this issue, the local authority and the KSCB have been slow to take decisive action to equip professionals to assess and respond to neglect within families. A draft multi-agency neglect strategy is yet to be approved. (Recommendation)

19. Child protection conferences and core group meetings are sensitively chaired and well attended by agencies. They are effective in ensuring that risks to children are understood and reduced. Children are supported to attend their meetings to ensure that their views are known and considered. However, social workers are not clear about recent changes in how to access advocacy services. As a result, the number of referrals to the commissioned advocacy service has reduced.

20. Inspectors saw some good examples of outcome-focused plans, created and owned by families, that reflected children's needs well, but overall the quality of plans is too variable. Weaker plans are not sufficiently outcome-focused and do not track change effectively, which hampers progress. A small number of children's cases seen by inspectors had been stepped down from a child protection plan to a child in need plan before sustained change had occurred. The impact of this was that concerns re-emerged and children re-entered the child protection system. Social workers visit children regularly and develop trusting relationships with them. Inspectors saw many examples of effective and creative direct work by social workers to enable children to express their views and inform assessments and intervention plans.

21. The quality of management oversight and supervision is not yet consistently good. Supervision generally covers immediate casework issues, but is not sufficiently rigorous in driving planning and reviewing overall progress. As a result, complexities and concerns in children's lives are not fully explored, and,

for a small number of children, this has led to drift and delay in taking decisive action to meet their needs and to ensure that they are protected.

22. Specialist disabled children's teams support children who have disabilities effectively. Social workers provide good-quality, child-focused work, which leads to improved outcomes for children.

23. A good range of services are available, and these are improving outcomes for children, including those who have experienced domestic abuse. Multi-agency public protection arrangements and multi-agency risk assessment conferences are effective in sharing information, identifying risks and developing appropriate protective responses for children who have contact with adults assessed as high risk.

24. The Public Law Outline is in place, with letters to parents clearly outlining concerns and actions required. When children's circumstances do not improve or risks escalate, legal planning meetings are, for the majority of children, swiftly convened. However, management oversight and monitoring needs to improve to ensure that letters are timely and children do not spend extended periods at this stage with no progress made against agreed actions.

25. Robust strategic partnerships support early identification and management of children at risk of sexual exploitation. Operational practice within the multi-agency child sexual exploitation team is effective, with many examples of successful risk reduction. However, the quality of risk assessments needs strengthening to ensure that they are regularly updated and proactively used to inform safety plans. The district ARM panels vary in effectiveness, with some lacking clear actions and safety planning. As a result, professionals are not clear about what they should collectively do to safeguard children, and risks do not reduce quickly enough. (Recommendation)

26. The local authority has recently strengthened its response to children who go missing from home, school or care. Two missing coordinators within the CRU track and record all missing notifications effectively. They ensure that local authorities who place children looked after in Kent are informed of missing episodes. Social workers or early help workers offer children return interviews. Some of these conversations are meaningful and help practitioners to understand children better, but they are not always timely and the quality of the records is not consistently good enough to inform safety plans and reduce risk. (Recommendation)

27. Arrangements for tracking children missing education are effective. The children missing education team works closely with schools and other partners to return children to school or improve attendance. Alternative provision meets the needs of 668 children well, and virtually all are on full timetables.

28. Notifications to the local authority of private fostering arrangements have increased in the past year. At the time of the inspection, 40 children were living

in private fostering arrangements. Children's needs are assessed, but assessments are not sufficiently rigorous to ensure the suitability of placements. Inspectors saw a small minority of children living in arrangements that were not meeting their needs, with delays in visiting and in providing appropriate support. (Recommendation)

29. When young people aged 16 and 17 present as homeless to district housing departments, they are offered support and mediation to help them to return to their families. However, district housing departments do not refer all young people to specialist children's services for a joint assessment of need. As a result, some young people are placed in bed and breakfast establishments by district housing departments. The local authority recognises that this is unacceptable and intends to review the housing protocol as a matter of urgency. (Recommendation)

30. When allegations are made about adults who work with children, the designated officer provides a timely and effective response. Work to raise awareness of the designated officer role has taken place, with a wide range of professionals engaged, including foster carers.

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

Summary

A range of good services appropriately support children who are on the edge of care, to remain living safely with their families whenever possible. Decisions for children to become looked after are timely and proportionate. When children return home, they are well supported and monitored.

The large majority of children looked after live in stable, local placements in which their identified needs are met. Children develop meaningful and consistent relationships with social workers who visit them regularly and know them well. Children benefit from regular direct work, including life-story work, which helps them to understand their histories. Children regularly participate in their own timely reviews. The majority of children's assessments are of good quality, with their wishes and feelings carefully considered. However, the quality of children's plans is more variable.

Senior managers closely monitor children's plans for permanence. Fostering panels are used well to agree long-term placement matches for children. For a small number of children, there is a lack of clarity about the steps required to formalise living arrangements with family and friends.

Inspectors saw appropriate action taken to monitor and reduce risks for children who are missing or at risk of sexual exploitation. However, inconsistencies in the effectiveness of district ARM panels means that risks are not always reducing for some children. Children benefit from regular and thorough health assessments and access to well-established services for emotional support.

