Oxfordshire 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 date: 29 April 2014 – 21 May 2014

Report published: 30 June 2014

The overall judgement is **good.**

The local authority leads effective services that meet the requirements for good.

It is Ofsted's expectation that, as a minimum, all children and young people receive good help, care and protection.

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**

The effectiveness of the Local Safeguarding Children Board (LSCB) is **good.**

The LSCB coordinates the activity of statutory partners and has mechanisms in place to monitor the effectiveness of local arrangements.

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

Contents

Section 1: the local authority

Summary of key findings

This local authority is good because

1. When agencies are concerned about children, they know how to get the right level of help for them. Thresholds for the different levels of help, including social care, are clear and understood by professionals.

2. Agencies work well together. Early help services are well coordinated and have clear thresholds for support. The Troubled Families programme, Thriving Families, is well targeted and responsive, with good take-up by those families in most need. When children are referred to children's social care they almost always receive a prompt response and the right help. The large majority of social work assessments are good. Children are always seen and asked about their life and what they need to improve it. Assessments analyse risk carefully and what needs to be done to reduce it. Hospital-based social workers complete good assessments that result in effective planning and discharge arrangements for newborn babies who may be in need of help or protection.

3. The large majority of child protection enquiries are carefully planned by children's social care with the police and other agencies and investigated thoroughly. Social work action to protect children when they need it is decisive and proportionate.

4. Consultation and advice are readily available to professionals who are concerned about possible child sexual exploitation. The Kingfisher team provides a consistent service for children identified as at risk of sexual exploitation. Their work is clearly focused on reducing risks as well as on meeting children's and young people's wider needs.

5. A stable workforce in children's social care means that most children experience consistency of social worker and say they have a significant, sustained relationship with them.

6. Decisions about whether children should become or remain looked after are timely and based on evidence about the child's needs. When necessary, care proceedings are initiated quickly to ensure that children are not exposed to harm for extended periods.

7. The Family Placement Support Service is a particular strength. It works effectively with families to prevent the need for children to become looked after. It also supports families when a child returns home after being looked after.

8. Long-term planning to secure stable futures for children is given a high priority. The search for suitable alternative families starts at the earliest

possible stage. The contribution made by the adoption service is good. The number of children placed for adoption has increased over the last two years and includes improved adoption rates for older children.

9. Young people are well supported when they leave care. The quality of most pathway plans is good and, whilst some lack detail, most reflect clear and timely actions to help young people make the transition to independence. Most care leavers feel well supported by their social workers and describe effective and consistent relationships that enable them to develop trusting relationships.

10. A 'Staying Put' scheme has enabled a growing number of care leavers to remain with their carers beyond the age of 18. This is bringing demonstrable improvements to the life chances of most care leavers, for example in increased emotional stability as well as a secure base while in education.

11. Services for children and families are given a high priority by senior leaders and elected members. The local authority knows its strengths and weaknesses well. Strategic priorities are identified and informed by feedback from children, young people, parents, carers and staff. Leadership is strong and effective and services make a demonstrable difference in improving the life chances of some of the most vulnerable children in Oxfordshire.

12. Elected members have high aspirations for looked after children and young people in Oxfordshire and have prioritised continued investment, for example in additional social worker and team manager posts. They hold senior officers to account for the quality of services.

13. Management oversight of practice is good. Performance data are used effectively to inform change and drive improvement. This learning culture is further supported by the effective identification and dissemination of lessons from audits and serious case reviews.

What does the local authority need to improve?

Areas for Improvement

14. Undertake a review of all children subject to child protection and looked after procedures and ensure that children are not unnecessarily subject to both processes.

15. Recruit more foster carers within Oxfordshire so that looked after children can be placed in or near their own communities unless there is a specific need for a placement further afield.

16. Ensure that life story work is carried out with all looked after children for whom the plan is a permanent alternative family, and not just those moving towards adoption.

17. Ensure that when children are placed with relatives or friends, all necessary assessments are completed and presented to fostering panel within the required timescales.

18. Strengthen the role of the virtual head teacher in challenging and supporting school leaders at all stages of education so that the attainment of looked after children improves to at least the expected level for their age.

19. Develop and implement an ambitious strategy to ensure that care leavers engage in education, training or employment that is commensurate with their ability and potential.

20. Ensure that all foster carers receive regular supervision that is properly recorded.

21. Establish effective governance arrangements between the Health and Well-Being Board, Children and Young People's Partnership Board and the Oxfordshire Safeguarding Children Board (OSCB) to ensure a robust framework for safeguarding children and young people.

22. Ensure that children and young people who are looked after or who receive a child protection service are able to have an independent advocate to represent their views if they wish.

23. Ensure that all children and young people have information appropriate to their age so that they understand how to complain.

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 six of Her Majesty's Inspectors (HMI) from Ofsted and one contracted inspector.

The inspection team

Lead inspector: Emmy Tomsett HMI

Team inspectors: Fiona Millns HMI, Sean Tarpey HMI, Pauline Turner HMI, Aelwyn Pugh HMI, Stephanie Murray HMI, Paul Johnston

Information about this local authority area[2]

Children living in this area

- Approximately 138,000 children and young people under the age of 18 years live in Oxfordshire. This is 21.1% of the total population in the area.
- Approximately 12.7% of the local authority's children under 16 are living in poverty.
- The proportion of children entitled to free school meals:
  - in primary schools is 11% (the national average is 18%)
  - in secondary schools is 9% (the national average is 15%).
- Children and young people from minority ethnic groups account for 13.5% 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 Asian/Asian British (5.8%) and people from Mixed/Multiple Ethnic groups (4.9%).
- The proportion of children and young people with English as an additional language:
  - in primary schools is 11% (the national average is 18%).
  - in secondary schools is 9% (the national average is 14%).
- Children of non-white ethnicity follow the same pattern of distribution in the county as adults, predominantly living in Oxford City and Banbury. At ward level, the highest proportion of non-white ethnicity among children under 18 was 58% in Cowley Marsh in Oxford City.

