Northamptonshire 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: 8 February 2016–10 March 2016

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Children's services in Northamptonshire require improvement to be good		
1. Children who need help and protection		Requires improvement
2. Children looked after and achieving permanence		Requires improvement
	2.1 Adoption performance	Requires improvement
	2.2 Experiences and progress of care leavers	Requires improvement
3. Leadership, management and governance		Requires improvement

[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

Northamptonshire children's services requires improvement to be good. Starting from a very low base, there has been progress in improving services across all areas of the child's journey since the last Ofsted inspections. Most of the progress, though, has yet to be fully embedded. There has also been too much of a focus by the council on processes needing to be completed rather than the day-to-day experience of children and young people and it is this that further improvements now need to address.

In 2013, three successive Ofsted inspections judged services for children and young people in Northamptonshire to be inadequate. Inspectors found serious and widespread weaknesses across all services, including child protection, children looked after and adoption. These deficiencies left many children and young people at risk of harm. Government intervention followed, including the establishment of an improvement board with multi-agency partners and an independent chair.

Over the last three years, there has been much focused work to improve services, with some success. On this inspection, inspectors saw no children at risk of immediate harm and this is a substantial improvement from the last inspections. There has been much work to improve the initial response to safeguarding concerns with: a robust multi-agency safeguarding hub (MASH) that responds to new referrals; a first response team that conducts child protection investigations; and the response to incidents of sexual exploitation (RISE) team, which focuses on children and young people who go missing or who are at risk of child sexual exploitation. Multi-agency work around early help support has also shown some improvements, although more still needs to be done to ensure the participation of all partner agencies. At the time of the last inspection, there were no dedicated services for care leavers: these were introduced promptly, providing much needed support to these young people.

Councillors and the chief executive have fully supported the improvement plan. They have committed an additional £62 million, over the last three years, to the service, and have confirmed to inspectors that this is the highest priority of the council, and that the budget increase will continue for at least the next four years. There has been more than a 20% increase in the numbers of children looked after, mainly due to the better recognition of need, but also to the increase in unaccompanied asylum seekers who are well supported by the council. The additional budget funds the greater costs of placements, the base workforce, the excellent social work academy and the substantial use of agency and temporary staff.

Over 43% of staff are employed through agencies, including managers at all levels of the organisation. Children and young people who were spoken to by inspectors repeatedly raised issues about agency workers who stayed for a short period of time, visited infrequently and at every changeover 'started again' in trying to get to know them and understand their complex histories.

Inspectors found the quality of social work practice to be variable, with much that needs further strengthening. In 2015, six basic standards were introduced by the council. As a result, all children and young people are now allocated to social workers who have more manageable caseloads and who are receiving some supervision; children and young people are being visited and their views sought; all cases now have a plan; and recording has improved, with chronologies and genograms, case summaries and visits noted. However, in many cases there were gaps or the supervision was poor, there were issues about the frequency or quality of visits and plans were not sufficiently focused. Inspectors also found, in the minority of cases, drift and delay experienced by children and young people.

Further improvements to ensure consistency, to focus on outcomes and to improve the quality of social work support will be substantially compromised if Northamptonshire children's services continue to rely on temporary staffing to provide the vast majority of its frontline services to vulnerable children and families. The council is well aware of these risks and is currently planning to develop a children's trust to outsource its children's services and improve its ability to attract high-quality permanent staffing. The plans are in too early a stage for inspectors to make any judgement over whether this will result in the essential improvements being made for children and young people in the county.

The council knows itself well. A self-assessment produced for this inspection was accurate. Overall, performance management provides a comprehensive picture of frontline services, although further work is needed to provide live data on the support being provided to care leavers: a new report is currently being piloted for this specific purpose. Quality assurance occurs across children's services. Inspectors found that audits were of variable quality, with some being excellent and others failing to identify poor work. They also found some examples of where deficiencies had been identified by auditors, child protection conference chairs or independent reviewing officers, but no changes had then occurred to address the identified delays. This was more often found in cases that were being managed by temporary staff. The quality of work from those social workers who had been through the social work academy was much better, with examples of good work.

Further improvements have been identified as needed by inspectors across the services for children. Most are focused on the need to ensure the consistency of social work and management practice, for example the quality of assessments, permanence plans and personal educational plans (PEPs). There are some areas that require more urgent focus: social work involving the council's legal services has too many unnecessary delays; private fostering is poorly responded to; children and young people who go missing from out of county placements do not receive the high-quality service provided for those who live in county; and the range of placements, including accommodation for care leavers, is insufficient to provide for all of those whose needs could be met in Northamptonshire.

Contents

The local authority

Previous Ofsted inspections

- The local authority operates four children's homes. They were all judged to be good or outstanding in their most recent Ofsted inspection.
- The previous inspection of the local authority's arrangements for the protection of children was in February 2013. The local authority was judged to be inadequate.
- The previous inspection of the local authority's services for looked after children was in July 2013. The local authority was judged to be inadequate.

Local leadership

- The director of children's services has been in post since March 2013.
- The chair of the Northamptonshire Safeguarding Children Board (NSCB) has been in post since March 2014.

Children living in this area

- Approximately 161,000 children and young people under the age of 18 years live in Northamptonshire. This is 22.5% of the total population in the area.
- Approximately 15% of the local authority's children are living in poverty.
- The proportion of children entitled to free school meals:
  - in primary schools is 13.3% (the national average is 15.6%)
  - in secondary schools is 11.8% (the national average is 13.9%).
- Children and young people from minority ethnic groups account for 12.6% of all children living in the area compared with 22% in the country as a whole.
- 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 13.7% (the national average is 19.4%)
  - in secondary schools is 10.5% (the national average is 15.0%).

Child protection in this area

- At 31 January 2016, 4,676 children had been identified through assessment as being formally in need of a specialist children's service. This is an increase from 4,180 at 31 March 2015.
- At 31 January 2016, 1,052 children and young people were the subject of a child protection plan. This is an increase from 988 at 31 March 2015.
- At 31 January 2016, 17 children lived in a privately arranged fostering placement. This is an increase from 13 at 31 March 2015.

- Since the last inspection, 21 serious incident notifications have been submitted to Ofsted and four serious case reviews have been completed or are ongoing at the time of the inspection.

Children looked after in this area

- At 31 January 2016, 977 children are being looked after by the local authority (a rate of 61.4 per 10,000 children). This is an increase from 935 (58 per 10,000 children) at 31 March 2015. Of this number:
  - 228 (or 23%) live outside the local authority area
  - 125 live in residential children's homes, of whom 56% live outside the authority area
  - none lives in residential special schools[2]
  - 655 live with foster families, of whom 15% live outside the authority area
  - 24 live with parents, of whom 17% live outside the authority area
  - 124 children are unaccompanied asylum-seeking children.
- In the last 12 months:
  - there have been 72 adoptions
  - 75 children became subject of special guardianship orders
  - 389 children ceased to be looked after, of whom 5% subsequently returned to be looked after
  - 38 children and young people ceased to be looked after and moved on to independent living
  - six (of whom five are in university/student accommodation) children and young people ceased to be looked after and are now living in houses of multiple occupation.

Recommendations

1. Prioritise the recruitment and retention of good-quality permanent social care staff. This should include ensuring that measures are in place to minimise the impact of the turnover of agency staff on individual children, young people and families.

2. Take steps to strengthen the role of first line managers, ensuring that this group is stable and that they consistently provide high-quality case supervision that reviews and drives plans for children and young people.

3. Improve quality assurance, including the auditing of casework, to ensure that there is a robust focus on tackling weaker practice.

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

4. Ensure that all children and young people identified as being in need, including unborn children and children looked after, benefit from timely, regular and thorough assessments of their needs. Subsequent plans should be outcome focused, and include appropriate timescales as well as clear contingency plans.

5. With partner agencies, improve the response to homeless 16- to 18-year-olds, including improving the range of suitable accommodation.

6. Improve the consistency of the quality of child protection enquiries, including ensuring that unnecessary investigations are not undertaken.

7. Review the assessment and planning for those children and young people subject to private fostering regulations to improve identification of such children and young people and ensure that they receive appropriate services to support their needs.

8. Strengthen the arrangements for children and young people who go missing, including for those placed out of county, and undertake an analysis of all return home interviews in order that the local authority can better understand the needs of these young people.

9. Increase the availability and range of local placements to enable children and young people to be placed in accordance with their needs. This includes increasing the range of safe and appropriate accommodation available to care leavers.

10. Improve the timeliness and the quality of evidence for court work, including pre-proceedings work. This should also include ensuring that assessments of connected persons are timely and robust and that children, young people and their carers receive appropriate support.

11. Ensure that the permanence plans for children and young people are progressed with the pace and urgency that is needed, including achieving legal or emotional security for children and young people.

12. Improve the availability and take-up of independent visitors for children looked after.

13. Increase the focus on personal educational plans so that all children looked after have meaningful targets that promote their educational and emotional development and focus on spending of pupil premium plus fund effectively.

14. Ensure that children and young people are prepared well for moving to their permanent home, including starting life story work at an earlier stage.

