Milton Keynes 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: 12 September 2016 – 6 October 2016

Report published: 25 November 2016

Children's services in Milton Keynes 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

Milton Keynes children's services require improvement to be good. The vast majority of the recommendations from the safeguarding and children looked after inspection (2012) have been completed. However, progress, such as ensuring that strategy discussions consistently take place in response to child protection concerns or improving the quality of chronologies, has been too slow. Services for children looked after have been improving since action was taken in 2015 to strengthen performance of the service, following the appointment of the director of children's services (DCS).

The DCS and his senior management team are focusing on the right things. In some areas, this is making a real difference to children's lives, particularly through the very good work taking place to support children and families through the children and families practices (CFPs) and the family assessment and support team (FAST). Despite this focus, senior managers were unaware of a number of shortfalls in areas of practice until they were highlighted by inspectors. The senior leadership team took decisive action to respond to these deficits during the inspection. However, not all children experience a consistently good service because of these weaknesses.

The population growth in Milton Keynes has resulted in a substantial increase in demand on children's services. Political and corporate leaders have invested in strong early help and family support services, which make a tangible difference to children's lives. This investment supports the local authority's principle of working in partnership with families under child in need processes and preventing escalation to child protection when possible. Inspectors identified effectively insufficient rigour in child in need planning to support this approach for some children.

The local authority's quality assurance framework, although extensive, has not been effective in identifying key weaknesses in practice prior to the inspection. Audits focus too heavily on compliance, rather than on quality and children's experiences. As a result, there is not a consistent coherent approach to strengthening practice or learning. Performance information is underdeveloped, data is not reliable in all areas, particularly relating to care leavers and adoption, and performance management oversight is not sufficiently robust. This means that elected members and senior managers cannot be confident about the effectiveness of the services provided.

The Milton Keynes level of needs document is well understood and effectively applied by partner agencies. Managers in the multi-agency safeguarding hub (MASH) ensure a prompt response to referrals. Consent is sought and information is shared. The practice of undertaking only one visit to carry out child and family assessments and a maximum of two visits to carry out statutory child protection enquiries results in superficial assessments. Concerns received by the MASH about children's welfare often lead to pre-assessment visits by social workers and police officers from the MASH without formal strategy discussions taking place. This practice means that relevant agencies are not involved in supporting evaluations of risk. If relevant agencies are not involved, the effectiveness of planning and safeguarding action is undermined. Work to support children subject to child protection plans is effective.

The designated officer effectively tracks allegations against staff who work with children, but there is insufficient analysis in respect of children who have disabilities.

Strong partnership working is effectively addressing the risks of sexual exploitation, female genital mutilation and radicalisation. The profile of children at risk of sexual exploitation is understood across the partnership, and there are effective interventions and disruption activities in place, alongside awareness raising with schools and the wider community. The quality and timeliness of return home interviews is too variable.

The local authority has comprehensive and effective arrangements in place for children who are on the edge of care. Decisions to look after children are appropriate and mainly timely. There is a need to strengthen permanence planning for children, to ensure that permanence is considered at the earliest opportunity. Care plans for children looked after are too variable in quality and lack clear timescales for change. Reviews of these care plans are timely but independent reviewing officers (IROs) do not consistently provide rigorous challenge to ensure that progress is achieved promptly, which has led to drift for a small minority of children.

Most children looked after benefit from stable placements, and the local authority does well at keeping children within their extended families, supported by a comprehensive range of services. Children looked after who are aged between five and 11 are making good progress educationally, but attainment for older children at key stage 4 is too low. Placements for older children are a significant challenge for the local authority and, as a result, placement choice within the local authority area is limited. Life story work for children looked after is not always completed when it is needed, which means that not all children understand why they become looked after. Decisions to place brothers and sisters together or apart are not always informed by a formal assessment. The engagement of children looked after in the Children in Care Council 'Our Voice' is limited.

The number of children adopted has declined. Children for whom adoption is pursued have their needs assessed well and they receive effective post-adoption services. Centralised strategic oversight of the service is insufficient and, as a result, senior managers do not fully understand the reasons for the small number of children adopted.

The majority of care leavers have a trusting relationship with their personal advisers. Pathway plans are not of sufficiently good quality, and reviews are neither timely nor subject to scrutiny by managers. Pathways into vocational, academic, further or higher education, or training from age 16 onwards, are underdeveloped. Not all care leavers are aware of their rights and entitlements.

Senior managers have taken effective action to improve the recruitment and retention of staff. As a result, the stability of the workforce has significantly improved and staff morale is high.

Contents

The local authority

Information about this local authority area[2]

Previous Ofsted inspections

- The local authority operates three children's homes. Two were judged to be good and one was judged to require improvement in their most recent Ofsted inspections.
- The last inspection of the local authority's safeguarding arrangements was in July 2012. The local authority was judged to be adequate.
- The last inspection of the local authority's services for children looked after was in July 2012. The local authority was judged to be adequate.

Local leadership

- The DCS has been in post since January 2015. The DCS is also responsible for adult services and holds the statutory director of adult services role.
- The chair of the Local Safeguarding Children Board (LSCB) has been in post since September 2015.

Children living in this area

- Approximately 66,123 children under the age of 18 years live in Milton Keynes. This is 25.3% of the total population in the area.
- Approximately 18% of the local authority's children are living in poverty.
- The proportion of children entitled to free school meals:
  - in primary schools is 11.1% (the national average is 14.5%)
  - in secondary schools is 9.4% (the national average is 13.2%).
- Children from minority ethnic groups account for 29.7% of all children living in the area, compared with 21.5% in the country as a whole.
- The largest minority ethnic groups of children in the area are Black African and mixed heritage.
- The proportion of children with English as an additional language:
  - in primary schools is 27.4% (the national average is 20.1%)
  - in secondary schools is 20.1% (the national average is 15.7%).

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

- Milton Keynes is one of the fastest growing areas in England. The number of children starting primary school in 2016 is almost 30% larger than the number leaving Year 11.

Child protection in this area

- At 31 July 2016, 1,613 children had been identified through assessment as being formally in need of a specialist children's service. This is an increase from 1,584 for the year ending 31 March 2015.
- At 31 July 2016, 82 children were the subject of a child protection plan. This is an increase from 57 as at 31 March 2015.
- At 31 July 2016, 11 children lived in a privately arranged fostering placement. This is the same number as at 31 March 2015.
- Since the last inspection, five serious incident notifications have been submitted to Ofsted. One serious case review has been completed since the last inspection.