Child protection in this area

- At 31 March 2014, 3,151 children had been identified through assessment as being formally in need of a specialist children's service. This is a reduction from 3,471 at 31 March 2013.
- At 31 March 2014, 512 children and young people were the subject of a child protection plan. This is an increase from 430 at 31 March 2013.
- At 31 March 2013, 34 children lived in a privately arranged fostering placement. This is a decrease from 37 at 31 March 2012 (the 2014 submission is not yet available).

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

Children looked after in this area

- At 31 March 2014, 467 children are being looked after by the local authority (a rate of 33.7 per 10,000 children). This is an increase from 416 (30.0 per 10,000 children) at 31 March 2013. Of this number:
  - 125 (26.8%) live outside the local authority area
  - 61 live in residential children's homes, of whom 57.3% live out of the authority area
  - 9 live in residential special schools[3], of whom 44.4% live out of the authority area
  - 327 live with foster families, of whom 25.0% live out of the authority area
  - 13 live with parents, of whom 7.7% live out of the authority area
  - 20 children are unaccompanied asylum-seeking children.
- In the last 12 months:
  - there have been 44 adoptions
  - 28 children became subjects of special guardianship orders
  - 257 children have ceased to be looked after, of whom 6.6% subsequently returned to be looked after
  - 22 children and young people have ceased to be looked after and moved on to independent living
  - the number of children and young people who have ceased to be looked after and are now living in houses of multiple occupation is not available at this time.

Other Ofsted inspections

- The local authority operates 2 children's homes. Both were judged to be good or outstanding in their most recent Ofsted inspection.
- The previous inspection of Oxfordshire's safeguarding arrangements / arrangements for the protection of children was in March 2011. The local authority was judged to be Grade 2 (Good).
- The previous inspection of Oxfordshire's services for looked after children was in March 2011. The local authority was judged to be Grade 2 (Good).

[3] These are residential special schools that look after children for fewer than 295 days.

Other information about this area

- The Director of Children's Services has been in post since October 2011 in an interim capacity and April 2012 as substantive.
- The interim chair of the LSCB has been in post since October 2013.
- In May 2013, following a joint police and local authority investigation in Oxfordshire, seven men were convicted of child sexual exploitation. The OSCB initiated a serious case review but has not yet completed its investigations. In response to the investigation, and prior to the convictions, the local authority and its partners, including police, health and district councils, worked collaboratively to provide services to protect and support vulnerable children and young people. This has included setting up the dedicated Kingfisher Multi-Agency Team in November 2012, and creating a wider awareness about young people who are victims of sexual exploitation. Extensive training for staff across the partnerships has been delivered and the local authority recently hosted a national conference on child sexual exploitation.

Inspection judgements about the local authority

The experiences and progress of children who need help and protection are good

24. Early help assessments are completed by a wide range of agencies to identify what needs to change to improve a child's life. These also inform subsequent intervention, which is supported by regular 'team around the child' meetings to monitor progress. The 'Thriving Families' scheme is well focused on those most in need of support. It is intensive, well organised and cost-effective, and has led to clear improvements in the lives of particular families.

25. The Early Intervention Service (EIS) supports a wide range of families at early help stages. This includes help for children and young people in those families where there is drug and alcohol misuse by parents or carers. EIS help continues to be available if cases escalate to children's social care. It also supports an increasing number of children and families when social care intervention ends. This helps to reduce the risk of concerns re-emerging. The EIS introduced the 'Family Star' model in January 2014. This is beginning to provide evidence that early help is making a difference and improving outcomes for children.

26. Thresholds for the different levels of intervention are well understood and applied across the partnership. Excellent arrangements are in place to ensure that social work advice is available to support professionals from partner agencies. Locality senior practitioners and social workers based across all Children's Social Care teams including the hospital provide prompt advice and consultation to a wide range of professionals about actions they should take on cases. Social workers are linked to all children's centres and schools and provide regular formal consultation sessions. Advice is clearly recorded and reviewed by the locality senior practitioner and is of sound quality. This is an area of particularly good practice.

27. When safeguarding and child protection concerns are identified, they receive a prompt and proportionate response from children's social care. This includes when concerns arise out of normal office hours. Good arrangements are in place with the police to undertake child protection investigations where there is a risk of significant harm. Minutes of strategy discussions to plan and coordinate investigations include clear details of the next steps to be taken. Inspectors found no cases where children were left at risk.

28. Information sharing between professionals is usually timely and is bounded by excellent arrangements to secure informed consent from families in need of early help and lower level interventions from children's social care.

29. The large majority of Children's Social Care assessments identify risks and protective factors well and provide a robust analysis. They include a number of key elements that combine to produce a good understanding of the child's

experience. For example, they are informed by chronologies and so take into account historical factors when considering current needs and risks. Children are routinely involved in assessments and their experiences are central to them. The voice of the child is well reflected in the large majority of assessments. Assessments include consideration of fathers, even when they are absent. Social workers use a specific tool to assess the nature and impact of neglect on children. This enables them to tailor interventions to meet the particular needs of these children and to help them overcome the harm they have suffered. Overall, assessments provide a good platform for planning and intervention. However, they do not routinely consider children's identity needs fully, for example in relation to ethnicity, and this limits their value in some respects.

30. The single assessment has been recently introduced in Oxfordshire. Assessments are comprehensive and lead to the development of well-informed child protection and child in need plans. These are mostly outcome-focused, with specific actions to reduce risk and meet needs. More recent child protection plans make it clear to parents what they have to change and how they will be supported in doing so. This is reinforced by child protection conference chairs, who ensure that parents understand plans before they leave conferences. Parents told inspectors that they are aware of professional expectations of them.