Educational outcomes for children looked after are improving at key stages 1, 2 and 4. The virtual school uses personal education plans well to enable pupils to get the right support for personal and social development and academic progress.

Children who need to be adopted benefit from timely decision-making and effective planning. Good assessment, training and support are available for prospective adopters. Children enjoy stability and thrive in their adoptive families.

Care leavers form good relationships with their personal advisers, who know them well and visit them regularly. Pathway plans are effective and help care leavers to develop the skills needed for independent living. Managers and staff ensure the active participation of young people in service improvements, such as in the new pathway plan and in the recruitment of staff.

Inspection findings

31. Kent children's services appropriately support children on the 'edge of care' with a wide range of services. These include an effective family group conferencing service and the adolescent support teams who work alongside families to enable them to find their own solutions to effect change that is sustainable. As a result, children are able to remain safely in the care of their birth families whenever possible, and only become looked after when it is in their best interests.

32. At the time of the inspection, Kent was looking after 1,893 children. Inspectors found thresholds for children to become looked after were timely and proportionate. When children no longer need to be looked after by the local authority, they return home safely to their birth families with comprehensive support plans, which are regularly monitored.

33. Senior managers and legal representatives regularly meet with the local judiciary and the Children and Family Court Advisory and Support Service to ensure timely court decision-making for children. Close scrutiny and monitoring of the recent decline in timeliness of court performance is supporting the progression of court work effectively.

34. Children enjoy meaningful and consistent relationships with social workers who know them well and visit them regularly. Children benefit from regular direct work, including good-quality life-story work, which helps them to understand their histories. This is not yet consistent across all children in care teams. Children are encouraged to use an advocate if needed. Some children benefit from having an independent visitor. However, the service does not currently have the capacity to allocate a visitor to all children who would benefit from this. At the time of the inspection, 28 children were waiting for an independent visitor.

35. Inspectors found regularly updated, comprehensive assessments of children's needs. A minority of plans seen were of poorer quality, but plans do routinely outline children's wishes and feelings. Management oversight demonstrates a clear focus on improving less effective care plans and placement plans, to ensure that they are clear, with a focus on meeting children's needs in a timely way.

36. There is a clear focus on ensuring that children achieve permanence at the earliest opportunity. Managers oversee permanence decision-making and ensure that children move to permanent placements in a timely way. Children who are long-term fostered are carefully matched at fostering panels. Social work teams track children who are waiting to be matched with permanent carers effectively.

37. The identification of risks to children looked after, who are missing or at risk of sexual exploitation result in appropriate actions to reduce harm, with the

support of the child sexual exploitation team. However, discussions at the ARM panels vary in their effectiveness, resulting in risks not always reducing for some children.

38. Work with health partners over the last 12 months has significantly improved performance relating to health assessments and dental checks for children, ensuring that their identified needs are well met in children's timescales. Child and adolescent mental health services (CAMHS) for children looked after are undergoing a substantial redesign as part of the re-tendering of local emotional and mental health services. Innovative health practices for unaccompanied asylum-seeking children, jointly run with a local university, provide advice and support across a range of areas, such as nutrition and sleep projects. Work is under way to further develop this so that it will benefit all children looked after.

39. The large majority of children looked after attend schools judged by Ofsted to be good or outstanding. A very small proportion who are not on a school roll are children who have specialist complex needs and are waiting for an assessment, or unaccompanied asylum-seeking children awaiting assessment at a reception centre.

40. At key stages 1 and 2, children looked after typically make better progress and improve their levels of development after a period of stability in placement. In 2016, at key stage 2 the proportion reaching the expected standard in reading and mathematics was in line with national rates and above these in writing. The number achieving 5 GCSEs A*–C in English and mathematics at key stage 4 improved from previous years and is in line with the national rate for children looked after.

41. The attendance of all children looked after up to the age of 16 is 90%. No children looked after are permanently excluded. Robust approaches by the inclusion and attendance officers of the virtual school, together with improved curriculum arrangements, have contributed to the decrease in the numbers of those experiencing fixed-term exclusions over the previous year to January 2017.

42. The careful monitoring of the progress and achievement of children looked after by the virtual school has resulted in a decrease in the differences in achievement between children looked after and their peers at the different key stages. Several supplementary and highly appropriate arrangements, such as activity days, buddying and participating in fostering workshops, improve the confidence, self-esteem and resilience of children. There are 39 children in alternative provision, mainly at pupil referral units, primarily for behavioural reasons. Participation and progression officers work effectively with local schools to secure re-entry of these pupils to appropriate schools.

43. Sound use of the Pupil Premium funding and other additional payments have contributed to improving the outcomes for children looked after. For example, it is used to fund appropriate tuition. English language support and 'school ready'

projects for unaccompanied asylum-seeking children are provided, alongside literacy and numeracy development programmes and projects that improve the emotional and social well-being of pupils. Personal education plans show clearly how well the Pupil Premium is used, directly related to the needs of the pupils. Plans focus well on pupils' attendance and identify activities that will benefit their academic progress and social development. However, targets are not precise enough and plans do not show pupils' views about their progress, achievements and aspirations. They also do not contain meaningful contributions from foster carers towards supporting pupils.