Children looked after in this area

- At 31 July 2016, 358 children were being looked after by the local authority (a rate of 54 per 10,000 children). This is an increase from 340 (52 per 10,000 children) as at 31 March 2016. Of this number:
  - 141 (or 39%) live outside the local authority area
  - 38 live in residential children's homes, of whom 92% live outside the authority area
  - one lives in a residential special school[3], outside the authority area
  - 278 live with foster families, of whom 33% live outside the authority area
  - 14 live with parents, of whom 43% live outside the authority area
  - 36 children are unaccompanied asylum-seeking children.
- In the 12 months to 31 March 2016:
  - 19 adoption orders were granted
  - 12 children became subject of special guardianship orders
  - 175 children ceased to be looked after, of whom 8.6% subsequently returned to be looked after
  - 41 children ceased to be looked after and moved on to independent living
  - four children ceased to be looked after and are now living in houses of multiple occupation.

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

The casework model used in this area

- The local authority uses the Signs of Safety model.

Recommendations

1. Ensure that assessments undertaken by social workers in the MASH are proportionate to the needs and risk of individual children.

2. Ensure that strategy discussions take place with relevant agencies in response to referrals that indicate a child is at risk of harm, or in response to escalating concerns, and that they lead to a more child-focused service, which is recorded on the child's social care file.

3. Strengthen the quality of audit activity and strengthen analysis, so that all managers and elected members use findings to improve the quality of practice across the service.

4. Strengthen the quality of performance management information, particularly for care leavers and adoption, so that deficits are identified and this leads to effective action.

5. Ensure that all care plans are clear, with measurable outcomes within specific timeframes, and that they are regularly updated following a review, so that care plans are responsive to children's changing circumstances.

6. Ensure that early permanence planning is in place for all children and progress is rigorously tracked.

7. Improve the quality of services to care leavers by ensuring that:

    - the quality of pathway plans is strengthened, that they are reviewed regularly and include managerial oversight to ensure that they support young people in making progress towards their goals

    - care leavers are aware of their rights and entitlements

    - personal advisers are provided with an appropriate range of training that enables them to respond to young people's needs effectively.

8. Ensure that all decisions about brothers and sisters living together or apart are informed by formal assessments that provide a clear rationale for recommendations.

9. Ensure that all children looked after receive timely support to complete life story work in order for them to make sense of their histories.

10. Strengthen the focus on improving attainment at key stage 4, and capturing progress made and further developing educational pathways for children looked after and care leavers from the age of 16.

11. Broaden the range of children who are able to participate in the children in care council and ensure that it includes those who live outside the area.

12. Ensure that elected members robustly and consistently champion the needs of children looked after and care leavers, and that children have the opportunity to attend the corporate parenting panel to have their views heard and to influence service provision.

13. Ensure that allegations or concerns about staff or volunteers working with children who have disabilities are tracked and evaluated, to identify themes and learning.

Summary for children and young people

- Inspectors found that services for children in Milton Keynes are not yet good. Managers know where they need to improve services and already have some plans in place.
- Most of the time, social workers take quick action when children need help and protection but sometimes, when difficulties get worse, children do not get help quickly enough.
- Many different services in Milton Keynes give good support to families early on, to stop their difficulties getting worst.
- When there are difficulties for children to live with their families, in most cases, social workers hold a meeting with the family called a family group conference. These help families to sort out any problems that they have.
- Senior managers have worked hard to ensure that there are enough social workers, but too many children looked after have had many different social workers. This means that children find it hard to get to know and trust their social worker.
- Social workers work hard to understand the wishes and feelings of children, but these are not always written down clearly in children's case files.
- There are not enough foster carers in Milton Keynes, so some older children have to live further away. Senior managers are working hard to increase the number of foster carers in Milton Keynes.
- For children who cannot go back to live with their families, social workers make plans early enough to ensure that children have alternative permanent homes.
- Nearly all children looked after go to a good school, and most children's attendance is good.
- Social workers ensure that children looked after have plans in place to help to keep them healthy.
- Children looked after are not helped quickly enough for them to understand what has happened to them and why they are not living with their families.
- Well-trained foster carers provide good support to help to meet children's and young people's health needs.
- For children who are adopted, decisions are made quickly to find the right family. Children live with their brothers and sisters when possible.
- Young people who are leaving care value the support that they receive from their personal advisers, but finding suitable accommodation can be difficult for some care leavers in Milton Keynes.
- Our Voice, the children in care council, has worked on the design of the pledge but more needs to be done to increase membership and to ensure that those children and young people who are looked after outside Milton Keynes have their voices heard and their views represented.

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

Summary

Although agencies understand thresholds and make appropriate referrals to the MASH, these do not always result in a clear decision by managers about whether they meet the threshold for statutory intervention. In these circumstances, social workers in the MASH undertake visits to some families, to determine whether there is a role for children's social care. In some situations, social workers and police officers in the MASH undertake pre-assessment visits to families in response to concerns about children's welfare. These visits do not always result from a strategy discussion with partner agencies, to determine whether the threshold is met to undertake child protection enquiries, and they are not always recorded by children's social care. As a result, not all relevant partner agencies are routinely engaged in considering the risks to children and planning the joint approach to protective action.

For a very small minority of children, the thresholds for convening strategy discussions and holding child protection conferences are too high. In these situations, action is taken to ensure that children are safeguarded, but, for some children, risk is not managed effectively.

Social workers consistently seek the views of children and carry out individual work with them. However, in too many cases, this does not lead to a clear picture of what daily life for children in their families feels like from their perspective. The recording of social workers' home visits requires improvement so that the purpose, content and outcomes are summarised more concisely.

Supervision and management oversight take place regularly, though the rationale for decisions is not sufficiently evident in case file recording.

Children and families who have emerging problems are offered an extensive range of high-quality early help services to support them to address their difficulties, preventing them from becoming more serious and entrenched. Children and families are very well supported by a high-quality and very responsive FAST, which provides a comprehensive and intensive range of evidence-based support services which extend into evenings and weekends. This results in children being supported in their families.

Well-managed multi-agency risk management review meetings (MARMM) provide an effective response to children who go missing from home or are vulnerable to sexual exploitation. However, for some children, there are delays in return interviews taking place.