31. Core group meetings are regular and well attended by professionals. They are effective in monitoring the progress of families where children are on a child protection plan and in holding parents and professionals to account. In the majority of cases, core groups are instrumental in driving effective action to progress plans swiftly, leading to improved or improving outcomes for children. Arrangements for considering child protection issues for children with disabilities are effective, with co-working arrangements in place between the assessment teams and disability social workers. This ensures that the protection needs of the child are fully considered as well as those relating to their disability.

32. Child in need plans are afforded the same priority as child protection plans. They are increasingly valuable in ensuring that children's needs are met. They are used well to shape continuing support for children and families who previously had child protection plans. This helps families to sustain the positive changes they have made. However, a small minority of child protection plans were over-complicated and did not enable parents to understand the changes they needed to make.

33. A small minority of children are currently subject to both child protection and looked after arrangements. This means that some parents and children unnecessarily experience additional meetings and processes. The local authority has recognised this and is reviewing all these cases to ensure this issue is rectified.

34. Child protection chairs are passionate and committed. They recognise the need to develop more outcome-focused protection plans. Their quality assurance function is not yet fully developed, though plans are in place to develop this aspect of their role.

35. The number of children subject to a child protection plan continues to rise in Oxfordshire. This is due in part to improvements in the targeting of intervention, better decision-making and more robust management oversight. Core group meetings take place regularly, and there is evidence that most are effective in developing the outline protection plan into an effective working tool and in monitoring progress.

36. Management oversight of casework is evident in case files and supervision records. It is effective in providing both quality assurance and clear direction to work done with children and families. Staff report that they are well supported by managers.

37. Children benefit from a stable workforce which affords children consistency of workers. Social workers know their children well and it is clear that they have meaningful discussions with them about their experiences and advocate well for them. Independent advocacy services are not frequently used by young people. The local authority recognises the need to promote these services more effectively.

38. Work done by the Kingfisher service, a specialist team working with young people who have suffered or are at risk of child sexual exploitation (CSE), is of high quality. It focuses both on reducing risks and meeting wider needs for young people, as well as providing good consideration of the young person's holistic needs. Large numbers of professionals have been effectively trained to identify potential indicators of child sexual exploitation. The consistently high use of a child sexual exploitation screening tool by professionals who are concerned about possible CSE is leading to more young people being helped earlier. The Kingfisher team provides good quality consultation and advice to a wide range of professionals on child sexual exploitation. Excellent awareness-raising activity takes place with young people on a continual cycle and is now taking place with parents and carers.

39. Good arrangements are in place to respond when children go missing from home and care. The police undertake a 'safe and well' visit when children return home and provide very prompt reports to the local authority. Social workers visit promptly after each missing episode of a child known to the service. They complete a return interview with the young person to understand the reasons for the missing episode. All missing episodes are effectively recorded and risk assessed, with appropriate plans to reduce the risk of future missing episodes. The authority has effective systems for identifying, monitoring and responding to those children who are missing from education and those who are educated at home. Officers provide support and,

where necessary, challenge to ensure the quality of the education provided in this way.

40. Sound arrangements are in place to assess and meet the needs of 16 and 17 year-olds who become homeless. The local authority takes good steps to identify appropriate housing for young people, including in emergencies. Continuing support is available to young people through children in need plans when they choose not to become looked after. Two young people were in temporary bed and breakfast accommodation at the time of the inspection. Their situations have been fully risk assessed and appropriate action is being taken to secure more permanent accommodation.

41. Good arrangements are in place for privately fostered children. Awareness raising work across Oxfordshire, and particularly with local language schools, has been successful in increasing the number of referrals overall.

42. The Local Authority Designated Officer (LADO) arrangements for managing and responding to allegations of abuse or mistreatment of children by professionals and carers are effective. Allegations are investigated thoroughly to ensure that risk to children is identified and prompt actions taken to reduce it.

43. Multi-agency risk assessment conferences (MARAC) are chaired by a senior police officer and well attended by relevant partner agencies. This process increases the protection of children and young people who are at risk of harm caused by domestic abuse. Referrals to MARAC are appropriate and timely. Similarly, multi-agency public protection arrangements (MAPPA) demonstrate a coordinated multi-agency response and shared understanding that reduces risk to children.

The experiences and progress of children looked after and achieving permanence are good

44. Children and young people in Oxfordshire who are on the edge of care are well supported to remain with their families where this is appropriate.

45. Decisions about children coming into care are consistently made by senior managers and are proportionate and timely. The Public Law Outline is well understood and legal advice is clear. Decisions made about thresholds for proceedings take account of family history, the motivation of parents to change and the impact of adult need and behaviour on children.

46. In Oxfordshire care proceedings are being concluded swiftly. The current average timescale is 27 weeks, which is better than the national average. While the quality of assessments and reports is variable, most are good. Social workers thoroughly explore all support options to help birth families care for their children safely. Where this is not possible, they give a high priority to securing alternative permananent arrangements. Social workers speak authoritatively and warmly about children and young people who are

looked after. They understand their histories, work hard to make sure they live within homes that meet their needs and think carefully about their long term outcomes. The vast majority of young people who spoke to inspectors made positive comments about their social workers and one said, 'My social worker never left me, she stayed by my side'.

47. In the large majority of cases, children and young people are settled and thriving in their current placement, with improved outcomes in all or most areas of their lives. Most children looked after experience great stability in their short- and long-term placements. The vast majority of children placed out of area are well supported and are not adversely affected by the fact they do not live in Oxford.

48. In the majority of cases, looked after children are seen regularly by their social workers. However, the ability of young people and their social workers to make and sustain meaningful relationships is reduced in a small minority of cases where visits take place every three months. Whilst this visiting pattern had been agreed by the child, this is not a sufficient monitoring frequency.