44. The large majority of children live with their brothers and sisters, benefiting from stable local placements, with access to a wide range of educational, social and recreational opportunities. Comprehensive assessments inform decision-making regarding whether children should be placed with their brothers and sisters. A helpful in-house supervised contact service ensures that children are able to maintain regular contact with family members.

45. Close monitoring of performance in relation to short-term placement stability is in place, with appropriate actions being taken to improve the figure of 13% at the time of inspection. For example, the 'sense of belonging' project, outdoor activity days and residential courses provide more targeted support for carers and children. A relaunched focus on thorough matching and placement planning was due.

46. In response to the large number of children who are placed in Kent by other local authorities (1,309 at the time of the inspection), the local authority has innovatively appointed an out-of-area officer who assertively liaises with the 106 placing authorities.

47. The high demand for placements for unaccompanied asylum-seeking children has had an impact on placement availability for all children. However, effective commissioning arrangements and monitoring of external placements for children, alongside the fostering recruitment strategy, are working to increase the range of local placements available. Since June 2016, the appointment of new senior managers in the fostering service has led to active and successful progression of a wide range of developments, and has ensured that high-quality foster care is in place. Foster carers spoken to by inspectors were positive about the implementation of these developments.

48. Inspectors found that the fostering service was mostly compliant with fostering regulations. While assessments of connected carers and special guardians are comprehensive, confusion over the procedures for assessing connected carers has resulted in a very small number of placements being unregulated for short periods of time. Inspectors found that while regulations had not been robustly followed for the children in these arrangements, appropriate actions had been taken to ensure that their needs were met and they were safeguarded. Senior managers have acknowledged this issue and taken immediate action.

49. The three Children in Care Councils, separated into children of primary school age, children of secondary school age and young people aged over 16, are well established. Children's views regularly inform the corporate parenting panel, service development and commissioning activity, through a range of engaging participation events.

50. The very large majority of children participate in their own timely reviews, with their wishes and feelings carefully considered by independent reviewing officers (IROs) who know them well. Caseloads for IROs are manageable. IROs meet children before their reviews, and monitor the progress of plans between reviews. A culture of challenge is in place across the service, and appropriate dispute resolutions are progressed.

The graded judgement for adoption performance is that it is good

51. Adoption is considered as an option for all children at the earliest opportunity. Planning is purposeful and any unnecessary delays are avoided. The local authority actively pursues parallel plans for children to minimise delays in securing permanence. During 2016, the local authority placed 88 children for adoption. Of these children, 41 had additional complexities to consider when matching with adoptive families. The local authority is successful in securing adoption for older children and brothers and sisters together. Very few children experience disruption. On the rare occasion that this happens, managers take steps to identify what they can learn from the child's experience.

52. In January 2016, a four-year partnership for externally managing Kent adoption services ended and Kent resumed the management of its adoption service, while continuing to work with the provider as an improvement and innovation partner. Effective oversight of this transition has seen adoption performance improve. Senior managers track and maintain regular oversight of each individual child's progress to adoption effectively. This is proving successful, and for those children coming into care in the last 12 months, they have achieved timely adoptive placements and adoption orders. The head of the adoption service, supported by experienced managers and teams, scrutinises all performance and drives improvements effectively.

53. Children are well prepared for adoption. Child permanence reports are thorough, focus on the child and inform their plans well. Adopters report positively about how well they are informed about children and prepared for introductions. Wherever possible, birth parents are involved in meeting prospective adopters and supporting their child's plan. A number of adopters noted that their child had recognised them when they arrived for a first visit, which demonstrates how well prepared children are to meet them.

54. Children have colourful and individual life-story books and direct work to help them understand their history. Adopters receive helpful training to support their child's ongoing life-story work. Children receive informative and sensitively written later-life letters to help them make sense of their identity and history when they are older.

55. The local authority has made steady progress since 2012 in reducing the time it takes for children to be matched with, and move to live with, their adoptive families. The local authority's data demonstrates that performance continues to improve, with a reducing number of children waiting to be linked with families or to be placed for adoption. However, for a very small minority of children efforts to find adoptive families went on too long before alternative plans were made.

56. Children benefit from timely adoption orders once they are placed, and make good progress in their adoptive families. Adopters are very positive about their experiences of contacting the service. They consistently told inspectors that they had received clear information and prompt responses to enquiries, and that the quality of the training prepared them well. Prospective adopter assessments are thorough, and reports are analytical and child-centred, with clear rationales for supporting the recommendations to approve prospective adopters. A number of adopters had already successfully adopted with Kent. This demonstrates their confidence in the experience they will have in adopting their second or third child. The local authority has a well-promoted policy for fostering to adopt, and this has successfully supported children to form early attachments and not experience further moves when adoption becomes the plan. The capacity to offer fostering to adopt placements continues to increase, with six carers due to be considered for dual approval at adoption panel at the time of inspection.

57. The adoption panels provide effective scrutiny, focus on children and test information to carefully consider their recommendations for approving adopters and matching children. The panel quality-assures all presenting information and regularly reports to the agency its findings on the quality of practice. This has supported improvements, for example in the quality of prospective adopter reports. The agency decision makers (ADMs) make timely decisions, and challenge on the rare occasions that information is insufficient. The ADMs meet regularly with panel chairs and undertake appraisals to maintain oversight and accountability. Panel members receive regular appraisals and comprehensive training to ensure that their contributions are informed by current practice and developments in the service.