Inspection findings

14. Although agencies make appropriate referrals to the MASH, and in most cases, decisions by managers are appropriate, in a small minority of children's cases duty visits are undertaken to determine thresholds for statutory intervention. These visits are not recorded as assessments, which means that families are not always clear about the purpose of the involvement. The local authority took swift action to respond to inspectors' concerns about this practice, putting in place guidance to ensure that such visits only take place following a threshold decision by a manager and that they result in a formal assessment taking place, when required.

15. Information gathering by social workers in the MASH is thorough, and consent to share is appropriately sought from parents, but this is not always well recorded. Referrals received which indicate concerns about children's welfare result in a police officer and social worker carrying out a pre-assessment visit to determine whether there are child protection concerns. As there is no formal strategy meeting in which to plan and agree actions, other agencies are not party to the decision to conduct such visits. This practice is contrary to statutory guidance. Only the police record the decision to undertake these visits. Potentially, the out-of-hours emergency social work service may not be aware of this action should the child concerned come to the attention of the service outside daytime office hours. This pre-assessment visit process lacks transparency for families, regarding the statutory authority under which such visits are conducted, and invalidates the subsequent strategy meeting that takes place to determine whether a child protection enquiry is needed. This practice also results in a lack of multi-agency ownership of planning and incomplete initial risk evaluations. (Recommendation)

16. Some systems and procedures in the MASH are too prescriptive and inflexible to adapt to children's specific situations. An example is the practice of one visit to complete children and family assessments and a maximum of two visits to undertake statutory child protection enquiries. These assessments are often superficial and lack analysis of children's individual circumstances. Although some assessments are built upon during subsequent intervention by the family support teams, social workers may not have sufficient time to assess the child's needs and to identify any emerging risks. The overall quality of case recording in the MASH is too variable, commonly lacking structure and concise summaries of the purpose and outcomes of home visits. Decision making on contacts and referrals is timely and this contributes to the effective through-put of information.

17. At the time of the inspection, the police were gradually reducing a backlog of 400 domestic abuse notifications that required further screening. The police define these as low-level notifications, which involve adults who do not have children, or refer to incidents in which children were not present or not affected by the incident. The police have invested additional resources in the MASH to tackle this backlog. Some of these backlogged cases were sampled during the

inspection. Inspectors did not identify any risks to children, but the backlog could result in some children's needs for protective measures being avoidably overlooked.

18. The vast majority of approximately 1500 children who require specialist, statutory social work support are subject to child in need plans. The local authority has made a significant investment to promote a model that supports families, aiming to prevent unnecessary statutory intervention in their lives. This model is making a positive difference to many children's lives. Most child in need plans are purposeful, concise, regularly reviewed and informed by agency involvement. However, there is an over-reliance on using written agreements with some parents to enforce desired behaviour in unrealistic situations. The local authority acknowledges that an over-reliance on written agreements has developed and that this is in part due to the expectations of the family courts.

19. In the majority of cases, strategy discussions are appropriately held in response to escalating risks. These meetings are well attended by relevant agencies and well recorded. However, inspectors identified a number of children in need for whom managers had not effectively identified and responded to increasing risks. In these instances, strategy discussions had not taken place with other agencies to determine whether the increasing concerns warranted child protection enquiries or an initial child protection conference to be convened. In some cases, contrary to the local authority's own policy, consultations with child protection coordinators had not taken place in response to escalating risk. Examples were seen by inspectors of consultations being inappropriately recorded as strategy discussions, despite the lack of police or other agency involvement. This practice reduces the effectiveness of safeguarding activity for children, as decisions are made by children's social care in isolation. (Recommendation)

20. Children who have disabilities are supported well through effective assessment and planning by the specialist children with disabilities team. Plans are clear and regularly reviewed but timescales are not always explicit. Child protection enquiries and assessments are timely, well recorded and comprehensively analyse children's circumstances. Recording provides good evidence of children's lived experiences, despite the additional communication difficulties for some children.

21. Most children's and families' assessments, including pre-birth assessments, are thorough and comprehensive. Not all assessments are routinely updated to reflect changing circumstances and increasing risks, and some children's circumstances consequently fail to improve at a sufficient pace. Direct work with children is routinely undertaken, but recording does not lead to cohesive analyses of children's experiences in their families. Regular management oversight is evident in almost all cases, but evidence of analysis and reflection are often absent in records and supervision is not consistently driving plans forward. Plans and interventions in the family support teams, supported by clinical supervision provided to social workers, result in children's needs being

met and appropriately 'stepped down' to targeted or universal early help services.

22. The FAST works alongside allocated social workers, effectively customising support packages to the prioritised needs of families. FAST services include primary mental health support to children and parents, intensive work on parenting routines, home hygiene and standards and protective behaviours work. Highly successful 'edge of care' interventions with children lead to the large majority safely remaining with their families. Tackling parental substance misuse and domestic abuse are also integral components in this extensive range of provision.

23. There were no children identified as being at imminent risk during the inspection. However, inspectors identified a number of children on child in need plans, for whom either progress is poor, risks have escalated or parental cooperation is weak. In these cases, strategy discussions should have been convened and consideration given to initial child protection conferences taking place to determine whether a child protection plan was required. The local authority accepted the concerns in the majority of these cases and took action to strengthen the plans or to progress to strategy discussions to consider whether an initial child protection conference was necessary.

24. At the time of the inspection, 92 children were on child protection plans, three of whom have disabilities. Only six children (6.5%) were subject to child protection plans under the categories of sexual or physical abuse. Despite the fact that the majority of children are subject to child protection plans due to concerns regarding neglect, the local authority has a limited understanding or analysis of why this is so.

25. Child protection plans are comprehensive. They are concise, with specific actions, closely focused on reducing the primary identified risks to children. Social workers' visits to children on child protection plans are timely. They see children on their own and their views inform ongoing assessment and planning. Core groups are well attended by professionals from relevant agencies and clearly recorded, carefully measuring the progress of children's plans.

26. Improvements in providing an independent advocate for children involved in the child protection process are very recent. Representation is increasing but from a very low starting point. Many children, parents and carers do not receive agency information prepared for child protection conferences early enough and are not, therefore, informed or prepared for effective participation at their meetings.

27. An extensive array of coordinated, effective early help services are provided primarily through three CFPs. These CFPs offer targeted support for children and families whose difficulties are on the edge of the threshold for specialist, statutory social work intervention. For many children and families, these services prevent the need for escalation to statutory services. The CFPs work

with approximately 300 families at any one point, and completed 1886 assessments and 1214 interventions in the twelve months up to July 2016. The majority of these interventions resulted in effective help, with only 9% 'stepping up' to statutory social work specialist services. Focused assessments and plans result in carefully designed services to meet a diverse spectrum of needs. Most children receive carefully considered help at the right time.