15. Ensure that adopters are well prepared during the matching process.

16. Improve care leavers participation in education, employment and training, in particular in apprenticeships run by the council. This should include improving

pathway planning and ensuring that personal advisers challenge care leavers and set challenging and demanding targets for them.

17. Improve the proportion of young people aged 19 to 21 years who remain with their carers in 'staying put' arrangements.

Summary for children and young people

- Senior managers have worked hard to improve services for children, young people and families and have made progress since inspectors last visited. However, these services are not yet good enough.
- Professionals, such as social workers and teachers, have become better at providing children, young people and families with the right help when they need it. When professionals first look at a case, they usually make the right decisions and pass the case on to the right people. However, workers are not always thorough enough when they look at the risks to children and young people and they do not always do enough to understand what children and young people need. Their assessments of the needs of parents and their unborn babies are not good enough.
- When professionals produce plans to help children, young people and families, they do not make them clear enough and they do not make sure that actions are completed in time. Staffing changes mean that social workers are changed too often, and this slows down the speed with which they are able to help.
- When children need to become looked after, social workers do not always make sure that arrangements are the best they could be for children. There are too many delays in making sure that children and young people are placed in the right type of care. Changes to social workers slow down the speed with which permanent arrangements are made. There are not enough placements available for children and young people, so children and young people are being placed far away from their families.
- When homes are found for children and young people, they are usually good. Children and young people are safe, happy and feel that they belong. Foster carers are helped to make placements as good as they can be.
- Children looked after do not do as well at school as other children, although they do as well as children looked after in other parts of the country. Staff from the local authority have made many changes and work hard to ensure that all children looked after go to the school that is best for them. However, the plans that they make with teachers and social workers to help these children to do better at school are not good enough.
- The number of children looked after who are adopted is increasing. Managers understand the things that cause delays in adoption and have made improvements. However, adoption processes remain too slow and adopters are not prepared well enough. This means that children and young people wait a long time to be adopted and, in some cases, adoption plans are not worked out.
- Many children and young people leaving care are given enough help to make sure that they can cope. Personal advisers stay in touch with care leavers and help them to live on their own. However, there are not enough suitable places for them to live, and not enough of them stay with their foster carers when they are over 18 years old. Personal advisers often do not do enough to get young people into jobs or education.

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

Summary

Since the Ofsted child protection inspection in February 2013, the council has committed substantial resources to ensure that children and young people are immediately protected. Children and young people are visited, their views recorded and addressed and assessments are undertaken. However, there continues to be too much variability in terms of basic social work practice and in management oversight.

Early help services for families have improved, but there remains work to do to embed the local authority changes in practice and ensure that all partner agencies are engaged in providing and coordinating early help to meet the needs of children and young people who do not meet the threshold for social care intervention.

A well-resourced multi-agency safeguarding hub (MASH) is enhanced by the co-location of key agencies. Partner agencies understand thresholds better and this leads to effective and timely referrals. Out of hours services (OOHS) provide a good response and coordinate well with the daytime services.

Assessments are not consistently thorough. As a result, the needs of children and young people are not always well understood, including where there are concerns prior to children being born. In most cases, there is an up-to-date plan in place, but a high proportion of these do not fully address the needs of children and young people. The quality of strategy meetings and child protection enquiries is variable, and too many young people are unnecessarily subject to investigations that do not result in further action. Child protection conferences and reviews are not always routinely driving plans. Although there has been some recent improvements due to increased stability in the team who chair these conferences, the impact has not yet been fully realised.

The quality of support for children and young people who are subject to private fostering is poor, and these vulnerable children do not receive the help and support that they need. Support for homeless 16- to 18-year-olds is also poorly coordinated, and too many are placed in bed and breakfast accommodation.

There is a robust multi-agency response to children and young people who go missing or who are identified as being at risk of child sexual exploitation, through the RISE team, which delivers effective services to reduce risk. Return home interviews occur, but there is no analysis of whether there are any themes to improve the support to this vulnerable group.

There is good and coordinated work to tackle domestic abuse incidents and address concerns about radicalism and female genital mutilation.

Inspection findings

18. The local authority has recently undertaken a review of its early help services and, as a result, allocated additional resources, which has improved this work. Improvements include the development of an early help multi-agency hub, staffed by relevant agencies and supported by a team of knowledgeable and experienced staff, including a domestic abuse adviser and qualified social workers. Through the NSCB, training has been delivered to over 800 professionals and this has resulted in a substantial increase in early help assessments (EHAs), from 1,565 in 2013–14 to 2,747 in 2014–15. Overall though, the quality of early help support continues to be too variable. Much still needs to be done to embed the changes in practice across the county, evaluate impact and ensure that all partner agencies, such as health, housing and adult services, are fully identifying needs and assessing families that may need help.

19. In the main, agency representatives told inspectors that they now better understand the thresholds for referring families to children's social care and that these are appropriate. Most agencies describe a positive experience in contacting the MASH. The MASH is supported by an efficient and well-run council customer service centre, leading to a timelier and better quality response to requests for assistance.

20. The MASH is well resourced, with key agencies such as the council social workers, Northamptonshire Police, health partners and education co-located, which enhances communication and information sharing processes. All referrals are Red, Amber and Green-rated and practice managers make good use of a visual tracker tool that identifies the progress of each case. Priority referrals are almost always progressed promptly. Where cases are not identified as urgent, a prompt response has not always occurred from all agencies, in particular from health partners. Additional resources have recently been secured from partner agencies to improve their response times to non-urgent referrals. Inspectors did not identify any child left at risk because of the delays.

21. Qualified and experienced social workers always make decisions about actions and outcomes. This includes making extensive efforts to ensure that consent from parents is in place and that parents understand what this means. A 'safe decision check' system ensures that senior managers double-check case outcomes, enhancing management oversight of safeguarding practice. The council provides feedback to agencies when referrals lack clarity or they have not promptly contacted the MASH.

22. The OOHS is effective. The dedicated team provides an emergency response outside of office hours for children, young people and families who are in crisis, and offers appropriate interventions in the vast majority of the cases. OOHS work is comprehensive and well coordinated, with a good consideration of risks. Daytime teams receive appropriate information to assist with follow-up where needed.

23. The council had a high number of repeat referrals from other agencies. At the end of 2014–15, this stood at 35.6%, and was well above the national average of 24%. However, the changes to the coordination of early help and the MASH have led to a reduction in re-referral rates to 27%, which is more in line with the national average.

24. The Northamptonshire housing protocol for homeless 16- to 18-year-olds is not robust. There are a number of district councils with responsibility for provision of accommodation. There is, though, no joint process involving social care and no provision of family support, mediation or family group conferencing to prevent homelessness at an early stage. Council records show that nine young people aged 16 to 20 years have been placed in bed and breakfast accommodation over the last six months. In three of these cases, the use of this accommodation was as an emergency measure to respond to an immediate need and the young people were moved rapidly to more appropriate accommodation. However, in the remaining six cases, there were substantial and unnecessary delays in securing more appropriate accommodation (recommendation).

25. Northamptonshire has higher numbers of children and young people subject to protection plans than the national and statistical neighbour average. It has seen an increase from 49.8 per 10,000 population in 2013–14 to 64 per 10,000 in 2014–15 (the statistical neighbour was 41.3 and England national average 42.9 for the same year), reflecting the more robust approach by the council to addressing safeguarding concerns.

26. In the main, the quality of child protection work in the MASH is good. Where children and young people are referred to the MASH as potentially at risk of harm, strategy meetings take place promptly and are attended by multi-agency partners and chaired by a social care manager. Risks are effectively evaluated to determine actions needed to safeguard the child.

27. The quality of the child protection work in the longer-term social work teams is inconsistent. Although threshold decisions for child protection enquiries were appropriate overall, in some cases, the rationale for decisions lacked clarity, key information was not always recorded and risk analysis was limited. Inspectors found a small number of young people over the age of 16 years who had been unnecessarily subject to child protection processes.

28. Assessments are not consistently thorough. They do not always effectively evaluate the experience of a child or young person and, as a result, social workers do not always understand their needs well enough. Case histories do not always inform the assessment and this leads to some poor analysis. For instance, on some cases, there has been a lack of understanding of the impact of parental mental health or substance abuse issues on children and young people. Research is rarely used to inform the findings of the assessments. Pre-birth assessments are also not consistently timely and are variable in quality,

which leads to some children not having robust plans in place when they are born.

29. The council has recently introduced, what they describe as, a single assessment process. Contradictorily, this is in two stages: some work is planned to be conducted in the first response service and other longer-term work in the safeguarding and care planning teams. Inspectors found, though, that almost all assessments were done quickly in the first response service and that as a result some children, young people and families did not receive the thorough assessment that they needed. However, most assessments take into consideration the potential or actual impact on the child of disability, ethnicity and religion. Good work was also seen by inspectors in assessing the needs of unaccompanied asylum seekers.