58. The local authority works closely with two neighbouring local authorities to ensure that a wider resource of potential adopters can be considered for the needs of children. At the time of inspection there were 14 Kent adopters approved and waiting for a link. The local authority utilises all local, regional and national events to link adopters and children. If no matches can be

identified at an early point, the local authority promptly refers to the adoption register and adoption link.

59. The quality of post-adoption support is excellent. There is an effective and innovative range of options and services provided by a multi-disciplinary team under partnership arrangements. The support offered is flexible, and options include group workshops, training, specific and tailored support groups for adults and children, mentoring of newly approved adopters, and individual and family therapeutic interventions. There is creative and very successful use of the adoption support fund to support adoptive families. The team members are intuitive and use their expertise well. The capacity of the team has recently been increased to ensure that it can provide the full scope of therapeutic assessments and interventions. Adopters are extremely positive about the post-adoption support they and their children receive. For example, one adopter described the support as 'phenomenal, so pertinent to what we need'.

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

60. Care leavers in Kent receive good support and, for the vast majority of young people, outcomes are good. The local authority has high aspirations for its care leavers and has taken timely, proactive steps to plan for the increase in unaccompanied asylum-seeking children who became looked after during 2015–16 and are due to turn 18 during the forthcoming months. Personal advisers in the 18-plus service support 1,278 care leavers effectively, of which 586 arrived as unaccompanied asylum-seeking children.

61. Staying put arrangements are in place and enable young people to remain with their foster carers as they progress into adulthood. The local authority has recognised that arrangements for young people moving from the children-in-care teams to the 18-plus service do not start early enough. Advanced plans are in place for young people to be introduced to personal advisers at an earlier stage.

62. The vast majority of young people enjoy positive and trusting relationships with their personal advisers, who are enthusiastic, persistent and tenacious on their behalf. Young people who met with inspectors spoke highly of their personal advisers' commitment to 'getting things done'. When young people lose touch with the 18-plus service, personal advisers make persistent efforts to engage them and continue to support them indirectly through family members. Assertive steps are taken to trace young people through last-known associates. However, managers and personal advisers have not maintained sufficient oversight of, and contact with, care leavers in custody. The result is that pre-release planning is not always effective and does not help young people to find

suitable and stable accommodation and reduce the likelihood of reoffending. (Recommendation)

63. Personal advisers engage young people positively in developing their pathway plans. The large majority of pathway plans are comprehensive; they identify risks, contain appropriate actions and contingency plans, and are regularly reviewed.

64. Young people receive information about events and resources to help them with decisions about their future. Foster carers and accommodation providers attend helpful workshops on how to support transition to adulthood. Unaccompanied asylum-seeking young people regularly attend 'drop-ins' run by a voluntary organisation that provides helpful emotional and practical support for independent living.

65. Personal advisers work closely with the Home Office, immigration services, police and partners from adult services. They recognise risks such as those related to trafficking, sexual exploitation, female genital mutilation and possible radicalisation. A panel considers young people who are missing or at high risk of harm, and provides sound management oversight of these young people to ensure that risks are mitigated and managed.

66. A range of professionals, including the family nurse partnership, provide good support to care leavers who are parents. However, the practice of referring all care leavers who are expecting a child to children's specialist services for an assessment is not proportionate to young people's differing needs. Senior managers acknowledged that there was some confusion in practice and are taking immediate action to clarify practitioners' understanding.

67. Young people benefit from the support they receive from personal advisers in maintaining their accommodation and budgeting. Personal advisers ensure that they make applications for permanent accommodation in a timely manner, and young people attend workshops to help prepare them for managing their tenancies. The local authority reports that 92% of those that they are in touch with are living in suitable accommodation. Taking careful account of the views of young people, it has increased its supported accommodation and shared housing. Good placements meet the needs of the vast majority of young people, and all those spoken with by inspectors felt safe in their accommodation and reported that it was in a good state of repair.

68. A very small minority of young people aged 19 and 20 were in bed and breakfast accommodation at the time of the inspection. This type of accommodation is used only in exceptional circumstances, and some young people in bed and breakfast accommodation had rejected other suitable alternative accommodation offered to them. The local authority recognises that the use of bed and breakfast accommodation is not acceptable practice and is actively reducing this. It has introduced safety pods to provide emergency accommodation for young people while more permanent options are explored.

69. Care leavers receive appropriate advice and support from the 18-plus support officers to help them into education, training or employment. As a result, the numbers of young people not in education, employment or training reduced from 305 in 2015–16 to 179 in February 2017. The virtual school has supported care leavers to undertake apprenticeships and supports care leavers in higher education.

70. Some care leavers who have more recently transferred to the 18-plus team have not received initial health assessments or their health history. The health service is rectifying the situation through the provision of increased resources. It has also responded well to increased demands to meet the emotional and mental health needs of asylum-seeking young people by providing innovative support programmes.

71. Personal advisers help young people to understand their rights and entitlements. Care leavers also receive a pack of information about their rights and the pledge, which is translated when necessary. The authority has approved a new leaflet describing financial entitlements.