49. The clinical psychologists, family therapist and specialist senior practitioner within Oxfordshire's ATTACH Team (Attaining Therapeutic Attachments for Children) provide effective therapeutic intervention to children. This work has been successful in reducing the number of children entering the care system as well as preventing placement breakdown

50. Independent Reviewing Officers (IROs) provide consistent and rigorous scrutiny of care plans for looked after children and young people. They challenge decisions and plans effectively where appropriate and stay in touch with young people, particularly during times of change or uncertainty. Although they routinely see children a few days before their review, and clearly know them well, they do not consistently have face-to-face contact with young people between their reviews.

51. The recruitment of foster carers is well targeted and the number of carers approved has increased. Despite this recent increase in approvals, there is still a shortage of carers for older teenagers and children requiring long-term care. This is having an adverse impact on the local authority's ability to match children and young people immediately to appropriate in-house placements.

52. The Multi-dimensional Treatment Programme (MTFC) provides 14 specialist therapeutic placements to children and young people aged 3 to 16, with 58 children being placed to date. Children placed within the programme benefit from the involvement of a strong and responsive team of professionals, leading to a better understanding of their needs. Targeted therapeutic intervention is making a difference to the lives and futures of most children and young people seen. The programme has seen positive outcomes for children including their return to their family, adoption and permanent placements under Special Guardianship Orders.

53. Careful thought is given to the suitability of extended family members and other connected persons when thinking about long-term options for children of all ages. However, social workers are not consistently ensuring that friends and family assessments are completed and presented to fostering panel within the required 16 weeks and therefore unnecessary delay has occurred in a minority of cases.

54. Most children who are unable to return to live with their families say that their social workers have explained to them clearly the reasons. Social workers routinely help children to make sense of what is happening to them. Inspectors saw examples of social workers using play with trains on a track to help children understand their journey towards a 'forever family'. Older looked after young people reported to inspectors that their social workers had really helped them to understand their lives so far. Children with a plan for adoption are routinely engaged in life story work, but for children with plans for other forms of permanent alternative family it is not always done early enough. The vast majority of care plans and reviews are up to date and comprehensive. Most plans reflect clear arrangements for looked after children, as well as the views and wishes of the child or young person. Educational progress is consistently explored, with recognition of the young person's progress and achievements, together with targeted actions to address any concerns about attendance, behaviour or attainment.

55. The quality of looked after reviews is good. Young people and their families are encouraged to be involved and in the vast majority of cases children participate fully in the discussion and planning stages. The needs of young people are well reflected on written records, with important events, achievements and challenges all given equal emphasis.

56. Looked after children's health needs are effectively monitored. Social workers routinely notify looked after children's nurses of new admissions to care. They arrange initial assessments within two days and this ensures that children's health needs are understood early. Strength and Difficulties Questionnaires (SDQs) are completed routinely for all looked after children by their carers as part of the annual health check undertaken by the looked after children nurses. The results of these questionnaires enable health professionals to identify individual needs and ensure advice and support is effectively targeted to meet this need.

57. Looked after children and young people who are at risk of emotional harm are well supported by the Child and Adolescent Mental Health Services (CAMHS). A pre-CAMHS service offers a single point of entry and looked after children are prioritised through direct referral and effective triage processes. CAMHS services are further strengthened through the provision of an outreach support and crisis assessment team (OSCA). This service provides good support for children living out of area and within a two hour drive of Oxford. To ensure that looked after children and young people are receiving health services that meet their specific needs, the designated doctor undertakes

regular visits to those children with high risk, complex needs who live in specialist placements.

58. The young people's drug and alcohol service provides treatment and support for young people aged up to 19 years, including looked after children. The service also offers support to those affected by a parent's or family member's substance misuse. There is an increasing number of looked after young people accessing support from this early intervention service and this has led to improved emotional stability in most cases. Offending rates among looked after children are low at 3.6%. When children go missing from care there is a well-defined reporting process which means that the social worker, team manager and IRO are immediately informed. Return interviews are timely and include thoughtful discussions with young people about why they went missing and what they did when they were away from their placement.

59. Looked after children and young people are encouraged and supported to pursue leisure activities. Looked after children receive leisure passes giving free entry to some leisure facilities within Oxford. The local authority organises innovative events for its children. For example a ball was attended by 100 looked after children and care leavers, and young people spoken to as part of the inspection report that this was a great success.

60. The Children in Care Council is a well-led, passionate and highly effective group of young people who are making a tangible difference to the experiences of all children who are looked after in Oxfordshire. For example, the CICC has effectively reviewed the Pledge as well as reviewed strategies to ensure children placed out of area are well included in both events and communication processes. Their views are well considered by senior managers. The group is helping the local authority to understand what makes a good social worker, and is assisting it in recruiting those who are most likely to fit this profile.

61. Foster carers are well supported by their supervising social workers and are helped to develop skills and expertise through a range of training opportunities. While formal supervision is of good quality, records suggest that it is not always frequent enough.

62. The great majority of looked after children have an up-to-date Personal Education Plan (PEP). These plans are reviewed regularly and focus on their attainment and progress, as well as their personal, social and emotional development. However, they do not always set out actions and success criteria clearly enough. All the plans showed that pupil premium funding was being used appropriately but none of them included success criteria to measure the impact of this investment on the children's attainment and progress.

63. The virtual school is well led. Its staff have worked hard to establish close relationships with schools and to challenge as well as support them. There is

evidence that the virtual school is engaged in children looked after reviews and their contribution is leading to detailed and helpful discussions and plans relating to children and young people's attendance, attainment and goals.

64. Absence from school rates for looked after children have improved, partly as a result of daily monitoring of those placed outside Oxfordshire, as well as within the authority. Those with high absence rates receive a range of additional support, including a programme to help them re-engage with education. A small minority of looked after children attend schools that are less than good. Where a school has been judged inadequate, education officers closely monitor education arrangements and scrutinise impact on individual looked after children.