30. The development of the dedicated disabled children's team has led to increased knowledge and specialism in this area. Historically, children were transferred to the adult transition teams at the age of 14 years. Now, however, children's social workers hold cases until a young person turns 18 years old, with gradually increased interaction with the transitions workers. This leads to a more effective handover to adult services. A range of developments within the last six months includes improving the short breaks policy and procedures to increase the range of available support. Children in need work carried out in this team, and seen by inspectors, was similarly variable in quality to that in the longer-term child care teams.

31. Social workers visit children and young people and usually they see them alone. In the main the views of children and young people are recorded appropriately. Not all children and young people benefit from comprehensive good-quality direct work. Too often, the focus of the work is on monitoring parents and not on understanding the experience of the child or young person.

32. Children, young people and parents have good access to independent advocacy to support them in attending child protection meetings. In 2015–16, the service directly supported children and young people to attend 82 conferences and gathered the views of 279 children and young people to ensure that their voices are heard in such meetings.

33. Due to the high number of temporary and agency workers and managers, a small number of children and young people experience drift and delay in the progression of their plans. In most cases, there is an up-to-date plan, but these are of variable quality and do not always fully address the needs of the child. Overall, inspectors found that plans were not SMART (specific, measurable, achievable, realistic and time-bound) or outcome focused and did not contain appropriate timescales. Contingency planning has not always been identified. These shortfalls in written plans are particularly critical given the sometimes frequent change of social worker.

34. Child protection conferences and reviews have not always been effective at co-coordinating plans. There have been some recent improvements to the reviewing service, including an increase in the number of child protection chairs and this has led to some stability in the service, but the impact of this has not yet been fully realised. The multi-agency commitment to child protection meetings is variable, and performance information highlights that for some recent child protection reviews only 45% of invited agency representatives attended.

35. There are effective systems in place to deal with allegations against professionals who may present risks to children and young people. Awareness raising about the management of such allegations has led to a 6% increase in referrals this year. Cases seen by inspectors demonstrated a robust and timely management of referrals, with police and other agencies involved appropriately.

36. Children and young people who are at risk of sexual exploitation benefit from the services of the specialist multi-agency RISE team. There are effective systems in place, with episodes of going missing and other intelligence considered daily. The service undertakes all return home interviews (RHI) for those children and young people who go missing and live in Northamptonshire, including those placed there by other local authorities. Overall, 82% of incidents of going missing resulted in a RHI being offered and 62% of those were within the 72-hour timescale set by the council. The RHIs that were observed by inspectors were detailed. The risk analysis was comprehensive and they included management sign-off. Social workers, review officers and police routinely receive copies of the completed reports. However, an overall evaluation of RHIs has not been undertaken to help leaders understand the wider patterns and trends. This reduces the impact of the otherwise strong arrangements.

37. The inclusion team has effective processes in place to trace children and young people who go missing from school. Council data identify that there were 249 children and young people who were not attending their elected school in December 2015, of which nine were newly identified and 18 had recently been traced. The data is monitored by senior managers and the NSCB. Reviews occur if the child or young person is not immediately located, and where there is a safeguarding risk the team makes referrals to the MASH.

38. There are appropriate systems in place for monitoring children and young people who are electively home educated. There are currently 506 children and young people being home educated in the county. Where a child or young person is withdrawn from school or where parents elect not to register them with a school, the inclusion team makes contact with the family to ascertain the reasons for this and, if appropriate, to plan for a return of the child or young person to school. The inclusion team will make approaches to the parents to arrange a visit to see the child and to ensure that parents have an appropriate programme of work for their child. The inclusion team provides a small number of services to support elective home education. For example, they provide a

facility to register children for GCSE examinations. The inclusion team holds an annual review to monitor and promote the needs of the small number of children and young people who have a statement of special educational needs.

39. If a child or young person is known to social care and becomes home educated, there is a joint investigation of the child's or young person's circumstances by the inclusion team and the social care team. Where there are concerns, including fears of radicalisation and extremism, the team refers the case to the MASH for further assessment.

40. The council and its partner agencies are aware of their 'Prevent' duty and, due to their awareness raising and training programmes, there has been a small increase in the number of referrals, in particular from schools.

41. Effective awareness raising has enhanced multi-agency understanding of female genital mutilation. Inspectors saw good responses by professionals to these issues.

42. Work to tackle domestic violence is well coordinated and professionals understand thresholds. Domestic abuse incidents receive effective triage through the MASH where social workers and multi-agency partners assess risk appropriately using the domestic abuse, stalking and honour based violence tool. Schools and health services now also receive information relating to domestic abuse incidents. This helps them in providing additional support to children, young people and families. Multi-agency risk assessment conferences (MARACs) take place regularly throughout the county, and professionals provide detailed and relevant information to help inform the risk management plan. Multi-agency plans are well formulated and the local MARAC coordinator ensures that actions are completed.

43. The number of private fostering notifications is low, with only 16 children and young people identified as being subject to private fostering regulations at the time of the inspection. Fifty per cent of these are overseas students staying with host families. Overall, the quality of assessments, visiting patterns, plans and reviews are weak. A lead manager for private fostering is now in post, but this is too recent to be able to demonstrate impact (recommendation).

The experiences and progress of children looked after and achieving permanence	Requires improvement

Summary

Since the Ofsted inspection of services for children looked after in July 2013, there has been a substantial amount of work to improve support for children looked after. In particular, the council created a care leavers team, restructured services to better support those children and young people on the edge of care and focused on better meeting the needs of children and young people in need of permanence.

There has been a focus on improving the quality of placements and the outcomes achieved by children and young people in care. As a result, the majority of children looked after live in good and stable placements that meet their needs and keep them safe. However, the council has not been effective in meeting its sufficiency target for increasing the volume of local placements for children looked after. As a result, too many children and young people are placed over 20 miles from home.

The quality of the social work support is too variable, and in some cases remains very weak. Updated assessments are not completed: the reports prepared for reviews of children looked after are identified as carrying out this task, but are not fit for that purpose. The absence of a holistic assessment means that historical information, important recent events and increasing risks are not always effectively identified.

Court work is weak. Pre-proceedings work is not always considered for all cases where they would be of benefit, and delays occur in care proceedings. Children and young people's plans have not been consistently progressed with the pace and urgency that is needed. As a result, some children and young people have remained in placements without the legal or emotional security that would be achieved through legal proceedings or long-term matching with carers.

Some children looked after who return home from care have their needs assessed effectively and are well supported, but this is not consistent. Assessments of connected persons are too often delayed.

Children looked after who go missing or who are at risk of sexual exploitation receive well-coordinated support. Return interviews are offered to all children looked after within the local authority area who go missing, including those placed in Northamptonshire by other local authorities. However, for children and young people placed outside the local authority area, return interviews do not always happen and the quality of support lacks coordination.

The educational attainment of children looked after is too low, although it has improved. While the vast majority of children looked after attend a school that can meet their needs, their individual plans often lack clear targets and the spending of pupil premium plus funding is not sufficiently focused.

Systems to improve adoption performance have had some positive impact in, for

example, tracking of family finding and assessments of prospective adopters. There continues to be, though, a small number of children and young people who experienced poor support due to the previous inadequate practice. Currently, effective direct work is not being consistently undertaken at an early stage with children and young people including life story work. Some children and young people have not been robustly matched with their adoptive placements.

Many care leavers receive an appropriate level of support. However, there is insufficient specialist housing for them, and consequently too many live in unsuitable accommodation. Few care leavers have taken advantage of 'staying put' arrangements and remained with their previous carers. Too many young people leaving care fail to engage in employment or education. One of the key reasons is that personal advisers, although helpful and supportive, do not challenge young people enough or set demanding targets for them.

Inspection findings

45. 44. Most children and young people are positive about the support that they receive. Almost all describe living in good-quality placements that meet their needs. Frequent changes in social workers, however, adversely affect the continuity of relationships between them and their workers. The children spoken to by inspectors said that, although social workers provide them with the help that they need, they change too often.

46. Improvements have been achieved in the timeliness of statutory visits, with 90% of children and young people visited in timescales set by the local authority. Social workers see children and young people on their own and some use direct work to help children and young people make sense of their experiences.

47. Regular assessments are not completed for children looked after. For some young people, this has meant that it has been some years since their last formal assessment. Six-monthly reports produced for children looked after reviews are regarded by the local authority as the assessment task, allowing plans to be updated based on changing needs. However, weaknesses in some of the reports seen by inspectors make this process unreliable. Reports did not have sufficient breadth or depth and did not sufficiently address important changes in children and young people's circumstances. This meant that some children and young people were not having their needs fully met (recommendation).

48. Care plans appropriately consider key issues such as permanence plans, placements and contact with family and friends. However, the majority of care plans require improvement: some lack specificity and do not take into account enough the child's or young person's personality, interests or achievements. Only a minority of plans are good: these provide a rich source of information, sensitively identifying the specific needs of children and young people, including

religion, culture and sexual identity. Direct work, in particular life story work, is not consistently provided to children and young people at the stage in their lives when it is needed to help them make sense of their lives.

49. As a result of a newly developed co-located multi-agency health and social care team, there has been progress in the completion of health assessments, with 63.2% of initial health assessments and 93.6% of review health assessments completed in required timescales. Most care plans and reviews consider the health needs of children and young people, including smoking cessation and healthy eating. Performance in respect of the completion of dental checks is low at 57%, which is well below the local authority's own target. Health partners report that this is due to recording issues, which are being addressed through the development of the co-located service.