72. Managers and staff ensure the active participation of young people in service improvements, for example in the development of the new pathway plans and in the recruitment of staff. The Young Adults Council, facilitated by an apprentice from the virtual school, has been involved in reviewing the pledge and the council's commitment to care leavers. Personal advisers take pride in the young people they work with and take steps to ensure that their achievements are recognised and celebrated.

Leadership, management and governance	Good

Summary

Determined senior leadership, sustained over a number of years, and firm political support are key factors in the steady progress made by Kent in improving services for vulnerable children from a low base. Senior managers have adopted a systematic approach to analysing practice through comprehensive quality-assurance activity and detailed performance information. This has ensured that, in almost all parts of the service, leaders have an accurate view of whether practice meets expected standards, and whether the help families receive is leading to good outcomes for children. Senior managers seek external advice and peer review to identify weaknesses and plan service improvements. This has led to positive changes in key areas, such as in the fostering and adoption services.

Senior and political leaders are proud to be the corporate parents of Kent's children looked after and care leavers. They demonstrate this through listening to children's care experiences, the comprehensive work programme of the corporate parenting board and members' self-critical analysis of their progress against the promises made to children in the pledge. Key forums receive and interrogate helpful performance information. However, some data relating to care leavers is not accurate or reliable enough to enable proper scrutiny and oversight.

The local authority works well with partners in the police and health services to agree priorities, such as tackling domestic abuse and ensuring a comprehensive response to children at risk of sexual exploitation or radicalisation. A common purpose is evident. This facilitates improvements in service provision when a need is identified. Together with its partners, the local authority is recommissioning services such as CAMHS, early help, accommodation for care leavers and domestic abuse. Although not all new services were in place at the time of the inspection, the approach evidences detailed needs analyses and close consultation with young people and families in order to provide better services. Close partnership working at a strategic level has helped staff to find creative solutions to challenging problems, such as the co-location of Kent staff with the Home Office to provide a more joined-up early response to unaccompanied asylum-seeking children.

Senior managers engage well with the KSCB and are influential in the work of the board's sub-groups, but the local authority does not share detailed enough data with the board to enable partners to scrutinise safeguarding performance. Social workers are positive about the environment they work in. Morale is good, workforce stability is improving and staff at all levels have ample opportunity to develop their skills and experience. However, not all team managers provide sufficiently challenging, analytical or supportive supervision. Although staff have access to largely comprehensive procedures, guidance and training, more work is needed to ensure that staff in early help and specialist children's services are properly equipped to understand and respond to neglect within families.

Inspection findings

73. Led by the DCS, senior and political leaders have established strong relationships with each other and with key partners. In most cases, these relationships have been sustained over a number of years, cemented through local challenges, such as the influx of unaccompanied asylum-seeking children. Leaders routinely share child-related concerns and service risks, strengths and weaknesses. Cross-party commitment is clear. This is underpinned by financial investment, which supports improvement, such as the substantial additional funds dedicated to the leaving-care service in order to meet demand and reduce caseloads. The lead member for children's services has a good understanding of the needs of vulnerable children and brings his influence to bear on behalf of children and social workers. He has been instrumental in improving reward packages for social workers who are loyal to Kent, and in improving mobile technology for staff.

74. Appropriate formal links between local authority leaders and the KSCB are in place. Senior managers positively influence the work of the board through the chairing of sub-groups and work-streams. However, senior managers have not engaged assertively enough with the board to ensure that it has the right information to scrutinise frontline practice within children's services properly. For example, the board does not receive data relating to the conversion rates from strategy meetings, child protection enquiries, conferences and plans, or the rate of repeat child protection plans. This is a joint responsibility. (Recommendation)

75. Senior and political leaders are committed and nurturing corporate parents. They aim high for children looked after and care leavers, and enthusiastically congratulate them on their progress and achievements. The co-chairs of the corporate parenting board are passionate and well-informed; this helps the board to interrogate data effectively and improve children's experiences. Children attend the board regularly and participate well. Children were actively involved in developing the pledge, which has received full council sign-up. Senior and political leaders seek out opportunities to hear what young people think about their experiences, and routinely consult them about important decisions, such as the appointment of social care staff.

76. Through a proactive strategic and operational response, leaders have made good progress in increasing the sufficiency of accommodation for the unexpectedly large group of care leavers. The recommissioning of supported lodgings accommodation was well informed by detailed analysis and consultation with care leavers. The provider now provides places for 250 young people with host families who are carefully vetted and overseen. The two remaining stages of the accommodation review, to increase the range and quality of semi-independent accommodation and floating support, have not yet taken effect. Senior managers are taking appropriate steps to increase the range and number of placements for children looked after, with increasing

numbers of foster carers responding to targeted recruitment campaigns and subsequently being approved.

77. The children's services workforce is increasingly stable. The local authority almost met its target to achieve 83% permanent staff by 1 April 2016. Turnover is also steadily reducing. Senior and human resources managers have taken the right steps to attract and retain staff at all levels. Loyalty payments, targeted at the parts of the service most difficult to recruit to, complement a supportive environment in which staff at all levels can develop their skills and careers. Caseloads in most teams are manageable, and when they are not, there are firm plans in place to address this. For example, in Thanet the boundary lines have been changed to better balance the caseloads of the teams in that area.