65. For over five years, no child looked after by the authority has been permanently excluded from school. Whilst the rate of fixed-term exclusions is improving, it remains worse than for all looked after children nationally. The authority has identified schools where the rate of multiple exclusions is very high and has worked to help them improve the situation, for example by revising the care plans for children.

66. Attainment at the end of Key Stages 2 and 4 is well below the averages for all pupils in the county and nationally. The proportion of looked after children who make expected progress in mathematics and reading is higher than for all pupils nationally and locally but the proportion *exceeding* expectations is below average. Overall, the educational attainment of looked after children in Oxfordshire does not indicate sufficient aspiration for them by the local authority and its partners.

The graded judgment for adoption performance is good.

67. Oxfordshire's adoption service operates with a clear emphasis on quality and timeliness. It uses the National Register to identify potential placements and has increased the number of family finding staff. It has a knowledgeable, committed and enthusiastic workforce. These factors contribute to good outcomes for children.

68. Oxfordshire places a high priority on securing permanent homes for children. The drive to increase the number of adoptive placements has proved effective. In 2013–2014, Adoption Orders were made for 44 children. This is an increase of 38% on the previous year. The local authority has identified the need to increase the number of adoptions of children over 5 years and, as a result of effective targeting and recruitment, 13 adoptive placements were made in 2013–2014 for children aged 5 years and over.

69. Where there are potential delays in the adoption process they are carefully monitored, and the reasons understood. Most such cases are of children with particularly complex needs. The local authority prioritises the need to find the

right placement for children with complex needs even when this impacts upon overall timeliness statistics.

70. The improved timeliness of court proceedings in Oxfordshire at 27 weeks is helping to ensure that children are placed with adopters more quickly. The Adoption Scorecard shows that Oxfordshire is performing well, achieving an average of 450 days from the time a child enters care to being placed with an adoptive family. This is 30% better than the national average. The time between receiving the placement order and deciding on a match is 114 days, which is 45% better than the national average. In 2012–2013 the number of placement disruptions prior to the final adoption order being made was very small.

71. Monthly Permanency Planning meetings are held in each of the area social work teams. These are routinely attended by social workers and adoption team staff. Legal support, IRO input, and other contributions are provided where required. The key purpose of the meetings is to identify and begin to track prospective adoption cases at an early stage. They ensure that in most cases decisions to begin the process of family finding for a child are taken promptly.

72. Although the local authority demonstrates urgency and care in all adoption work, and there is some use of fostering to adopt and parallel planning, neither approach is fully embedded. As a result, a small number of children experience delay in achieving permanence. However action is now being taken to implement more effective parallel planning arrangements where this is deemed to be in the best interests of children.

73. The recruitment, preparation, assessment, training and support of adopters are good. Existing adopters are involved in preparation training for future adopters. This work has enabled potential adopters to understand better the implications of adopting sibling groups. As a result, more sibling groups have been adopted over the past year. In addition, this work has been particularly effective in leading to a small increase in adoptions of children with complex needs.

74. There are three agency decision makers, who have the knowledge and experience to undertake their role effectively. They all understand the need to ensure that they are not involved in making decisions about cases for which they have direct accountability. The independent adoption panel chair services three Panels, each of which has its own vice-chair. This ensures consistency in relation to both process and decision-making. Panels are always quorate, and can be quickly convened when urgent decisions are required, for example to meet legal deadlines. This flexibility contributes to the avoidance of delay for children.

75. Legal and medical advice to adoption panels is readily available and of good quality. Training for panel members is regular and relevant. Recent training

events have involved adopters describing the process to panel members from their perspective and discussions on the issue of diversity.

76. An annual adoption report is submitted to the Corporate Parenting Panel. Management information on adoption is prepared every six months for discussion by the senior management team, ensuring that the local authority has an effective managerial overview of the service provided.

77. Support for adopters is comprehensive. The adoption service includes social workers whose specialism is providing support to adoptive parents. Parenting courses are provided and adopters are able to access some of the courses run by the learning and development team. Effective support is also provided by the ATTACH team through specialist therapeutic interventions.

78. The adoption service maintains a list of all adopters and ensures that they receive newsletters and information. The quarterly Oxfordshire Adoption Support Newsletter is a good source of professionally produced material for adopters. This includes information about legislative changes, training and support opportunities and events aimed at assisting adopters to form their own networks.

79. A buddying system enables new adopters to benefit from the knowledge of more experienced adopters who have been trained to offer one-to-one support. This ensures that adopters are well supported and their expectations are clear, and helps limit the number of placement breakdowns.

80. The adoption service also provides good support to birth relatives through the process of adoption and beyond. A dedicated worker, independent of the decision-making processes for adoption, has initiated a group for birth mothers whose children have been adopted, and is in the process of setting up a similar group for birth grandparents.

The graded judgement for the experiences and progress of care leavers is good

81. Care leavers told inspectors that they feel safe in their accommodation and in their local community. They feel well supported by their social workers and personal advisers, who are good at helping them become independent. Examples of this include financial advice, cooking and healthy eating.

82. Pathway plans are of good quality and are in place for all care leavers. Case recording is up to date and demonstrates regular and effective work with care leavers. There is a clear focus in pathway plans on preparation for independence. All plans include clear evidence of management oversight. They clearly identify the specific needs of the young person, including contact arrangements with family and friends, issues with regard to identity and, where necessary, health and safety.

83. Care leavers know how to contact their social worker and personal adviser. However, the frequency of planned contacts with care leavers was often set at three monthly. While this minimum frequency is often amended in light of emerging needs, a small minority of care leavers don't see their social worker or personal adviser as often as they would wish. This reduces the scope for early help in any problems that may arise.