50. Children looked after also have access to a specialist Child and Adolescent Mental Health Service children looked after service, which provides a good range of psychological support services to foster carers and social workers. The council has strengthened its understanding of the emotional needs of children looked after by reintroducing the strengths and difficulties questionnaires. To date in 2015–16, strengths and difficulties questionnaires have been completed for 67.5% of children looked after, which is a significant improvement from only 2% in 2013–14.

51. Virtual school staff work closely with schools and other stakeholders to ensure that the educational needs of children and young people are met when they move schools, both at transition points and when the child's or young person's circumstances change. While the proportion of children looked after who attend a good school is low at 69%, which reflects the performance of schools in Northamptonshire, staff of the virtual school have made sure that in all but a very small minority of cases the child's or young person's school is able to fully meet the educational and emotional needs of the child or young person. A small number of children and young people, for whom attendance at school is difficult, attend alternative providers. Staff of the virtual school monitor closely the quality of this provision. For each of these children or young people, there are plans in place to return them to a full timetable as soon as possible.

52. Educational attainment of children looked after has improved and is now broadly in line with the low national rates for children looked after at all key stages. The progress made by children looked after in key stages 1 and 2 and key stages 2 to 4 has increased and is now broadly in line with national rates for children looked after. The proportion of children looked after who are persistently absent is 5.8%: this is higher than the last published national figure, which was 4.7%. This is despite the use of a third party service to check the attendance of children and young people daily and strenuous efforts to support them to attend regularly.

53. The number of children looked after who were excluded from school for a fixed period is declining steadily. Although the published data show that in 2014–15

the exclusion rate was higher than for other authorities, figures up to the end of December 2015 show that 8.3% of children looked after had at least one fixed term exclusion over the preceding 12 months, which is lower than the last published national rate of 9.8%.

54. The quality of personal educational plans (PEPs) is too variable. PEPs are not always completed at the appropriate intervals and the weaker PEPs do not include enough information about the needs of the child or young person, do not record attendance, fail to include the child or young person in the process and have few meaningful targets. PEPs do not sufficiently monitor the use and impact of pupil premium plus funding (recommendation).

55. Children looked after are encouraged to engage in a wide range of hobbies and leisure opportunities. Children and young people spoken to by inspectors said that they feel safe and are encouraged to participate in a range of activities. Several spoke about the positive difference being in care had made to their lives.

56. Children and young people spoken to by inspectors were aware of their entitlements and knew how to complain. Some spoke of having raised concerns with senior managers and having received a prompt response. They are also aware that they can access the support of an advocate if they want one. They are making use of this service, particularly in respect of concerns regarding placements. Advocates also visit each Northamptonshire County Council residential home monthly to offer advocacy support and advice. Northamptonshire has an independent visitor scheme. However, only a low number of children and young people have been identified who might benefit from this support. There is also a shortage of volunteers for this role. As a result, only 18 are children matched, with 28 children waiting for an independent visitor. There is an action plan in place to address these shortfalls, including a recruitment drive within the fostering service and improved training and support (recommendation).

57. The children in care forum has been re-energised by the commitment of senior and political leaders to learn from their experiences and views. The young people are firmly holding their corporate parents to account, with a determination to improve the experiences of the wider children looked after population. A second group, which has an open access to all children looked after, enables children and young people to find out what the forum is doing and to have a say. The young people who met with inspectors said that they feel that their involvement is leading to positive change.

58. Children looked after placed in Northamptonshire who go missing receive effective support. The local authority's independent return team (IRT) provides a dedicated service to respond to all children and young people who go missing within the county borders. The team also provides the same service for children and young people placed in the area by other local authorities. Between April 1 and 31 January 2016, there were 238 episodes of children looked after going

missing. A sample of RHIs were seen by inspectors that demonstrated detailed recording of the visit and a good evaluation of risks, with vulnerabilities identified. Workers use a range of approaches to try to engage children and young people. The IRT has started to conduct return interviews for children looked after placed in neighbouring counties, but this service is not available to those children and young people placed at a distance. As a result, not all children and young people placed outside Northamptonshire have been receiving effective support in response to episodes of going missing. For example, some children and young people have not had return interviews, while other interviews were not sufficiently independent, having been undertaken by the providers themselves. The local authority has recently commissioned a return interview service for children and young people placed out of area, but it has yet to demonstrate impact.

59. The quality of risk management for children looked after is variable. Where concerns are identified about child sexual exploitation, risk assessments and management plans are completed and support is provided by the RISE team, alongside the allocated social worker. Cases seen by inspectors show that this work is having a positive impact in reducing risk for children looked after. However, further work is required to ensure that risk management plans are more robustly integrated into the care plans of children and young people. The RISE team does not provide a service for children and young people who are placed outside the local authority area.

60. Where there were safeguarding concerns, most cases seen by inspectors evidenced a good identification of risk, followed by robust action to increase safety. However, in a few cases, there were shortfalls in practice, including delays in convening strategy discussions and poorly coordinated section 47 enquiries. These shortfalls were more notable for children and young people who live out of area. No children or young people were seen to have suffered harm as a result, although a more robust approach would have identified earlier the fact that the children and young people were protected (recommendations).

61. The number of children looked after in Northamptonshire has increased from 767 in September 2013 to 977 at the time of this inspection. The significant increase is due to a more rigorous response to risk and concern since the previous inspection, as well as a recent increase in the number of unaccompanied asylum-seeking children who account for 124 of the total children looked after population.

62. The combination of effective work and management oversight at the MASH and the OOHS ensures that children and young people do not enter care inappropriately in emergency situations. Planned admissions to care are also well considered by an edge of care panel that identifies when further support is needed to enable children and young people to remain at home.

63. Children and young people accommodated under voluntary arrangements made up 35% of the children looked after in Northamptonshire. The high number of

voluntary arrangements are a consequence of a previous legacy of a lack of rigorous managerial oversight, as well as a lack of effective response for children and young people on the edge of care. The council is addressing this effectively through the newly introduced edge of care panel and strengthened edge of care services. This renewed focus on reducing drift and strengthening care planning is evident in the reduction of children and young people in voluntary arrangements from 31 March 2015, when such cases formed 47% of the overall children looked after population.

64. Senior managers have reviewed all cases where children and young people are voluntarily accommodated in response to recent case law, which has impacted on all local councils. As a result, a number of children and young people have been identified whose welfare would be better promoted through issuing legal proceedings. This is an appropriate approach to seeking to improve outcomes for these children and young people.

65. The local authority maintains strategic links and good communication with Cafcass and the judiciary, both of whom report an overall improving picture, but ongoing issues with the quality of some court work and an unnecessary level of delays. Local authority legal services have not always been effective in ensuring that prompt action is taken when court orders are needed to look after children. Prior to the inspection, the council recognised these weaknesses and took action to address them, issuing new guidance, training and increased oversight by a case progression manager. These changes have only very recently been implemented and it is too early to demonstrate impact. Deficiencies include a lack of pre-proceedings work; 85 of 264 public law proceedings are outside of the 26-week national target timeframe; and although permanence planning has begun to receive a greater focus since the last inspection, social workers have taken too long to identify permanent solutions for a small minority of children and young people who have been looked after for many years (recommendation).

66. The number and rate of children and young people leaving care under a special guardianship order (SGO) has increased steadily from 9.5% in 2013–14 to 17.1% in 2015–16 to date. There were 54 SGOs from April to December 2015. In the vast majority of the cases seen by inspectors, assessments and plans were of a good standard, clearly evidencing the rationale for the order. However, there are substantial weaknesses in the assessments of connected persons, such as family and friends, who have come forward to care for children looked after. These assessments are often delayed and lack sufficient consideration of the long-term needs of the children and young people. The council has recently focused on improving the quality and timeliness of this work, but this has not been consistently achieved (recommendation).

67. Inspectors saw a number of cases where effective work had been undertaken to enable children and young people to return home to their family. However, this was not consistent for all children and young people, and several cases were seen where children and young people had returned home without an

assessment of their needs and where the plans to monitor their progress were unclear.

68. Independent reviewing officers (IROs) are actively involved in overseeing the plans of children and young people. IROs visit children and young people prior to reviews to strengthen participation. Between 1 April and 31 December 2015, 94% of children and young people participated in their children looked after reviews and this is good. These improvements resulted from increased investment in the service, leading to manageable caseloads.

69. Inspectors saw many examples of IROs challenging drift and delay in care planning and raising appropriate escalations. However, a lack of response by social workers or first line managers mean that, too often, IRO challenges do not address shortfalls or take too long to resolve. The IRO service has recently taken steps to ensure that escalations are tracked and reported to the senior management team monthly to strengthen this area.

70. The quality of most placements for children and young people is good. Inspectors saw good matching of the needs of the children and young people with the placements and effective support of those placements, whether foster, residential care or independent accommodation.