78. Most social workers say that they enjoy working for Kent and they appreciate the training they receive, which is comprehensive. Morale is good. The principal social worker has led the successful implementation of the chosen model of assessment, and inspectors saw the positive effect of this approach in casework. However, further work is needed to ensure that social workers and early help practitioners have the right tools to properly understand the impact of neglect on children. (Recommendation)

79. First-line managers regularly oversee plans for individual children. Inspectors saw some good examples of analytical case supervision, which is helping social workers to work more effectively with complex families. However, not all social workers benefit from this high-quality oversight, support and direction. In the cases brought to the attention of senior managers by inspectors, managers had often not identified risks or sufficiently challenged a lack of progress in children's lives. The quality of staff supervision, including appraisal and attention to social workers' overall development needs, is also too inconsistent across teams. (Recommendation)

80. Quality-assurance activity is extensive across specialist children's services and early help. Overall, it is helping managers to gain a clear view of practice and it is leading to service improvement. Robust monitoring of minimum standards ensures clear messages to staff about the importance of, for instance, comprehensive chronology. Senior managers have not taken a 'one size fits all' approach to interrogating the quality of practice. They use a range of methods, including a strong emphasis on individual observation and coaching through a team of professional development officers, overseen by the principal social worker. Managers at all levels are involved in case-auditing, and they plan to strengthen this activity further through the imminent roll-out of a more analytical and reflective auditing tool. Overall, case audits undertaken by managers for the inspection were an accurate appraisal of practice. Senior managers have identified a need to track more robustly all quality-assurance related actions to ensure maximum whole-service learning. During the inspection, inspectors identified a small number of weaknesses that had not previously been identified, for example the lack of performance monitoring of

'no further action' decision-making in the CRU, and the quality of support for children who are privately fostered.

81. Performance information and data are comprehensive overall. Management information lead officers work closely with senior and operational managers to ensure that data is intuitive, easy to navigate and flexible to changing priorities across specialist children's services and early help. Commentary and clear benchmarking help to ensure that performance information is well understood and valued by leaders, managers and key forums in all parts of the service and is supporting service improvement. For example, a recent detailed analysis of children who go missing identified gaps in the recording of the reasons why children run away. Improving this has resulted in the identification of an increase in children looked after going missing to see family and friends, and to emerging targeted work to support older children to enjoy this contact in a more planned way. The live-data dashboard, updated each night, is tailored to the needs of each team. It is particularly useful to managers in analysing the work of their teams. However, inaccuracies and anomalies in data relating to care leavers have limited the line of sight of senior leaders in some key areas, such as the proportion of care leavers who are in touch with the service. (Recommendation)

82. The corporate complaints team ensures that, in most cases, the response to complaints made by children and parents is timely and proportionate. The analysis of themes and issues raised by complainants is increasingly detailed, and this is helping leaders and managers to better identify the need for service changes. The next step is to establish a more coherent approach to ensuring that specific actions are followed up, and that the experiences of other children and families improve as a result. Most children who complain do so with the support of an advocate, but for some children more could be done to resolve their issues and worries at an earlier stage.

83. The oversight and coordination of commissioned services improved in the six months prior to the inspection. Clear commissioning plans are now in place. Detailed mapping and consultation informs specific reviews such as the recommissioning of early help services. Senior managers and partners engage well with children, families and stakeholders, such as general practitioners, when they are planning to change a commissioned service. The major review and recommissioning of CAMHS and emotional well-being services demonstrate a commitment across the partnership to increasing service capacity for the most vulnerable children. Although only part of the new service is in place, the firm plans to create a single point of entry for all children who need emotional or mental health support evidences an understanding of the needs of local children, including those who have been placed in Kent by other local authorities.

84. It is positive that the local authority has been proactive in establishing a 0-25 health and well-being board, to promote a clearer focus on children, including vulnerable children. The 0-25 board has been instrumental in establishing local

children's partnership groups in all 12 districts, each signing up to an agreed set of local indicators linked to Kent health and well-being priorities. Although a recent development, with some groups not yet fully functional, it is an important step in public health, clinical commissioning groups and the local authority integrating the district councils with the health and well-being agenda. A named council member is linked to each group. Grant funding facilitates commissioning of local services to meet local need.

85. Partnership working is effective. The local strategic response to child sexual exploitation and children who go missing is informed by a careful analysis of the community, joint investment in services, and a strong commitment to educating the local community to be able to spot the signs of abuse. A well-developed strategy and clear structures are in place to ensure that the 'Prevent' duty is implemented across the county in a proactive rather than reactive way. Good in-house expertise and effective links with Home Office and counter terrorism units are used well to develop comprehensive training packages for a range of professionals, including foster carers, elected members and school governors. Appropriate referrals to the channel panel are increasing.

86. Despite tenacious follow-up by Kent specialist children's services, routine sharing of information from return home interviews for other local authority children looked after who are placed in Kent, does not routinely occur. This hampers the development of strategic local knowledge, limiting opportunities for targeted disruption activity to reduce risks for all children.