84. Care leavers are able to remain in their foster placements beyond the age of 18. This opportunity is welcomed by most care leavers and ensures that undue pressure is not placed upon them to move before they are ready. It also enables them to make the transition to further or higher education, employment and training from a stable home life, and this increases the chances of success.

85. A very small number of care leavers were in bed and breakfast accommodation at the time of the inspection. These are cases where the young people have refused to accept alternative accommodation offered. The local authority has completed comprehensive risk assessments to minimise the adverse effect of this accommodation. Management scrutiny of the welfare of these young people is frequent and challenging and ensures that suitable alternatives are actively sought.

86. Bespoke support services are provided to unaccompanied asylum seeking children. An independent provider has been commissioned to provide semi-independent accommodation specifically for unaccompanied asylum seekers and high quality support is provided in relation to their legal status, communication and other issues.

87. Effective commissioning arrangements are in place for some types of accommodation for care leavers, for example supported lodgings schemes. All contracts now include a 12-week notice period so that, in all but the most serious of situations, sufficient time is made available to allow for negotiation with the young person and the provider and, when required, for an alternative plan to be put in place. This ensures that the number of placement disruptions is minimised.

88. The health needs of care leavers are routinely monitored and addressed through the pathway plan. All care leavers have a health passport. Care leavers report that their health is well promoted and they are encouraged to live a healthy lifestyle. Most care leavers know how to access their health records should they wish to do so.

89. The proportion of care leavers who are not in education, employment or training (NEET) has increased and is significantly higher than the proportion for all young people in Oxfordshire. There are currently 70 care leavers at college, and 32 at university, and it is not clear how the progress of this group of care leavers is monitored by the local authority. The colleges do complete NEET support plans for those young people who are not attending but,

although these are shared with social workers and personal advisers, the virtual head is not made aware of them routinely. This adversely impacts on effective scrutiny and tracking of individual care leavers.

90. A number of care leavers are involved in CiCC. Many have made helpful contributions by describing their care experiences, and it provides an additional source of support and advice for young people as they move towards independence. Officers working to support the CiCC speak warmly of the achievements of many care leavers, there are good relationships between care leavers and these staff.

91. Financial support packages are available for care leavers, and in most cases entitlements are clearly explained. However, care leavers who were consulted had variable levels of understanding about some of the details, especially in relation to support into further or higher education.

Leadership, management and governance are good

92. Effective and resolute leadership in Oxfordshire has resulted in improving services and outcomes for children and young people. The local authority knows its strengths and weaknesses well. Its own assessment of its services for children and young people is comprehensive, and identifies strengths and priorities for development. Feedback from children, young people, parents, carers, staff and stakeholders in Oxfordshire is central to identifying strategic priorities and informing service development.

93. The key priorities for Oxfordshire Children, Education and Families are identified and reported through the children and young people's plan. This aligns with the Joint Strategic Needs Assessment (JSNA) and the priorities of the Health and Well-Being Board. The priorities are reflected in the Business Strategy, Early Intervention Strategy, threshold matrix, commissioning strategy, and placement strategy.

94. Clear lines of accountability and scrutiny between political leaders, strategic directors and operational staff ensure that key issues, challenges and strengths in services for children are well understood. The DCS has effective working relationships with the chief executive, political leaders and OSCB chair. He demonstrates clear ambitions for children and young people and has developed a culture of learning. He works well and has developed strong and effective links with partners in both statutory and voluntary sectors.

95. Despite the significant work and commitment to planning and service development, the Children and Young People's Partnership Board (part of the Health and Well-Being Board) has not yet established effective governance arrangements with the OSCB to ensure a robust framework for safeguarding children and young people. While the local authority recognises the need to ensure governance arrangements are strengthened, it is evident that current arrangements have not had an adverse effect on the work of the OSCB.

96. The local authority, through its placement strategy, has identified and is responding to the need to develop a wider choice of services for children and young people across Oxfordshire. Working closely with partners, especially health services, it is securing additional provision within the county to improve outcomes for children and keep the 'riskiest closest'. The placement strategy is aligned to other key priorities aimed at ensuring a sufficient supply of adopters, foster carers, edge of care services and supported housing. However, the number of foster carers needed, particularly for older looked after children, remains insufficient for the local demand. Following consultation with parents, carers and children, a new jointly-commissioned residential academy for children and young people with autism has been commissioned and is opening in September 2014.

97. Commissioning is largely effective, though the failure to recruit enough foster carers within the county boundary means that too many children are placed away from their own communities. Commissioning priorities derive form the JSNA, Health and Well-being Board and Young People's Partnership Board. They are informed by learning from serious case reviews and the views of children, young people, parents and carers. This ensures that provision such as early help is well targeted. Contracts with providers are subject to robust quality assurance that includes routine monitoring and review. For example, clear procedures are followed by social workers when a children's home or fostering agency is judged to require improvement or to be inadequate. This ensures that necessary steps are taken to ensure children are safe and their needs met.

98. Corporate parenting panel members are enthusiastic and committed to looked after children in Oxfordshire. The CiCC have dedicated agenda time to meet with the panel and discuss their issues. To enable them to have a clearer understanding of issues and to drive improvement, the corporate parenting panel has requested additional information on matters such as children missing from care, the role and effectiveness of the virtual school and supported housing for care leavers. The panel members maintain a high profile across the local authority and have effective links with district councils, as well as regular contact with the local authority's children's homes, children's centres and early intervention hubs.

99. Children and young people are actively consulted and their views considered in the development of services, staff recruitment and training processes. They have influence through their strategic representation on the Children and Young People's Partnership Board. They are regularly involved in recruitment of social workers and have provided an 'expert by experience' view to conferences, for example the OSCB conference on risky behaviours. The views of children and young people have also informed service development and redesign, for example in relation to advocacy and independent visiting.