71. However, there are not sufficient placements within Northamptonshire and too many children and young people are placed over 20 miles from their home. Increases in the number of children looked after, particularly adolescents who have more complex needs and unaccompanied asylum-seeking children, has impacted on capacity. Particular pressures are experienced in seeking to identify local placements for adolescents with more complex needs or in seeking to place sibling groups together. Recently, senior managers have responded to these shortfalls by, for instance, strengthening the commissioning service; introducing weekly placement management reporting, which drives forecasting, intelligence and wider commissioning activity; and recruiting a manager with a commercial focus. However, these actions have yet to have an impact on ensuring that the young people who do not need to be in specialist placements are placed nearer to their home (recommendation).

72. In the past, the recruitment and retention of foster carers was not effective at improving the availability of in-house placements. However, recent recruitment campaigns have shown a substantial increase in the number of enquiries from people considering becoming a foster carer for Northamptonshire. There continues to be a particular shortage of carers for teenagers and mother and baby placements.

73. Foster carers report that they are well supported by committed supervising social workers. Carers have received some good-quality training, but core training has not been consistently undertaken by all foster carers. Although an increasing number of foster carers have clear written delegated authority, this is not yet the case for all of them.

The graded judgement for adoption performance is that it requires improvement

74. Ofsted inspections of the local authority adoption service in 2012 and 2013 judged the adoption service to be inadequate. Since these inspections, systems for adoption have improved, with increasing evidence of progress in the timeliness of decision making and actions taken. However, there are still a small number of children and young people who have experienced substantial delays due to the previous poor practice. Although more recent support has been better, the quality of adoption work remains too variable, with a small number of adoptive placements being poorly matched and supported, lack of life story work and a recent decline in the number of potential adopters recruited by Northamptonshire.

75. There is an effective partnership between a voluntary adoption agency (VAA) and the council, which is improving systems for adoption. This is part of the Department of Education Innovation Programme. The partnership with the VAA has led to a more effective understanding and use of data to monitor timescales, through the child's journey to being adopted, in order to improve practice.

76. The VAA undertook a diagnostic of the Northamptonshire adoption service, which led to improvements in systems. There is now better tracking of both the assessment of prospective adopters and family finding for children and young people. This has led to better timeliness of assessments of adopters and to some improvements in the timeliness of children and young people being matched with adopters. For example, the majority of children and young people who had placement orders granted between April 2015 and January 2016 had taken less time to be matched with adopters than those in the previous year.

77. The council demonstrates a strong commitment to finding adoptive families for harder to place children. There has been an increase in the number of children being adopted with 70 children being adopted in 2014–15. This increase has continued with 59 children being adopted so far in 2015–16. Of those adopted in the last year, a high proportion were aged over five years and had a disability. This demonstrates a good focus on some of the most vulnerable children awaiting adoption. The number of placement orders granted is increasing, with 61 granted between April 2015 and January 2016.

78. Children and young people have waited too long to be adopted. During 2011–14, children and young people waited an average of 644 days between entering care and being placed for adoption. This is 97 days more than the national threshold of 547 days and 16 days more than the national average. However, it was 22 days fewer than statistical neighbours. Although the draft adoption scorecard for 2012–15 shows a slight increase to 649 days, which is more than

the national average and the revised national threshold, this performance is impacted on by the cases of a few children and young people who have waited too long due to the historically inadequate practice seen on previous Ofsted inspections. There was a similar picture for children and young people with a placement order waiting to be matched, due to the previous poor service.

79. Adopters who inspectors met were positive about the quality of support that they receive from the adoption team. They describe a good experience of assessment, matching, support and the quality of training. Adopters describe how the adoption support services have been effective in supporting their families.

80. There has been a substantial increase in pre-order disruptions – seven from April 2015 to January 2016. Inspectors looked at these in depth and identified deficits, including the quality of the child permanence reports and ineffective preparation of adopters and children. The council has ensured that learning from these deficits has been disseminated and improvements have been made, such as life appreciation days that now take place and enable adopters to have a good understanding of the experience of the child and the impact of the child moving into their permanent home. Although some of these deficits are due to previous poor practice, inspectors concluded that more needed to be done now to ensure that all adopters and children were effectively prepared (recommendation).

81. Good-quality direct work is not being consistently undertaken with children and young people. In particular, life story work is not being undertaken at an early stage. This does not support robust preparation of children and young people for their adoptive placements. Life story books seen by inspectors were well presented and described the history of the child or young person. However, these were undertaken by a separate team rather than being central to the preparation of the children and young people. The council recognises that the separation of life story work from the life story book is not effective practice and plans for this work to be integrated and undertaken by the social worker in the permanence team in the future. Life story books and later life letters are now tracked to improve their timeliness (recommendation).

82. The local authority tracks all the children and young people with a plan or likely plan for adoption. Systems are now in place to ensure the earlier identification of children and young people where adoption needs to be considered as a permanence option. Children and young people who are now entering the care system are experiencing a more timely response in relation to decisions about their permanence. Almost all permanence decisions are now made by the second review. Permanence planning meetings enable earlier identification of children and young people with a potential plan for adoption. There is evidence of earlier family finding: 14 children and young people have been placed in fostering to adopt placements from April 2015 to January 2016 and family finding is taking place for a number of unborn children.

83. The local authority has improved performance in completing legal proceedings. However, performance is still worse than the 26-week target. There are unnecessary delays in the court process due to the local authority not always being sufficiently robust in identifying all family members and completing potential viability assessments at an early stage. Poor communication between social workers and the legal team leads to delay in some cases.

84. A permanence team has been in place since June 2015 to improve the quality and timeliness of adoption work. Recent child permanence reports seen by inspectors evidenced improvements in this area of practice. The quality of 'together or apart' assessments is variable, with the different needs of siblings not always being sufficiently explored, which does not support robust decision making.

85. The council has two effective adoption panels, quality-assuring reports and providing individual feedback on child permanence reports and prospective adopter reports. Panel advisers quality-assure reports before going to panel and have found inconsistencies in the quality of child permanence reports, which they have reported back to improve future reports. The panel chairs meet regularly with the local council managers and provide effective feedback on performance through six-monthly reports.

86. In 2014–15, the council approved 75 adopters, which is higher than previous years. In 2015–16 so far, this figure has decreased, with only 45 having been approved, with 23 prospective adopters in the final stages of the assessment process. The local authority is now part of a regional consortium and has successfully matched children and young people through these arrangements. However, this has not ensured that there is a sufficient increase in the number of adopters, with 93 children and young people having been identified as potentially needing an adoptive placement.

87. The adoption support service sends a newsletter to over 500 adopters and arranges support days. There is an increasing number of referrals for adoption support and this is good. There have been 126 referrals for post-adoption support since April 2015 and currently 84 children and young people with adoption support plans. The council has recognised that families had not received adoption support at an early enough stage and has now taken action to address this. As a result, families, children and young people now have access to a wide range of support. Effective use is also made of the adoption support fund and a range of therapeutic interventions have been commissioned. Although all children and young people have an adoption support plan, when the children and young people are placed, these plans are not always effectively tailored to the individual needs of the children, young people and their families.

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

88. At the last Ofsted inspection of looked after children's services in July 2013, there were no dedicated services for care leavers. In the last three years, considerable work has been done to address the deficits caused by this previous poor practice. The council created a care leavers team that includes personal advisers to better support the young people. However, there continues to be too much variability in the support provided, in particular in preparation for independence, meeting health needs, supporting education and employment and in relation to accommodation, including 'staying put' arrangements with former foster carers.

89. Care leavers have frequent contact with personal advisers and other professionals. In most cases, these professionals develop good relationships with the young people, enabling them to explore a range of themes related to their personal safety, health and well-being and education. This extends to the young people who are in custody. Personal advisers are caring and supportive and help young people either directly or through referral to other agencies. However, in a small number of cases, young people do not develop such good relationships with professionals and this occasionally impacts on their well-being.

90. There is a shortage of specialist accommodation for care leavers. Nineteen 19- to 21-year-olds are known to live in unsuitable accommodation. (A further 13 are in custody.) Although there are clear protocols for giving care leavers priority in accessing local authority accommodation, inspectors saw that bed and breakfast accommodation had been used to support homeless care leavers in an emergency, and that the work to resolve their housing needs had been too slow.

91. The proportion of care leavers who do not access education and training is too high. Thirty-two per cent of 16- to 17-year-olds and 63.2% of 19- to 21-year-olds do not engage in education, employment or training. Those young people aged 16 and 17 years who continue their education are supported well to do so. A small number, 13 current care leavers, progress to higher education and receive appropriate support to do so (recommendation).

92. The council has not done enough to enable care leavers to access apprenticeships within the local authority. For example, care leavers do not get early notice of apprenticeship vacancies or preferential treatment at the application stage. Due to many care leavers lacking the academic attainment required to be successful on such programmes, the leaving care team has developed a work experience programme to help care leavers into apprenticeships. However, this is not yet sufficiently well developed to provide a good progression route into these roles (recommendation).