87. Inspectors saw a number of examples of strong and creative work with partners, such as the actions taken with health, education, housing, the police and the UK Border Agency in response to the increase in unaccompanied asylum-seeking children. The co-location of Home Office and Kent staff is a creative and child-focused development. Leaders continue to seek opportunities to develop services in an innovative way, for instance through a partnership with an independent agency to support the transformation of children's services using a whole-system approach. Social innovation money is funding a different model of working through the launch of a new kind of family group conference. The approach is designed to build safe and enduring relationships between children looked after and their friends, carers and family members in order to promote resilience as they head towards independence. Early signs, based on pilot meetings and consultations with staff and families, are promising.

The Local Safeguarding Children Board (LSCB)

The Local Safeguarding Children Board requires improvement

Executive summary

The Kent Safeguarding Children Board (KSCB) requires improvement to be good. The board is meeting its statutory responsibilities, and the experienced chair has ensured that robust governance arrangements are in place. In some areas, the board positively influences local safeguarding arrangements, such as the strategic response to child sexual exploitation and radicalisation. However, it does not collect all the performance information that it needs to be able to fully challenge partner agencies and hold them to account. An audit programme is in place, but it is not robust enough to enable the board to assure itself about the effectiveness of local safeguarding practice. The board does not have a mechanism to ensure effective oversight of the key risks that might reduce the ability of partner agencies to safeguard children.

Partners are well represented on the board and attendance is good. The board has two lay members, who are valuable participants. A well-developed sub-group structure ensures that the board is able to deliver its work programme. The board's website includes helpful information about campaigns and safeguarding updates, alongside reports on recent learning reviews and serious case reviews. Up-to-date multi-agency procedures are in place and are available on the website. The board has not responded to the issue of neglect at sufficient pace; a multi-agency strategy is yet to be approved and multi-agency training is underdeveloped. The board's annual report does not provide a comprehensive analysis of all key areas of safeguarding practice.

The case review group and the child death overview panel (CDOP) are well developed and effective. The board has taken appropriate steps to disseminate learning from serious case and child death reviews. However, due to a lack of robust follow-up, there is limited evidence that the impact of learning from these reviews has improved practice. Robust strategic and operational arrangements are in place to safeguard and protect those children who go missing, are at risk of child sexual exploitation, or are at risk of being radicalised.

The board has ensured that an up-to-date multi-agency threshold document is in place, and has taken reasonable steps to ensure that it has an understanding of the application of thresholds. Although the board has identified a lack of agency understanding about these thresholds, it has not done sufficient further work to fully understand this. Although a process for undertaking and learning from multi-agency Section 11 audits is in place, local schools have not conducted a regular and comprehensive evaluation of their safeguarding arrangements. Through their active engagement, young people are positively influencing the work of the board.

Recommendations

88. Ensure that a comprehensive multi-agency dataset is in place to enable the board to scrutinise local safeguarding performance.

89. Ensure that the board has systems in place to monitor risks that have the potential to have an impact on the ability of agencies to safeguard and protect children.

90. Further develop a comprehensive programme of single- and multi-agency audits to improve the scrutiny of safeguarding practice across partner agencies.

91. Develop the annual report to ensure that it provides rigorous and transparent assessment and scrutiny of frontline practice, the effectiveness of safeguarding services and the work of the independent reviewing service, as well as learning from serious case reviews and child deaths.

92. In partnership with the local authority, launch the multi-agency neglect strategy and ensure that local professionals working with families, at all levels of need, are equipped to identify, assess and address neglect within families.

93. Put in place a system for the board to receive assurance regarding safeguarding practice within early years settings, schools and colleges.

Inspection findings – the Local Safeguarding Children Board

94. The board is meeting its statutory responsibilities, but has further work to do before it can be considered to be good. Governance arrangements between the KSCB and the local authority are effective, with a well-developed sub-group structure and appropriate communication between the board and the sub-groups to ensure that priorities and work plans are shared. The chair meets regularly with the head of Paid Service and the DCS, and a joint working protocol clearly defines the relationships between the different strategic boards. The chair, who attends the health and well-being 0-25 board, ensures that safeguarding issues are given a sufficiently high profile.

95. Partner agencies are well represented on the board at an appropriately senior level to be able to influence safeguarding practice within their own organisations. They regularly challenge each other to understand and improve services for vulnerable children. Attendance is good, and a shared commitment to delivering high-quality safeguarding services is evident. The board's two lay members bring a unique perspective to the board's work. Sitting both on the board and on a number of sub-groups, they have been able to offer challenge and honest evaluation of the effectiveness of agencies in safeguarding of children. The chair holds agencies to account for the delivery and improvement of services to vulnerable children in some key areas, and this has contributed

to, for example, a coordinated and effective response to unaccompanied asylum-seeking children.

96. Children and young people's experiences shape and influence the work of the board and its priorities. Young people deliver presentations to the board, in which they share and reflect on their experiences. This has resulted in appropriate action to improve services, for example in relation to police responses to youth homelessness and the provision of more suitable young people's housing by district councils.