100. The influence of the Principal Social Worker, appointed in December 2013, is developing and beginning to demonstrate improvements in service

development and outcomes for children and young people. The role, in line with the expectations of the College of Social Work, has sufficient status to influence the corporate management team but maintains an effective link with frontline services through performance management and quality auditing. Findings from 'listening events' led by the principal social worker in all three area social work offices have informed recent developments. These include caseload reductions for social workers, increased use of administrative support to improve efficiency, enhanced training for all staff and the introduction of action learning sets to meet the training needs of senior practitioners.

101. Performance management arrangements are well established with good reporting to senior managers and area teams. This contributes to improvements in practice in frontline services. Quality auditing is undertaken routinely across frontline services. Audits consider practice and casework issues and have resulted in improvements, for example in the quality of supervision and of assessment work. Thematic audits are commissioned by senior management in response to issues arising from performance data, complaints and serious case reviews. The team recently audited the quality of work for care proceedings and permanency planning.

102. Management oversight of practice is good, with effective use of performance data and an improving application of learning from audits and serious case reviews. Staff routinely receive supervision from managers. The quality of supervision is improving and inspectors found evidence of some good reflective supervision. This is strengthened by the introduction of 'signs of safety' meetings, providing effective oversight of casework to prevent drift and to focus on outcomes for children and young people.

103. In 2013–2014 only a very small number of young people made a formal complaint to the local authority. Children and young people in the CiCC were clear about their right to complain and felt confident in approaching senior managers if their informal 'grumbles' were not addressed. However, among all children and young people receiving a service who were surveyed by the, CICC, only 62% knew how to complain and 7% of these were reluctant to complain in case of any repercussion. The CiCC has produced a 'contact card' to advise looked after children on how to complain, and there are clear criteria within the 'Oxford Pledge', but this information is not in an appropriate format to help younger children understand how to complain.

104. Learning from complaints is used effectively to inform practice and service development. For example, effective learning from case auditing and complaints resulted in specific training for staff in working with fathers. This has led to an increase in the number of fathers actively involved in work under child protection processes. Consequently, the number of complaints about this issue has reduced. The corporate parenting panel routinely consider themes from complaints as part of their learning and development strategy.

105. Effective relationships between the Children and Family Court Advisory and Support Service (Cafcass), the local Family Justice Board and the local authority legal team have resulted in care proceedings now being dealt with within 27 weeks (better than the national average and almost meeting the government target of 26 weeks). This, along with improvements in the quality of assessments, contributes to the avoidance of delay in resolving children's progress towards secure, permanent arrangements.

106. Children and young people in Oxfordshire benefit from a stable workforce with low use of agency social workers. Staff report that this is because of a culture of effective support, reducing caseloads and a good living and working environment. The rate of social work staff turnover is 9%, with national levels at 15%. The use of agency staff is currently at 5.5% (approximately three full time staff), significantly better than that for comparable authorities and the national figure of 12%. Average staff sickness rates are 8 days per annum with a target of 7 days, again below that of similar authorities and England as a whole (10 days and 11 days respectively).

107. Oxfordshire's workforce strategy is linked closely to the social work reform board and employer standards. It includes clear actions to build a stable and competent workforce. Following a recent review, the local authority invested £1.4 million to reduce social worker caseloads, introduce an assistant team manager role to strengthen first line management, increase starting salaries for new social workers and develop a clear staff progression framework. Work is underway to develop a 'professional capabilities and competence' framework that is linked to progression and pay.

108. Children, young people and families are supported by staff who have appropriate skills and are suitably experienced. Training needs are identified well and often as a result of quality assurance findings, learning from complaints and serious case reviews. A comprehensive range of in-house training, including mandatory training, is provided. There are good opportunities through the use of devolved budgets for individual teams to commission specific training and resources, for example, team exercises, a central on-line assessment tool, conferences and development days.

What the inspection judgements mean: the local authority

An **outstanding** local authority leads highly effective services that contribute to significantly improved outcomes for children and young people who need help and protection and care. Their progress exceeds expectations and is sustained over time.

A **good** local authority leads effective services that help, protect and care for children and young people and those who are looked after and care leavers have their welfare safeguarded and promoted.

In a local authority that **requires improvement**, there are no widespread or serious failures that create or leave children being harmed or at risk of harm. The welfare of looked after children is safeguarded and promoted. Minimum requirements are in place, however, the authority is not yet delivering good protection, help and care for children, young people and families.

A local authority that is **inadequate** is providing services where there are widespread or serious failures that create or leave children being harmed or at risk of harm or result in children looked after or care leavers not having their welfare safeguarded and promoted.

Section 2: The effectiveness of the Local Safeguarding Children Board

The effectiveness of the LSCB is good.

Areas for improvement:

109. Increase the influence of the Board by clarifying and strengthening the relationship with other key strategic groups, particularly the Children and Young People's Partnership.

110. Ensure that the OSCB annual report has a closer focus on the child's experiences of safeguarding services.

111. Further develop work to ensure that the experiences of children, young people and their families contribute to improvement of services and training, and in particular, provide feedback to them to show how their contribution has influenced service development.

112. Improve the evaluation of multi-agency safeguarding training, particularly of its longer term impact on the quality of practice in partner agencies.

113. Accelerate the development and implementation of a strategy in relation to female genital mutilation.

Key strengths and weaknesses of the OSCB

114. The Board is appropriately constituted and fulfils its statutory duties. Its terms of reference are clear. It is compliant with the expectations set out in Working Together 2013 to submit an annual report to the Health and Well-Being Board. It is generally well attended by members, including two lay members who demonstrate independent challenge to the work of the Board. Members are of sufficient seniority in their own organisations to be able to commit resources to support the work of the Board.

115. A number of sub-groups are constituted alongside three Area Safeguarding Groups. These provide avenues for communication between strategic managers and practitioners. In addition, the safeguarding needs of vulnerable groups, including children and young people with disabilities, can be considered in greater depth.