93. In the past, care leavers have not been given their health passport, which means that there are many 19- to 21-year-olds who do not have important information about their health history and that of their families. All those currently leaving care receive this important information, and managers are making arrangements to address the backlog. Most of the health needs of care leavers are met. Personal advisers ensure that young people are registered with suitable services and access them at appropriate times. This includes, for example, dental check-ups. The health of care leavers is discussed at review meetings and most concerns are tackled promptly. Care leavers who met with inspectors reported that the support they receive for emotional and mental health is insufficient. They describe how when young people leave care, insufficient account is taken of any history of mental health difficulties.

94. Safeguarding support provided by the RISE team has generally been of good quality. The team has recently raised its age limit in order to focus on older young people, including care leavers, who are at risk of sexual exploitation.

95. Personal advisers produce and review pathway plans at appropriate intervals. In general, these pathway plans contain a detailed assessment of the young people's progress and needs, covering all appropriate themes. Managers review plans and give personal advisers constructive feedback. However, the action plans that they develop do not help young people to improve their lives and care leavers do not find them useful. In a few cases, the involvement of young people in the pathway planning process is not evident. Although personal advisers are clearly supportive, inspectors saw a lack of challenge in decisions that they were making and in raising the aspirations of young people (recommendation).

96. Until recently, young people have been insufficiently prepared for the transition to adulthood. As a result of the identified gaps in this work, a new programme has been introduced: 'The Daily Living Project' provides training in a range of skills. However, so far, only six young people have participated.

97. Social workers encourage young people to remain looked after until their 18th birthday, where this is appropriate for them. As a result, 79% of 16- to 18-year-olds remain looked after. This is higher than the last published national rate (67%). However, the proportion of young people aged 19 to 21 years who remain with their carers in 'staying put' arrangements is low. Only 24 of 440 young people aged 18 to 21 years (5.5%) have taken advantage of such arrangements, and managers acknowledge that there are more who would benefit from them (recommendation).

98. Care leavers are well informed about their rights and entitlements. The Young Northants website is well designed and provides key information. All care leavers receive printed guides that they find accessible and understandable.

Leadership, management and governance	Requires improvement

Summary

Senior and political leaders have an accurate view of the effectiveness of services to children and young people who need help, protection and care. Clear governance arrangements ensure that they are focusing on the right things. All of the weaknesses highlighted in the last inspections have been addressed, although a substantial amount of work remains to be done to embed these developments throughout the county to improve the quality of the support and, most importantly, the experience of vulnerable children who receive a service from Northamptonshire County Council.

Despite assertive and creative efforts to recruit and retain good-quality staff, agency and vacancy rates remain too high, particularly for social worker and practice manager posts. Most staff, including those who are employed by an agency, are loyal to Northamptonshire County Council, but children and young people experience too many changes and this upsets them. Managers have not done enough to limit the impact on children, young people and families. Management oversight was evident on almost all cases seen by inspectors, but the plans of children and young people are not always proactively progressed. Practice managers have all attended supervision training, but this has not been sufficient to ensure that they are able to consistently oversee and drive complex casework.

Senior managers have revised and re-launched the quality assurance framework. They take steps to improve practice where they find deficits in casework. However, audit arrangements are too variable and do not sufficiently focus on tackling the poorest practice.

Comprehensive live and retrospective datasets are used well to monitor and improve compliance. This enables managers, leaders and key forums to scrutinise performance and track progress. The corporate parenting board uses this data effectively. Children looked after say that the members of the board now listen carefully to what they say and are making changes as a result. However, the approach to learning from complaints made by children and young people is not sufficiently robust.

Too many children looked after live in placements too far from home because there are insufficient carers within Northamptonshire. The recently updated sufficiency plan addresses the key gaps, but it has not yet made a discernible difference.

Through the social work academy, senior and political leaders are investing in the managers and social workers of the future. It is an excellent example of how new social workers can thrive with the right balance of learning, challenge and care.

Inspection findings

99. Following the Ofsted inspections in 2013, leaders and senior managers spent a considerable amount of time in trying to understand the scale and depth of the problems within services for vulnerable children. Leaders acknowledge that, following these inspections, children's services deteriorated. A number of social workers and managers left the authority, some because their practice did not meet minimum standards. Senior leaders report that they embraced external scrutiny and review and this helped them to focus on the right things. For instance, they appropriately prioritised some critical changes, such as creating a leaving care team and developing a MASH.

100. The director of children's services was appointed following the highly critical Ofsted inspection of February 2013. He and his team have focused well on improving services. The Northamptonshire improvement board has also supported senior and political leaders to focus on key priorities and to benchmark success. Partner agencies signed up, ensuring that they recognised their part in assisting with the improvement journey faced by children's services. Overall, although there has been a sensible but appropriately stretching set of targets, and actions to manage the huge task of improvement, there has been an insufficient focus on ensuring that the experience of children and young people remains at the forefront of the changes. Inspectors saw far too many cases where, in briefings, audits and supervision, compliance with processes was identified as good work in itself, rather than the foundation to then ensure the individual needs of children and young people were safeguarded and promoted.

101. The council is committed to improving its children's services. Senior managers and leaders acknowledge that the council had previously provided inadequate services and that many children and young people were failed and not protected. Politicians have committed, so far, over £62 million to improve those services, and have continually reaffirmed to inspectors that this is the highest priority of the council and that the increase in budget will continue for at least the next four years.

102. There are plans for a children's trust to be established to independently manage the services for vulnerable children. At the time of the inspection, these arrangements were in the very early stage of development. As a result, it has not been possible for inspectors to form a view of the impact of these on children, young people and their families.

103. The single biggest issue affecting the local authority's ability to improve is instability within the children's services workforce. Political leaders have invested heavily since 2014, with 190 additional permanent posts increasing the overall establishment to 511 staff. The number of permanent staff is slowly but steadily rising, but the proportion of agency staff and managers remains too high at 43%, with some frontline teams being staffed almost completely by temporary staff. Agency staff receive the same training and supervision as

permanent staff and the majority have been in post for longer than six months; some for longer than three years. However, turnover among agency staff in the past 12 months was 27%, double that of permanent staff. Children repeatedly told inspectors that when social workers keep leaving this upsets them, as it means that they cannot build or sustain trusting relationships. Managers spend too much time appraising new social workers' case histories and plans. Social workers spend too long 'starting again' in working with children, young people and families who have long histories of variable quality support from children's services (recommendation).

104. High vacancy rates are preventing managers from reducing caseloads to the level that they know is needed, many caseloads are too high at between 25 and 30 children and young people, to ensure that good-quality work occurs consistently.

105. Children and young people help to select social workers and managers who meet the criteria that they have drawn up. The local authority has invested heavily in the social workers and managers of the future via the excellent local social work academy. Around 150 applications are received for each cohort and, to date, 53 permanent social workers have been trained, appointed and supported through this route. All but four have stayed. These social workers value the solid and safe start to their social work careers.

106. The supervision of staff is regular, but managers do not consistently or systematically drive practice improvement, for example through the use of performance and development plans. Management oversight was evident on most cases seen by inspectors, which is an important change from the previous inspection. In a few cases, managers had effectively progressed complex cases: this was the exception. Most supervision records are descriptive, with little evidence of plans being proactively progressed or of consideration of different ways to address casework challenges.

107. The importance of good-quality supervision is recognised and training has been provided to all first line managers and team managers in the past year. This was combined with 56 supervision observations, following which managers were supported to improve their practice. However, there is a lack of sufficient support to first line managers to help them to carry out their role consistently well. For example, not all practice managers are confident to manage all the steps in the public law outline and court process (recommendation).

108. Until relatively recently, the quality assurance framework was not sufficiently integrated into operational practice and its application was inconsistent. This limited the value of the considerable audit activity undertaken since the last inspection. A new framework was introduced in September 2015, but it has yet to be embedded. The shift towards in-house case auditing is appropriate, although not all operational managers consistently prioritise this activity. The framework places a strong emphasis on the involvement of senior and political leaders, for example in analysing casework or undertaking regular visits to

children's homes. Learning is disseminated to staff via newsletters, and inspectors saw instances where appropriate steps were taken to change practice. For example, managers have identified a section 47 champion in each team to improve the quality of these risk assessments. However, the overall approach to tackling practice weaknesses, identified through audit, has not been systematic enough. Inspectors saw a range of audits, including those undertaken on the cases chosen by the inspection team to look at in depth. Many audits failed to recognise deficits in practice, and in particular did not sufficiently address inadequate practice when this was seen. Managers are in the process of appointing a quality assurance manager, in part to address this gap. However, this has been slow progress on what needs to be a foundation for improving services (recommendation).

109. The principal social worker, appointed in November 2015, reports directly to the director of children's services (DCS). This connection to the senior management team, combined with links to frontline practice, is proving to be helpful. For example, she has worked closely with the DCS and assistant director for children's services to provide practical support to those social workers with the highest caseloads.

110. Social workers are, on the whole, positive about working for Northamptonshire County Council and regular 'temperature check' surveys confirm this. Access to training is good. Social workers value the visibility and personal interest of managers at all levels, including their commendations for good practice. Senior managers clearly want to establish a learning environment where quality and outcomes are more important than compliance, but there is a substantial way to go before this culture is embedded.