97. A multi-agency dataset is in place and some information is routinely received, such as the number of early help assessments undertaken and the number and rate of referrals made to specialist children's services. However, the board has not received data relating to the proportion of referrals to specialist children's services that result in child protection enquiries, or how many child protection enquiries lead to a child protection conference. This has reduced the board's ability to identify any potential themes or trends in the application of child protection thresholds. The board has considered the report of the designated officer and the annual private fostering report, but it has not had sight of the annual report by the independent reviewing officers IROs or performance reports from child protection conference chairs. The board recognises that the breadth and depth of the multi-agency performance information it receives needs to be further improved. (Recommendation)

98. The board maintains a risk register in relation to the delivery of its work programme as well as a challenge log. There is a reliance on partners to report any identified risks that have an impact on agency performance to the board, and these are not automatically transferred to the challenge log. In the absence of a single, shared risk register, the board cannot be confident that it has a sufficiently clear overview of risk across the partnership, and this makes it difficult for the board to be sure that any risks are addressed in a timely way. (Recommendation)

99. The board has ensured that a clear and up-to-date multi-agency threshold document is in place, and has undertaken some work to test the application of thresholds across the partnership. A number of audits undertaken in the 12 months preceding the inspection highlighted potential gaps in professionals' understanding of thresholds, inconsistencies in the consideration of consent and some concerns about the multi-agency use of safeguarding leads within professionals' own organisations. Although these issues were highlighted and shared, the board has not taken sufficiently assertive action to further interrogate or address these issues.

100. Effective strategic arrangements are in place to identify and safeguard children and young people who go missing or who are at risk of sexual exploitation. The multi-agency sexual exploitation sub-group oversees the multi-agency sexual exploitation team effectively and has recently completed a problem profile. A significant awareness-raising and training campaign has been delivered, and

child sexual exploitation champions have been appointed across agencies. These champions are appropriately trained and are expected to be proactive in advising colleagues and cascading learning. Following a review of the sexual exploitation tool, a shorter version is being developed to better support professionals in identifying and responding to sexual exploitation. Taxi drivers and hoteliers have received training to increase their awareness of child sexual exploitation. Direct and assertive action is taken when safeguarding concerns are identified. Considerable work has been undertaken across agencies to promote awareness and improve the local response to radicalisation.

101. The board, supported by the quality and effectiveness sub-group, has developed an audit programme that reflects its business priorities. A range of multi-agency audits are undertaken in order to analyse the effectiveness of frontline practice. Audits have identified relevant learning across the partnership, with appropriate recommendations to improve multi-agency working. The board is unable to assess fully how well agencies are implementing these findings, or to judge the impact of the learning on practice, because it has not put into place a robust process to track actions or analyse practice changes. The board also has not established a system for routinely overseeing or receiving the findings from single-agency audits. This means that it cannot judge whether each agency is doing enough to interrogate practice within their own organisation, and cannot assimilate or share relevant findings. (Recommendation)

102. The board undertakes a bi-annual programme of Section 11 audits. These audits are subject to appropriate peer review and provide assurance to the board regarding safeguarding practice within agencies. Underpinning evidence is robust. However, the board, together with the local authority, has not consistently required local schools, early years settings and colleges to undertake a regular and comprehensive evaluation of the arrangements they have in place to safeguard children. (Recommendation)

103. Established and clear arrangements are in place to review and learn from child deaths. The CDOP is effective and there is good multi-agency engagement in the child death process. The development of an innovative e-system has addressed the backlog of cases and ensured an effective and efficient response to, and consideration of, child deaths. The annual report is appropriately detailed, reflects the work undertaken by CDOP and identifies key priorities. The CDOP has led a successful campaign on safe sleeping, producing information and tools that have been distributed to parents and rolling out training for health professionals. Learning from child deaths is routinely shared with partners and cases are referred to the case review panel for consideration, as appropriate.

104. A learning and improvement framework ensures that decisions to initiate a serious case review or, in those cases which do not meet the criteria for such a review, a learning review, are appropriate. The board has completed two serious case reviews in the last 12 months, which are due to be published. A

number of events have been held alongside informative material to disseminate learning across partner agencies. Safeguarding procedures are regularly updated and reflect learning from audits and case reviews, as well as national developments. However, the board does not rigorously evaluate the impact of learning from serious case reviews on frontline practice.

105. The board delivers a wide range of multi-agency safeguarding courses. A training strategy is in place and is available on the website, alongside the 'training tree', which sets out a simple training development structure. Training events and courses reflect the findings from local serious case reviews and learning reviews, and trainers are subject to a thorough quality-assurance process. However, the board has been slow to ensure that local professionals are properly equipped to identify and assess neglect within families, and the current programme does not sufficiently address this. Action has been taken to improve agency attendance at courses and the completion of e-learning modules. A recently developed training matrix assists agency professionals in identifying appropriate courses to attend according to their role. The board has not undertaken a multi-agency training needs analysis to inform the future training plan, limiting its ability to target learning and training activity effectively. Evaluation of the impact of training on frontline practice has so far been limited and the board has identified this as an area for further development.

106. The annual report for 2015–16 includes data in an easy to understand format, highlights key achievements and identifies areas for development. However, it does not provide a rigorous and transparent assessment and scrutiny of frontline practice, or a comprehensive assessment of the performance and effectiveness of local services. While the report includes limited analysis of a number of key aspects of safeguarding, such as managing allegations against professionals, it does not include learning from serious case and child death reviews. (Recommendation)

Information about this inspection

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

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

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

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

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

The inspection team consisted of seven of Her Majesty's Inspectors (HMI), one regulatory inspector (RI) and two additional inspectors (AI).

The inspection team

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