116. Governance arrangements between the OSCB, its independent chair, the local authority's Chief Executive, the DCS and Lead Member are sound. However, links with other key partnerships such as the Children and Young People's Partnership and the Health and Well-Being Board are less mature and require further strengthening and formalisation.

117. The Board has until very recently been led by an interim independent chair who is held in high regard by partners. Despite the temporary nature of his

stewardship he has demonstrated constructive and robust challenge and has established a strong basis for continued progress. A new permanent chair has now taken over the role.

118. The Board has maintained progress in addressing the priorities within the current Business Plan (2013–15). Priorities have been informed by the JSNA as well as learning from serious case reviews, the comprehensive auditing programme and findings from the routine consideration of an extensive suite of performance information.

119. Progress is rigorously reviewed by the Board. Completed actions are closed down and remaining ones re-prioritised to meet objectives. This has led to tangible improvements in practice, including better attendance of relevant agencies at child protection conferences and core groups. Similarly, work is underway to develop a coordinated approach to tackling female genital mutilation.

120. Safeguarding is clearly a priority for the OSCB. Board members are well motivated and committed, and their desire to secure better outcomes for children, young people and their families is well evidenced by the progress of work within the sub-groups. For example, the 2012–13 audit of complex cases informed the planning of placements for looked after children and contributed to the multi-agency development of the overall looked after children placement strategy.

121. The Board maintains effective links with the Children in Care Council, actively seeking the views of looked after children and young people to improve the coordination and effectiveness of services. This includes advocating on their behalf to ensure the commitments within the Pledge are met.

122. The Board commissioned an external review of its effectiveness in July 2013. This led to a range of measures to improve its functioning, including improved representation from schools and colleges. As a result, the Board has strengthened its support and challenge to schools to provide effective safeguarding services.

123. Safeguarding audits are undertaken to ensure partner agencies comply with statutory requirements. These have identified a need for some agencies to be more rigorous in applying safe recruitment practices. Learning from these audits has been augmented by a very effective peer challenge event for partners, including the five District Councils. This year a questionnaire was added for practitioners to complete to test their safeguarding knowledge and skills.

124. The OSCB has ensured that there is a comprehensive range of up-to-date policies and procedures in place to help professionals understand and respond to safeguarding and child protection concerns. These offer clear explanations of, for example, the continuum of need from early help to child protection and

consent issues in information sharing. In January 2014, the Board published a revised thresholds document to help professionals refer children to the right services for their needs.

125. The views of children and young people have informed business planning and priority-setting, for example at the annual OSCB development day. An example was the decision to give a higher priority to e-on-line safety, which is now a major theme in the Risky Behaviours training programme. The OSCB offers an appropriate, range of training that is informed by messages from serious case reviews, emerging best practice and case file auditing. For example, the audit of working with male care givers led to the development of a new training course that has been launched very recently. Attendance is monitored and evaluation returns indicate that the training is valued and of high quality. However, there is little evaluation of the long term impact of training on standards of safeguarding practice and management, so its contribution to improvement is not evidenced. Such training is complemented by safeguarding bulletins and a newsletter distributed widely across the County and available on a bespoke and informative OSCB website.

126. SCRs and learning reviews are initiated appropriately by the standing Case Review and Governance Panel. The Quality Assurance sub-group works effectively to disseminate learning from SCRs undertaken following local concerns. Most notably this has led to the creation of the Kingfisher Team that works highly effectively to consider the individual needs of young people as well as wider issues for those at risk of child sexual exploitation.

127. Analysis of learning from SCRs nationally has led to the commendable practice of sharing with schools all police domestic abuse reports where there are children over five years of age. This enables school staff to understand and respond to the situations faced by these children and young people. A newly created learning and improvement officer post within the OSCB will further support dissemination of learning and best practice across agencies.

128. The OSCB Annual Report provides a rigorous assessment of safeguarding services in Oxfordshire, including consideration of private fostering and LADO Activity. However, it does not always focus enough on its impact on the experience of children who receive safeguarding or child protection help.

129. The Board has brought a focus to shaping strategy, policy and practice across the partnership, including on domestic violence. The development of toolkits to support the identification of cases of neglect and child sexual exploitation has been highly effective. These are now used extensively by almost all agencies.

130. The Board liaises effectively with Oxfordshire's Child Death Overview Panel (CDOP). This has a membership of appropriate professionals, is well attended and has clear terms of reference. Reports are made to the Board that have led to consideration of broad public health concerns. For example, there has

been a recent awareness-raising campaign on the risks of parents 'co-sleeping' with infants. All expectant parents have been given a room thermometer that incorporates messages about the dangers of this practice.

131. In the previous three years there have been seven serious incident notifications; of these, two notifications are awaiting a decision to go to serious case review and five are in the process of being evaluated. Lessons learned from local and national serious case reviews are effectively disseminated and contribute to improvements in practice.

What the inspection judgements mean: the LSCB

An **outstanding** LSCB is highly influential in improving the care and protection of children. Their evaluation of performance is exceptional and helps the local authority and its partners to understand the difference that services make and where they need to improve. The LSCB creates and fosters an effective learning culture.

An LSCB that is **good** coordinates the activity of statutory partners and monitors the effectiveness of local arrangements. Multi-agency training in the protection and care of children is effective and evaluated regularly for impact. The LSCB provides robust and rigorous evaluation and analysis of local performance that identifies areas for improvement and influences the planning and delivery of high-quality services.

An LSCB **requires improvement** if it does not yet demonstrate the characteristics of good.

An LSCB that is **inadequate** does not demonstrate that it has effective arrangements in place and the required skills to discharge its statutory functions. It does not understand the experiences of children and young people locally and fails to identify where improvements can be made.

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