111. Comprehensive live and retrospective datasets are used well to monitor and improve performance, for example in relation to statutory visiting, where performance has improved greatly. Commentary is not always included but, where it is, it is helpful. The '13-week plan' methodology is informative and sensible, tracking performance over time. Targets are regularly revised to ensure that progress is sustained. Exception reports enable managers to drill down to team, social worker and child level. This methodology, along with service scorecards, was co-designed with managers. This means that managers have, overall, engaged with the purpose of these tools. This data also enable managers, leaders and key forums to scrutinise performance and track progress. Work is currently underway to ensure that 'live' care leavers data are produced to the same quality as for other services. Overall, groups such as the corporate parenting board and children's scrutiny receive the right information for them to be able to decide for themselves what to scrutinise.

112. At the time of the last inspection, the corporate parenting board was unfocused and largely ineffective, despite the support of councillors. A refresh of the group's terms of reference, together with the creation of six subgroups to progress key issues, has increased the group's effectiveness. The involvement of the chair of scrutiny facilitates the sharing of key priorities and concerns

across both groups. Most importantly, children and young people from the children in care forum (CICF) told inspectors about numerous things that have been tackled and changed in the last year. For example, young people said it was hard to move into independence, so managers have worked with children looked after and care leavers to create clear and helpful leaving care and financial guides.

113. Despite the poor care experiences of many of the members of the CICF, they have faith in senior leaders that they will listen to them, and this has re-energised the group. They value the direct interest of the corporate parenting board, particularly the lead member for children's services and the DCS. The annual ball is organised by children looked after. It is a popular event, where senior and political leaders affirm young people's achievements at an awards ceremony that forms part of the ball. The CICF has a list of things that they believe are still not good enough, such as emotional and mental health support for young people and the need for better social media to enable children looked after to share news and information.

114. The children looked after pledge was created in partnership with the CICF. It is written in straightforward and young person-friendly language. Members of the forum like the pledge and they feel well supported in ensuring that the promises are fulfilled.

115. Participation of young people is promoted. Children looked after have developed the viewpoint survey. They say it is easy and fun to use. In 2015, over 400 surveys were submitted by children looked after to their IROs. The members of children's scrutiny routinely analyse survey responses, enabling them to consider the views of children and young people alongside reports and performance information. Young people are enthusiastic members of the early help shadow board, and influence the strategic board through joint chairing arrangements. Their personal messages to senior and political leaders and partners are given prominence in the early help strategy and the corporate parenting strategy, including, 'We ask for commitment, not someone who sees us and disappears for weeks. We don't want to sound hard but we've already dealt with neglect… we look to you for guidance. So your hard work and pride in your work is important to us.'

116. The council does not meet its sufficiency duty. Too many children looked after live in placements too far from their friends and families because there are insufficient local carers. These children do not always receive good enough support because they live so far away. There is not enough suitable housing for care leavers, although this is being addressed, with 21 council-owned flats currently being converted for care leavers to use. The sufficiency action plan addresses the key gaps, but it has not yet made a discernible difference.

117. The overall response to complaints has improved since the last inspection, although resolving them still takes too long. A relatively low number of complaints are received from children and young people and the annual

complaints report does not distinguish between the issues adults and children are concerned about. This does not assist in the thematic analysis and prioritisation of issues. A recently developed 'lessons learned log', which includes information from complaints, helps managers to identify themes and areas for service improvement.

118. Appropriate governance arrangements between key strategic bodies, including the improvement board, children's scrutiny and the NSCB, promote the sharing of priorities and facilitate helpful communication. Commissioning is now closely linked to local need, underpinned by the commissioning statement of intent. Priorities are aligned with the joint strategic needs analysis with shared strategic objectives and an appropriate focus on vulnerable children. The redesign and restructure of the commissioning function in July 2015 was a positive move. Mapping of need is now comprehensive and the monitoring of supply and demand is well embedded. The commissioning team is in the process of updating all commissioning arrangements to ensure that services are rigorously evaluated based on their impact alongside their outputs.

119. Clear strategic arrangements provide effective oversight of the child sexual exploitation and missing agendas across key partnerships, such as police and health. These strategic arrangements underpin intelligence and information sharing and support proactive work on the ground. The DCS maintains a good overview of need and risk in this area through being an active member of the NSCB child sexual exploitation and missing subgroup.

120. The local authority's relationships with key partners are much stronger than at the time of the last inspection. The MASH and the RISE team are testaments to this, although there is further work to be done to secure the full engagement of health partners in the MASH. Relationships between the local authority and Cafcass are constructive, with helpful regular formal and informal liaison with senior managers and the case progression manager. The clinical commissioning group is an active member of the corporate parenting board. In some areas, though, operational partnership working is not yet effective and this affects children, young people and their families. For example, multi-agency attendance at child protection conferences is not consistent.

121. Diversity issues are addressed well in individual cases and in strategic planning. Significant population increases and changes to the ethnicity of the county are well acknowledged, with good consideration of what this may mean for vulnerable children. Good work was evident in relation to unaccompanied asylum-seeking children. One hundred and twenty-four children are being looked after due to these circumstances. This is mainly due to the motorway network bisecting the county and children being abandoned at the service stations. There is also good multi-agency work in relation to female genital mutilation and forced marriage and in supporting the 'Prevent' duty, tackling radicalisation.

The Local Safeguarding Children Board (NSCB)

The Local Safeguarding Children Board requires improvement

Executive summary

Since the last Ofsted inspection, in February 2013, there have been concerted efforts to improve the work of the NSCB.

It is independently chaired and has appropriate agency membership of sufficient seniority to make key decisions and commit resources. There are now good and effective relationships with other multi-agency partnerships, including the improvement board.

As a result, there have been some substantial improvements. Training is a strength, with a comprehensive programme provided. Policies and procedures are clear and concise and cover the broad range of safeguarding. The child death overview panel looks at these sensitive issues in depth and provides good support to parents. The strategic planning in response to children and young people who go missing and who are at risk of child sexual exploitation is well coordinated and ensures that these specialist services are of a high quality.

However, other aspects need continued focus. The current structure of the board does not enable it to progress its priorities effectively and additional task and finish subgroups have been necessary. This increase in the number of subgroups has resulted in agencies struggling to provide regular attendees of sufficient seniority to make decisions. The chairing arrangement of the subgroups is also too heavily reliant on council staff, which potentially impacts on the board's ability to challenge children's services effectively.

The scrutiny function of the board requires strengthening to demonstrate its influence on improvements. For example, section 11 audits are underdeveloped and lack a formal scrutiny process to evaluate partners' self-assessment. Performance information is good on providing an overview on child protection activity, but lacks oversight of some vulnerable groups, such as those receiving early help, children who are privately fostered, children who are looked after and placed out of area and homeless 16- and 17-year-olds.

A range of multi-agency activity and reports have been considered by the board, but audits commissioned directly by the board have been limited and there has been insufficient focus on action planning to improve practice.

The serious case reviews (SCRs) undertaken have been appropriate but they take too long to conclude and recommendations are not completed in a timely manner. There has also been a lack of overview by the board of the serious incident notifications sent to Ofsted and what these may mean about current practice.

Recommendations

122. Review the structure of the NSCB and subgroup chairs to ensure that they support the priorities of the board and are fully able to challenge all partner agencies including the council.

123. Strengthen the quality assurance functions to include evaluating and monitoring progress against section 11 and section 175 audits. Ensure that there is effective scrutiny of work with all the vulnerable groups for whom the NSCB should have oversight.

124. Strengthen the audit function with a programme of audits and SMART action plans that improve the quality of practice.

125. Strengthen the board's oversight and analysis of serious incident notifications and the commissioning of SCRs to ensure that these are competed in a timely manner, including progressing actions swiftly and ensuring that improvements in practice are monitored and evaluated.

Inspection findings – the Local Safeguarding Children Board

126. The NSCB has improved from a previously very low starting point. The board commissioned a peer challenge following the Ofsted inspection in February 2013, to evaluate its functioning. As a result, it focused its attention on three main areas: ensuring policies and procedures were fit for purpose; reviewing the subgroups and strengthening governance arrangements; and raising the profile of the board through a renewed website.

127. The NSCB is independently chaired and has appropriate agency membership of sufficient seniority to make key decisions and commit resources. The chair is highly regarded by partners for his pragmatic approach and his ability to ensure improvements through effective challenge. Governance arrangements are clear. The independent chair is held to account through quarterly accountability meetings with the chief executive and lead member for children's services within Northamptonshire County Council. These meetings ensure that the board is effective in holding all partners to account for safeguarding. In addition, the chair meets monthly with the DCS.

128. Two lay people provide strengthened independence and scrutiny and their challenge has been used to good effect in the redesign of the board's website, as well as through representation on the SCR subgroup. Most partners demonstrate a strong commitment through their attendance at meetings. However, attendance by some has been problematic and required the chair to successfully challenge irregular attendance. Consequently, members reviewed deputising arrangements to ensure that representatives are of sufficient seniority to enable them to make decisions on behalf of their organisation.

129. Agency contributions to the budget are sufficient to deliver the NSCB's work programme. Partners agreed to an approximate 10% increase in their contributions to the 2015–16 budget to ensure that the increasing range of activities are fully financed.