28. The 'Strengthening Families' programme, which is the local authority's national 'Troubled Families' offer, is closely aligned to targeted early help provision, providing a particularly strong emphasis on children who live in families affected by domestic abuse, substance misuse or mental illness. The targeted early help offer is well connected to universal early help services, largely constructed on a network of 17 children's centres. This extensive network of early help provision is integral to the local authority's long-established and effective approach of assisting families, without recourse to formal statutory social work processes.

29. A well-managed emergency social work team, supported by a pool of sessional workers, provides effective and extensive out-of-hours support to families. Timely information sharing, recording, decision-making and prompt communication with daytime services facilitate strong handover arrangements.

30. A dedicated social worker and housing officer complete joint assessments for young people aged 16 and 17 who present as potentially homeless. Proactive mediation work takes place to facilitate the safe return of young people to their families. The local authority provides high-quality commissioned, supported accommodation quickly when necessary. For those young people who request to be looked after, the local authority takes appropriate action, and effective support is provided.

31. Consideration of children's individual identities and diverse backgrounds was evident in some cases, but is not consistently well addressed by social workers in assessments and plans.

32. Multi-agency risk assessment conferences (MARAC) carefully consider dangers to children when there are serious concerns about domestic abuse. MARACs thoroughly evaluate children's safeguarding needs, and information is comprehensively recorded and shared. Multi-agency public protection arrangements panels are similarly thorough in evaluating risks to children from high-risk offenders, and carefully review the outcomes of actions, particularly concerning offenders in custody and due for release.

33. The MASH provides an effective initial response to children at risk of sexual exploitation. Children benefit from coordinated multi-agency identification, screening, assessment, interventions, prevention and disruption activities. MARMMs rigorously consider children at higher risk. The MARMMs are supported by three child sexual exploitation locality panels, which effectively consider and review risks to children at lower and emerging levels of

vulnerability. Intelligence is synthesised and patterns mapped, recognising the correlation between children who go missing from home and school, their engagement in youth offending and their heightened risks of exposure to sexual exploitation. Prevention work with hotels has been particularly successful, resulting in the closure of one establishment that had no reception facility, thus allowing perpetrators unconstrained access to bedrooms.

34. The local authority and police have implemented strong operational arrangements for children who go missing from home. More serious and repeated missing episodes lead to strategy meeting discussions and presentations to the MARMM. All missing episodes are responded to, and the vast majority of children receive a return interview from their allocated social worker in response to missing episodes. However, return home interviews are not consistently timely. Return home interviews are well recorded, demonstrating efforts to understand children's motivations and 'push and pull' factors. A police missing coordinator in the MASH systematically maps associations and gathers intelligence to support proactive work by the police to track and locate young people.

35. The LSCB has undertaken an effective multi-agency evaluation of female genital mutilation in Milton Keynes. The board understands the prevalence of this issue in the local area. There has been extensive awareness raising activity, and a range of practice tools are in use across the agencies, to support the identification of and response to concerns. The LSCB evaluation evidenced that professionals are increasingly confident about how to respond to female genital mutilation, and that referrals are made appropriately in response. Effective awareness raising resulted in 41 cases being presented to a multi-agency advice panel between November 2015 and May 2016.

36. The designated officer closely tracks allegations against staff or volunteers who work with children, and their outcomes. Tracking systems do not include any analysis of reporting in respect of children who have disabilities. The designated officer's annual report contains insufficient commentary and analysis on unsubstantiated allegations and allegations made by children against their foster carers. (Recommendation)

37. Changes in the spring of 2016 in the arrangements to identify and track children missing education, and to monitor electively home-educated (EHE) children, have promoted better communication and more effective joint working between the local authority, schools and other agencies. The children missing education team works closely with the virtual school and the case holding social work teams. By the end of September 2016, 25 children missing education were recorded, compared to 30 during the same period in 2015. Recording systems are sound. Effective systems are in place to identify and quickly track the location of children missing education. The number of children who were electively home educated was 200 at the time of inspection. The children missing education team has been challenging schools and parents to consider maintaining children in mainstream education, with some success, resulting in a

reduction in the number of children withdrawn from schools to EHE during April and July this year, to 46, in comparison to 70 in the same period last year. A team of specialist teachers visits the majority of EHE children at least on an annual basis. The children missing education team has no evidence that any EHE children in the area are attending unregistered schools.

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

Summary

In 2015, senior managers took decisive action to respond to significant performance issues in the corporate parenting team. Although this much-needed action has been effective in tackling identified weaknesses, and is beginning to result in improvements, it had the unintended consequence of adversely impacting on children's experiences. Many children have had frequent changes of social worker and there have been delays in the progression of permanence plans for some children. Despite these difficulties, many children have benefited from consistency of care in stable placements that met their needs during this period.

Although the local authority is not yet consistently achieving good outcomes for all children looked after, outcomes for most are positive. The vast majority of children are living in good-quality placements that meet their needs. The local authority has been responsive to an increasing number of unaccompanied asylum seeking children placed in the area, and these children's needs are met well through a range of effective services.

The large majority of decisions to look after children are timely. Care plans for children are variable in quality and lack clear timescales for change. Reviews of care plans are timely, but IROs are not providing enough challenge to ensure progress. When children go missing from care, return home interviews are not always completed or recorded.

There is a good use of legal proceedings and effective use of the Public Law Outline, although tracking of children within the Public Law Outline needs to be improved. Children's health assessments are timely, but children wait too long for services from child and adolescent mental health services (CAMHS). Life story work for children looked after is not always completed when it is needed, which means that children do not understand their histories.

The number of children adopted in Milton Keynes is small and reducing. Senior managers do not fully understand the reasons for this because they are not tracking all children who have a plan for permanence. As a result, the local authority cannot be confident that adoption is being considered for all children when appropriate.

The skills and expertise of care leavers' personal advisers are extensive. Housing for care leavers is a particular challenge, although senior leaders are focusing on this. Far too many 19- to 21-year-old care leavers are not in education, employment or training, and the number is increasing. Not all care leavers know their rights and entitlements.

Inspection findings

38. The restructure of the corporate parenting team was undertaken in response to significant performance issues across the service. Although this much-needed action has adversely affected children's experiences, it is beginning to result in improvements and stability across the service. All children looked after now have an allocated social worker, and almost all vacant posts are now recruited to, as a result of sustained investment and a comprehensive workforce strategy.

39. Social workers see the majority of children regularly. They see them alone and some know them well. Social workers spoken to by inspectors know more about the children than their records show. Some good examples of direct work are evident on children's files and are helping children to express their views and feelings and to understand their life stories. However, there is a delay in completion of life story work for some children who are fostered. This means that it is taking too long for them to be helped to understand their histories. (Recommendation)

40. The number of children looked after by the local authority has increased from 285 in 2012 to 358 in July 2016. A large majority of these children are over the age of 10 years (approximately 66%), and only 14% are under four years. This increase is partly due to the growing numbers of unaccompanied asylum seeking children, combined with the fast-growing population in Milton Keynes. Largely, the application of thresholds and decisions to look after children are appropriate, although, in a small minority of cases, children have been supported for too long under family support arrangements, despite the fact that their circumstances have not improved.

41. Children looked after have experienced disruption and too many changes of social worker, following the restructure of the corporate parenting service in 2015. Vacancies across the service and difficulties in recruiting locum staff resulted in the inappropriate allocation of children's cases to managers, with statutory visiting undertaken by duty social workers. This has made it difficult for children to establish meaningful relationships with a worker who has an in-depth knowledge and understanding of their circumstances. The local authority's own survey of children looked after (January 2016) confirmed that 60% of children had experienced changes in social workers and 38% reported that they were not made aware of the changes before they took place. One child told inspectors, 'They have been to see me, but it's a waste of time because I know I am going to talk with different people every time. Up until last week I didn't really have anyone to contact.'

42. The local authority has a commitment to keeping children in their family when it is safe and appropriate to do so. Family group conferences (FGC) are well established and used effectively to explore family options. A comprehensive range of services is available to support children, parents and carers to prevent family breakdown. During 2015–16, the tier one service, which forms part of

FAST, provided intensive support to 47 families with children on the edge of care, and 79% of these children remained living with their families.

43. Assessments and care plans do not consistently demonstrate good analysis of children's needs and are not routinely updated to reflect changing circumstances. Equality and diversity issues, such as ethnicity and faith, are not always effectively considered. The care plan is the document relied on by IROs to review and measure progress rather than a separate review document. As 32% of children's care plans were not up to date at the time of the inspection, too few reviews are informed by a current analysis of the child's situation. (Recommendation)

44. IROs routinely see children prior to their review and sometimes between review dates. The vast majority (98%) of children looked after reviews take place within required timescales. Reviews chaired by IROs are sensitive to the needs of children and family members. IROs do not always provide effective scrutiny and challenge, but they are beginning to monitor and record progress between reviews, following the introduction of a dispute resolution document to children's case files. The local authority reports that the number of children participating in their reviews is 89% (2015–16) and the number of children attending is low at 50%.

45. Children have access to a newly commissioned advocacy and independent visiting service. Advocates provide effective support to children looked after who live both in and outside Milton Keynes. The advocacy service and the children's participation officer are working to engage children more effectively, and IROs ensure that children are aware of their entitlement to advocacy and support from independent visitors. At the time of the inspection, 22 children were receiving effective support from an independent visitor. Further plans are in place to recruit and train more volunteers to meet the demand created by new referrals. IROs ensure that children are aware of their entitlement to advocacy.

46. Children do not always have clear permanence plans in place. The permanency tracking group has not met for six months, and the permanence tracker has not been used for several months. This action by the local authority was a proactive decision to return to a greater reliance on management oversight to ensure children's permanence needs were identified and progressed. However, the result has been a lack of robust monitoring of permanence decisions and insufficient focus or delays in progressing permanence plans, albeit in a very small minority of cases. (Recommendation)

47. Management decisions are recorded in the majority of case files, but the rationale is absent. This means that important information about the reasons for decisions made will be unavailable to children who wish to read their case files later in life. Chronologies are in place but do not consistently provide a good overview of children's circumstances, weakening their usefulness to inform assessment, planning and reviews.

48. Out of 358 children looked after by the local authority (at July 2016), 114 are looked after under a voluntary arrangement (Children Act 1989, section 20), of which 41 are unaccompanied asylum seeking children. The local authority has reviewed all voluntary arrangements to ensure that they are suitable and has established a process to continue to monitor their suitability. Cases sampled by inspectors identified that most voluntary arrangements are suitable, although there were some examples of delay in progressing plans for a very small minority of children.

49. The Public Law Outline is used effectively in the vast majority of cases. High-quality specialist assessments, produced in the FAST and specialist assessment and intervention teams, ensure that evidence provided for court proceedings is rigorous and has a particularly effective focus on the strength of children's attachments to their parents. Family group conferences take place to explore possible alternative family care arrangements and support. The average duration of care proceedings has increased and 68% of cases were completed within 26 weeks in 2015–16 compared to 75% in 2014–15. This decline in performance is predominantly due to the lack of capacity within the court system and the increase in the number of children in care proceedings.

50. The comprehensive placement sufficiency plan 2014–17 for children looked after and care leavers sets out the local authority's response to ensure sufficient accommodation. Since the development of the plan, the number of children looked after has significantly increased. A placement sufficiency project is in place to address the need for local placements for children looked after and accommodation for care leavers. However, targets to increase the number of fostering households have not been met. Not all work streams in the project have made progress, notably fostering. Providing sufficient and suitable placements for older children in care and care leavers remains a challenge for the local authority. The local authority recognises this, and appropriate targets have recently been set to remedy this.

51. The local authority's most recent data (30 June 2016) shows that the majority (77.9%) of children looked after are living within 20 miles of their home address. Children, including those who live at a distance, benefit from effective support to access health and education. Senior managers have reviewed all children placed at a distance to consider whether it is possible to return them to their home area when it is appropriate to do so. Child-focused, productive work has resulted in eight children returning to live in their area, either returning to birth families or moving to local placements. This has resulted in positive outcomes for some children, although it has been a contributing factor in the more recent decline in performance of placement stability, with 13% of children experiencing three or more placement moves in the rolling 12 months from August 2015 to July 2016. While the positive work carried out to bring children closer to home accounts for some of the decline in performance, the local authority does not sufficiently understand the reasons for this.

52. At the time of inspection, 14 children were subject to care orders and placed at home with their parents. Decisions for children to return home from care are informed by assessments that respond appropriately to risk and are endorsed by the weekly children's resource panel, chaired by the head of service. In the vast majority of cases seen, decisions to return children home are appropriate and include effective support to parents and their children. The low number of children that return to care (five children at the time of the inspection) indicates that the work undertaken to support these placements is having a positive impact.