130. The NSCB has taken a key role in the delivery of a range of actions from the improvement board. The independent chair sits on the improvement board and priorities are aligned that enable a multi-agency response to be coordinated and delivered. For example, the NSCB delivered events to 2,400 practitioners and managers to improve early help work, which included awareness raising of the thresholds and ensuring that professionals understand how to access the MASH and initiate complex case meetings. Targeted EHA training delivered to over 800 professionals resulted in a significant increase in EHA activity, from 1,565 in 2013–14 to 2,747 in 2014–15.

131. The board has used its authority to influence other strategic groups. The independent chair is an adviser to the Health and Well Being Board and the NSCB annual report is presented to this board to ensure that it tackles the key safeguarding issues for children and young people in Northamptonshire. The NSCB presents its annual report to the police and crime commissioner (PCC), outlining key safeguarding challenges and any action required for policing in the area. For example, strong links with the PCC led to a coordinated approach to a child sexual exploitation awareness-raising campaign.

132. Challenge by the NSCB to further improve practice is clearly recorded through a formal log. For example, the provision of health passports for children and young people leaving care was an issue of concern due to a large backlog. The challenge from the independent chair has secured a dedicated health resource to address this.

133. There are weaknesses in relation to the NSCB's broader scrutiny of partner agencies' safeguarding arrangements. Agencies produce a report under section 11 of the Children Act 2004 on a two-year cycle. The board has no systematic process to evaluate the partners' assessment, challenge evidence or monitor actions to ensure that improvements are made. As a result, the board is limited in its understanding as to how effective partners are in delivering their safeguarding responsibilities and how these are improving. Section 175 audits that schools can complete have been undertaken by 100% of schools. Although this is a good completion rate, the quality of this work is variable (recommendation).

134. The board business plan covers a two-year cycle. Although each subgroup works to a clearly defined action plan, linked to the business plan, the current structure does not easily enable the board to progress its priorities. Additional task and finish subgroups have been developed to focus on specific safeguarding activity. Currently, there are 10 subgroups with three task and finish groups, which poses a challenge for agencies in ensuring regular representation and to a sufficiently senior level. The board has recognised the

need to rationalise this structure. The chairing arrangements of the subgroups are too heavily reliant on council staff, rather than a range of multi-agency partner agencies, which impacts on the board's ability to effectively challenge the council's performance (recommendation).

135. The executive support group (ESG) monitors the progress against the business plan well through formal reporting against the action plans from each of the subgroups. The ESG meets monthly and reviews performance information, holding subgroup chairs to account. This group is also used to escalate any concerns identified in the subgroups.

136. The NSCB has good oversight of a broad range of safeguarding activity through attendance on other boards, such as the safeguarding adult board and corporate parenting. In addition, the board receives bi-monthly reports on 'Prevent', detailing referral data and awareness-raising activity.

137. The NSCB ensures that multi-agency safeguarding procedures are fit for purpose, and integrates lessons learned from serious case reviews. For example, the development and implementation of a dangerous dogs policy, following lessons learned from a recent SCR. The policies and procedures are available on the NSCB website. Key changes are highlighted and date-stamped to enable practitioners to quickly identify amendments and the date of their implementation. Details of additional support and contact information that professionals may find useful for specific areas of safeguarding are also detailed on the website, for example a helpline for professionals concerned about female genital mutilation.

138. The learning and development subgroup ensures that training provided is of a high quality and meets local needs. Subgroup members take responsibility for specific training areas and attend and evaluate the training to ensure its quality. The NSCB is explicit in its expectations of partners, in terms of minimum standards of training and the quality it expects, and this is good. The training is comprehensive and focuses on local needs. For example, an ongoing increase in the number of admissions to hospital of children and young people due to self-harm led to the board working alongside schools to train staff on how to recognise and respond to these behaviours.

139. E-training is provided and is available from basic safeguarding to more complex areas, such as female genital mutilation and child sexual exploitation. Over the last 12 months, 97 face-to-face training programmes have been delivered with an 83% attendance rate across partners. Between January 2015 and December 2015, 2,963 people accessed the range of NSCB safeguarding training and this attendance is good. Work to measure the impact of training on improving practice is in the early stages of development.

140. SCRs take too long to conclude and recommendations are not completed in a timely manner. There are currently four SCRs ongoing and an additional two reviews recently published. Of the four reviews, three date back to 2014. All

were appropriately commissioned, but delays in completing the reviews impact on the board's ability to progress the learning and improve practice (recommendation).

141. The SCR subgroup reviews referrals from a variety of sources and when the criteria for a SCR are not met, but potentially there is a need for learning, a case learning review is completed. All completed SCRs and case learning reviews have an action plan for disseminating the learning. However, these plans are not always SMART. Inspectors also identified that plans have not been fully implemented. For instance, there are actions to improve pre-birth assessments and the quality of child protection plans, yet there continue to be issues over the quality of these in Northamptonshire County Council current practice. A composite action plan is also produced and monitored through the quality assurance subgroup (recommendation).

142. A high number of serious incident notifications were made to Ofsted over the last three years. All of the most serious notifications have been discussed in the child death overview panel and serious case review subgroup. Outside these notifications, not all the cases have been reviewed by the serious case review subgroup. Consequently, opportunities for learning and identifying themes have been missed. In addition, of the 21 notifications, a third were inappropriate and did not meet the criteria for referral to Ofsted. The board has recently reviewed the notification systems, but it is too early to know whether this will result in changes to practice (recommendation).

143. The NSCB communicates the learning from SCRs through its website, monthly newsletters and well-focused seven-minute briefings. The board's website is clear, informative and easy to navigate for both professionals and members of the public. However, social workers spoken to during this inspection, in particular agency staff, were not fully aware of the work of the NSCB or lessons learned from reviews.

144. The work of the child death overview panel is of high quality. A robust action plan and action log prioritises the work of the board well and identifies key areas of learning from the reviews undertaken. For example, a comprehensive and multi-agency co-sleeping campaign has been delivered following the tragic death of a child in Northamptonshire. The panel ensures that families are supported appropriately. The child death overview panel annual report, though, is poor. It does not provide a clear understanding of the work of the panel and does not reflect the good work that is being undertaken by the panel in this highly sensitive area.

145. The remit of the quality assurance subgroup is too wide and is not delivering on the improvement agenda effectively. The group scrutinises audits from the improvement board, single agency audits, specific themed reports, section 11 audits, designated officer reports and progress on the serious case review composite action plan. However, NSCB multi-agency audits are limited, with only two, involving 12 children, having been completed over the last 12

months. Although there is a substantial amount of activity being monitored, action planning is more limited and improvements are not being robustly identified (recommendation).

146. The NSCB dashboard provides multi-agency data, but there is no benchmarking against England or statistical neighbours, which means that the board is unable to understand how well it is performing. The dashboard also lacks oversight of some vulnerable groups, for example children looked after placed outside the county, private fostering and homeless 16- and 17-year-olds.

147. The views of children and young people are not informing the board's agenda sufficiently. There had previously been a children's and young person's group, but this is no longer active. Consultation events are ongoing to inform how the NSCB can effectively engage with children and young people.

148. The work of the missing and child sexual exploitation subgroup is effective. It brings together information about children missing and at risk of child sexual exploitation and provides effective strategic oversight and coordination against a comprehensive action plan. There is a good range of work tackling child sexual exploitation coordinated through the group, such as campaigns to raise the profile of child sexual exploitation and the development of practitioner toolkits. The Chelsea's Choice initiative – which is one of a number of school-based dramas raising awareness of sexual exploitation – has been rolled out to 19 schools. However, there are over 300 schools covered by the board, so this is still in its infancy.

149. A female genital mutilation subgroup has recently been established. This is due to the diverse population of Northamptonshire being recognised as being at higher risk due to, in particular, the numbers of families from sub-Saharan Africa. The subgroup has made some good progress against its strategy. It has successfully developed a community group to guide and advise the subgroup, and is developing a set of pathways to improve professionals' recognition and response to these issues.

150. The NSCB Annual Report 2014/15 describes the activities completed during the previous year in some detail. However, there is insufficient analysis of agencies' performance, lessons learned from audit activity or analysis of published data. There is also a lack of oversight or information relating to the safeguarding of children looked after, some of whom are more at risk due to being placed far from Northamptonshire and who, as this inspection identified, have not consistently received a good response to safeguarding concerns.

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 eight of Her Majesty's Inspectors and two additional inspectors from Ofsted.

The inspection team

Lead inspector: Neil Penswick

Deputy lead inspector: Stephanie Murray

Team inspectors: Cath McEvoy, Donna Marriott, Paul D'Inverno, Russ Henry, Lisa Summers, Sheena Doyle, Fiona Parker, Kate Malleson

Senior data analysts: Judith Swindell, Patrick Thomson

Quality assurance manager: Nicholas McMullen

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Piccadilly Gate
Store St
Manchester
M1 2WD
T: 0300 123 4234
Textphone: 0161 618 8524
E: enquiries@ofsted.gov.uk
W: www.ofsted.gov.uk