53. During 2015–16, 88 children looked after went missing or were absent from their placement on 425 separate occasions. The majority of these returned to their placement on the same day. However, 87 episodes of missing from home involved 34 children and lasted more than 24 hours. Prior to the inspection, senior managers identified weaknesses in the social work response to missing episodes, including a failure to undertake return home interviews, in some instances, or delays in their completion. Senior managers rightly identified that the patterns and trends of missing episodes for individual children were not being fully analysed to inform the management of risk. They took robust action to strengthen the quality of support provided to children who went missing, using September as 'missing month' to raise awareness. Work included awareness raising in social work teams and auditing missing episodes, resulting in improvements in the response to missing episodes. When children placed outside the authority were visited by inspectors, placements were following clear protocols to respond to missing episodes and effective risk management and good multi-agency liaison were in place.

54. Effective arrangements are in place for children looked after identified as being at risk of sexual exploitation. Twenty-eight children looked after have been considered at MARMM meetings. At the time of the inspection, five children looked after were considered to be at high risk of sexual exploitation. While it was evident that risk is effectively managed, risk management strategies are not well articulated in some plans. Specialist placements are used appropriately to support children out of area when risk management plans indicate that these are needed. A commissioner and child sexual exploitation coordinator visit to assess these placements to ensure their suitability.

55. Contact between children looked after and their families is supervised when necessary by contact supervisors, who provide comprehensive reports to social workers. Children spoken to during the inspection told inspectors that they are happy with their contact arrangements.

56. Some children had waited too long to have their emotional and behavioural needs met by CAMHS. Inspectors found some examples of children not being able to access CAMHS for their emotional needs when they have been assessed to have unstable placements and behavioural problems. In some cases, schools have commissioned services to fill this gap. The local authority and the clinical

commissioning group have taken action to respond to this through the local CAMHS transformation plan, which has resulted in a reduction in waiting times.

57. Children looked after receive timely health assessments in the majority of cases, and 85% of review health assessments were completed within timescale during 2015–16. Good-quality health assessments result in plans that respond to identified needs. The nurse for children looked after undertakes reviews of children outside the area and she has been a consistent person in many of their lives when they have had changes of social worker. Foster carers receive effective training to help them to understand how to progress children's health plans.

58. Unaccompanied asylum seeking children receive good support. Supported by a clear protocol, the police and the corporate parenting team liaise effectively to provide immediate and sensitive help. This help is enhanced by the services of an on-call paediatrician. Swift referrals are made to the virtual school and health team, which result in children being able to access appropriate health and education services to meet their needs. Through the use of an interpreter, welfare calls are made by the social worker, in addition to social work visits. The local authority has been proactive in responding to the needs of unaccompanied asylum seeking children when they arrive in Milton Keynes, setting up a 'new to UK' support and information group to provide support and developing clear links to the refugee council.

59. The attainment of children looked after at key stages 1 and 2 in reading, writing and mathematics has been at or above national rates for the past three years, but the attainment of older children dips substantially. For example, the attainment of children looked after at GCSE at any grade has been very low for the past three years, although the picture has been improving marginally year on year. In 2015–16, only 17.5% of children looked after gained five good GCSE qualifications including English and mathematics, or five A*–C grades generally, although this is above the national average (13.8% 2014-15). GCSE attainment for all children who are in alternative education provision was even lower. The local authority does not have any data identifying whether the educational attainment of children who become looked after from key stage 3 onwards subsequently improves by key stage 4, so it is unable to gauge the impact of the support that it provides for children in these year groups.

60. The local authority and its virtual school have not developed structured pathways to guide children looked after into a broad range of appropriate vocational or academic further or higher education, or into training from age 16 to 18 and beyond. Current arrangements are substantially underdeveloped. Consequently, children looked after have negligible opportunities for work experience, work placements or apprenticeships, either with local employers or even with the local authority. The virtual school headteacher recognises that their provision for care leavers requires improvement and joint working arrangements with the corporate parenting team to develop such structured pathways are ongoing.

61. The virtual school team provides constructive and effective challenge and support to schools in and outside the Milton Keynes area. Virtual school staff and teachers in mainstream schools provide a swift and effective response to any instances of bullying. The personal education plan (PEP) review process was poor but has been comprehensively revised and is now being conducted regularly. The process is effective and generally provides good support for children looked after, particularly those in key stages 1 and 2, to overcome any barriers to learning. Children, parents and carers are practically and effectively involved in the PEP process.

62. Most children looked after are monitored very closely by virtual school staff, whether their school is in or outside the area. The team makes very good use of rich and detailed data on each child, including their daily school attendance, to implement appropriate action plans and interventions. A high proportion of children (84%) are placed in good or better schools. The pupil premium is being used well, particularly for children looked after in key stages 1 and 2, for example, for educational extension activities and individualised in-class support. There are numerous examples of the premium's positive impact on all children's attainment and progress.

63. There were two permanent exclusions from schools in the period from September 2015 to July 2016, in respect of two children looked after. The local authority-wide alternative education arrangements at primary level have been successfully restructured and the vast majority of 41 pupils have returned to and remain at mainstream school. The impact of alternative education at secondary level includes much-improved attendance by pupils compared to when they were in mainstream school, a good return to mainstream school for those at key stage 3 (75%), but a much lower return for those at key stage 4 (40%).

64. Foster carers receive effective support. They have access to a wide range of training and receive regular supervisory visits. A number of household reviews were delayed over the last year, and further work is required to ensure that annual reviews are completed on time. Matching information is shared with foster carers, and when possible introductions take place prior to placement. Arrangements are in place to provide foster carers with delegated authority, and they are aware of their responsibilities. Children are supported by foster carers to engage in activities and leisure pursuits which promote their well-being. The quality of foster carer assessments is generally good. Effective work takes place to match children to long-term carers. The newly combined foster and adoption panel approves these matches, to ensure that children are matched to carers who are able to meet their needs.

65. The quality of assessments to help decide whether brothers and sisters should be placed together or apart are variable. Most carefully consider family circumstances and use research to inform assessment conclusions. However, the rationale for decision-making was weak in most cases seen. This means that brothers and sisters will not always be clear in the future about the

reasons why they were placed together or apart. The vast majority of special guardianship order assessments and plans are of a good standard and evidence the rationale for the order. (Recommendation)

66. 'Our Voice', the new name chosen by children for Milton Keynes' children in care council, has contributed to updating the pledge. Individual members enthusiastically told inspectors how they hosted 'True Triumph', an award ceremony celebrating the achievements of children looked after, and that they are now working on developing a welcome pack for children newly looked after. However, the group has relatively low numbers of children who attend regularly, and more work is required to increase membership and to ensure that children who live outside the area have their views represented to inform service planning. (Recommendation)

The graded judgement for adoption performance is that it requires improvement

67. The local authority's adoption service requires improvement to be good because, although individual casework demonstrates a clear focus on adoption as a permanence option, the strategic oversight of the work is underdeveloped. In most cases seen by inspectors, children's need for permanence was appropriately considered, but there is an insufficient focus on ensuring that all children are identified for adoption early enough. Data and performance management systems are not comprehensive enough to enable senior managers to have a clear overview of this work. The number of children adopted in Milton Keynes is small and reducing, and the reasons for this are not understood well by senior managers, although the significant proportion of the care population being over 10 was cited by managers as a factor.

68. Senior and performance managers have not developed their adoption-related performance information sufficiently and, as a result, they are over-reliant on manual spreadsheets maintained by the adoption team manager. Planning for individual children is robust in most cases, but senior and operational managers do not have the benefit of comprehensive adoption data to assist them in analysing the overall performance of the service. The local authority's monthly performance report includes the number of adoption orders, but lacks other important details, such as timeliness. (Recommendation)

69. Nineteen children were adopted between 1 April 2015 and 31 March 2016, which accounts for 12% of all children leaving care in 2015–16. This is lower than the national average of 15% and statistical neighbours at 16% in the same period. Seven children were adopted between 1 April 2016 and 30 September 2016. Overall, harder-to-place children are less likely to be adopted in Milton Keynes than in similar local authorities. There are no children who have disabilities with a plan for adoption, and just five children over the age of five years were adopted in the 12 months preceding the inspection. One child was over six years of age. The proportion of children adopted who are from minority ethnic groups is 6% for 2012–2015. This figure is lower than statistical neighbours at 12% and the England national average at 9%.

70. Once decisions are made to seek permanence for children through adoption, care proceedings are timely and rigorous. Decisions to find permanent homes for children through adoption are timely, and family finding begins early. Between 2012 and 2015, the local authority took, on average, 501 days to place children for adoption after they had entered care. This is an improvement from 522 days in the previous three-year period. This was also better than statistical neighbours at 640 days and the England average of 593 days. The local authority reports that the 2013–2016 three-year average has improved further, at 455 days.

71. Children in Milton Keynes waited for averages of 256 days between the local authority receiving court authority to place and deciding on a match with an adoptive family. This was longer than the statistical neighbour (246) and the England (223) average. Recent local authority unvalidated data indicate that this is improving. At the time of the inspection, for the children adopted during the previous year, the average was 205 days. Cases seen by inspectors showed that the local authority makes effective use of resources, including the regional adoption agency, to ensure good matching arrangements. However, child permanence reports are variable in quality. The local authority is aware of this, and targeted work is taking place to improve these important documents.

72. At the time of the inspection, four children were placed with potential adopters under a 'fostering to adopt' arrangement, which is positive. These placements are enabling children to live with prospective adopters early and, in some cases, immediately from birth. This promotes stronger attachments and continuity for children. Fostering to adopt is routinely discussed with all potential adopters, and extra time is taken during the assessment process to examine issues and help to manage expectations. Adopters told inspectors that fostering to adopt had been a very positive experience for them.

73. Brothers and sisters are routinely placed together when it is assessed as being in their best interests. When together and apart assessments are undertaken, the rationale for decisions is not always clear. In cases seen by inspectors, children were benefiting from living with their brothers and sisters. However, the assessments for these children are not consistently strong. (Recommendation)

74. During the period April 2016 to September 2016, there were four changes in decisions away from adoption. Samples of these cases were seen by inspectors, and all evidenced that decisions by the local authority away from adoption were appropriate and met children's identified needs. Disruptions occur very rarely but when they do, problems are identified early, support is offered and appropriate action taken. Learning is in the process of being disseminated and the local authority plans for this to inform future panel training.

75. Children and families receive good post-adoption support. This includes imaginative support packages and good use of the adoption support fund. Between April 2016 and September 2016, 10 families received support through the fund. Inspectors saw a range of support that included an adoption surgery provided by the adoption team, therapeutic assessments, counselling, play therapy, dyadic developmental psychotherapy and therapeutic life story work. Many of the social workers have received therapeutic training, and a dedicated play therapist supports children throughout the adoption process.

76. Children adopted receive life story work in a timescale that meets their needs. It is child centred, detailed and presented in an attractive format, using photographs and personal information. In the examples seen by inspectors, a particular strength was the comprehensive information about birth fathers.

77. A minority of children's files have gaps in information. The local authority has a project that explores how to strengthen electronic record-keeping in adoption. However, accurate record-keeping is required to ensure that adults who have been adopted, seeking access to their records in the future, will have the information that they require.

78. The vast majority of adopters are assessed in a timely way, and prospective adopter reports are of a high quality. Care is taken by the adoption team to ensure that adopters are suitable and well prepared. A number of adopters commented that they had chosen to become adopters with the local authority because of its 'excellent' reputation. All adopters told inspectors that they had positive experiences of adopting in Milton Keynes and particularly praised the adoption team for its commitment and support.

79. Increasingly, adopters are waiting long periods before children are placed. Between 1 April 2015 and 31 March 2016, 83% of adopters waited longer than three months from approval to matching, compared with 74% in the previous year. At the time of the inspection, 26 adopters had waited more than six months. Adopters are not always referred to the adoption register. The local authority is aware of this and is taking action to ensure that all adopters who have waited more than three months are now referred to the register.

80. Birth families receive sensitive support, information and help from the adoption team. Recent developments include the introduction of 'settling in' letters sent by adopters to birth families, and examples of birth parents' views informing family finding for their children. The local authority also contracts with a voluntary adoption agency to provide a birth parents' group and therapeutic counselling.

81. Agency decisions are made appropriately. Decisions are comprehensive and thorough, and the agency decision-maker demonstrates a detailed knowledge and commitment to children. The successful transfer to a joint fostering and adoption panel, in January 2016, has been widely accepted. There is greater synergy between fostering and adoption, more informed decision-making and a deeper knowledge of adoption. The fostering and adoption panel chair is experienced and knowledgeable. There is a broad pool of panel members, who have recently undergone training and received annual appraisals.

82. The local authority is part of the Central East Regional Adoption Agency. It is developing strong partnership arrangements, and there is a clear project plan to develop adoption services in Milton Keynes.

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

83. Personal advisers are now part of the corporate parenting team, which has been subject to significant organisational change and disruption during the past year. During the inspection, almost all of the personal advisers expressed strong concerns that current management arrangements, following a restructure of their department, did not reflect a high enough priority given to care leavers generally, or sufficient focus on the quality of service being provided. These concerns were noted in a temporary senior manager's report produced recently for managers of the corporate parenting team.

84. The majority of personal advisers have been in post for more than 10 years, which has brought both continuity and stability to the 154 care leavers supported by the service throughout the restructure period. Each personal adviser has an allocation of between 20 and 25 care leavers, including some young people who live outside the local authority area, which means that they often spend extensive time travelling. The local authority has provided personal advisers with digital technology, so that they can record case notes when they are out of the office to support them to work effectively.

85. In the vast majority of cases, outcomes for care leavers are positive. Highly skilled personal advisers provide a resourceful and resilient service and have detailed knowledge of each young person. The vast majority of young people respect and value the advice, guidance and support that they receive from their personal advisers and engage with them productively. Most care leavers that personal advisers routinely go 'the extra mile' for them. However, in a very small minority of cases, the service provided was not sufficiently effective to respond to identified needs. For example, in one instance, there were significant omissions in the quality of service provided to a particularly vulnerable care leaver, and supervision and training had not been effective in rectifying this.

86. The information recorded in the vast majority of case files reviewed was comprehensive and provided a clear and detailed narrative, reflecting frequent contact, appropriate interventions or referrals and evidence of positive outcomes. However, the quality of pathway plans produced by personal advisers is too variable, and the plans are limited in their effectiveness. Young people do not value their pathway plans because they see them merely as a record of how things are for them at the time of the review and not as something designed to achieve specific individualised objectives. Plans are too vague, lack actions and timescales, are not reviewed or updated regularly enough, and there is insufficient oversight by managers. (Recommendation)

87. Inconsistent data input by personal advisers, combined with changes in the performance management function, has reduced senior managers' ability to

effectively monitor the service provided to care leavers during this period of transition. The local authority identified this issue in its own monthly performance management report in July 2016, but issues were still experienced in the timely production of good quality care leavers' information for this inspection. (Recommendation)

88. The local authority's own unvalidated data reports that personal advisers are currently in touch with all but two of the 154 care leavers for whom they have responsibility; one has refused support and contact has been lost with the other. This compares well to 2014–15, when the local authority was not in touch with nearly a quarter (22%) of care leavers. Better administration systems and a stronger focus on being in touch have been at the heart of the subsequent improvement.

89. Personal advisers know the young people whom they work with well and maintain regular contact with the vast majority of them. Care leavers transfer to the personal advisers at the age of 18 years. Prior to this, personal advisers co-work with case holding social workers, supporting the young people's transition to adulthood, including undertaking some early work to secure appropriate housing.

90. Care leavers' housing needs are prioritised from when they are aged 16, but the reality is that there is still too little appropriate accommodation immediately available when they reach the age at which they qualify for it. The local authority's own unvalidated data indicates that the vast majority of care leavers (92%) live in suitable accommodation. Cases sampled during the inspection identified that personal advisers are tenacious in seeking to support young people to find suitable accommodation. This includes a significant minority of care leavers (19%) who live outside Milton Keynes, in some cases as far away as Scotland and Wales, although such distant locations are generally the choice of the care leavers themselves. Care leavers spoken to during the inspection were living in appropriate accommodation and told inspectors that they feel reasonably safe in their current environments.

91. At the time of the inspection, one young person aged 18 years was in emergency bed and breakfast accommodation, and three care leavers (aged 18 or older) had utilised such accommodation in the preceding 18-month period. These young people had either exhausted all accommodation options or had refused to accept alternative accommodation offered by the local authority and secured the emergency accommodation on their own volition. Senior managers are clear that bed and breakfast accommodation is not a suitable option for care leavers. They had, however, been unaware that young people had accessed such accommodation, or that such accommodation had not been subject to risk assessment, until this was brought to their attention during the inspection. Senior managers took swift action in response to these concerns and issued a directive requiring all changes of temporary accommodation for care leavers to be subject to a risk assessment by personal advisers in future.

92. Young people are increasingly successfully encouraged to remain in their supported lodgings, which provide some welcome stability and continuity. Only five care leavers are in houses of multiple occupancy. Eight young people are in 'staying put' arrangements with their foster carers, beyond the age of 18, only three of whom are living out of area with independent fostering agencies (IFAs). The local authority recognises that it needs to do more to encourage more IFAs to agree to 'staying put' arrangements.

93. Personal advisers encourage and challenge young people to be independent and resourceful in their own right and make a successful transition to adulthood. This includes well-targeted work about safe relationships and dealing with the impact of past domestic or sexual abuse. In cases sampled, involving risks of sexual exploitation, clear risk assessments, good collaborative work by all agencies and prioritisation were evident. Effective support is provided for care leavers during pregnancy, and subsequently as new parents. One young person received effective and comprehensive support from a family nurse partnership in preparing for parenthood. The more experienced personal advisers are frequently adept at working with care leavers who have mental health issues.

94. Care leavers spoken to by inspectors reported that they had received useful practical information and guidance on life skills, such as cooking – though few had put this into practice effectively – and also on budgeting, which was both valued and applied. Care leavers expressed some concerns about their personal safety in Milton Keynes generally, but said that they feel safe in their current accommodation.

95. The designated nurse for children looked after completes care leavers' health histories, following their last health assessment. The designated nurse has been in post for many years and has detailed information concerning young people's health needs. Liaison with personal advisers ensures that they know whether life story work has been undertaken, which further informs the health planning for care leavers. All care leavers spoken to were up to date with their immunisations and generally healthy, but not all were aware of their health histories.

96. Care leavers spoken to were not all aware of their legal rights and entitlements but knew where to go if they needed to access information. Although the local authority has produced a children in care pledge, it does not have one specifically for care leavers. However, a commissioned service provides comprehensive support services, including safety work in the home, help in getting employment, access to supported accommodation and information regarding young people's rights and entitlements. (Recommendation)

97. Too few care leavers enter education, training or employment, and the local authority is not doing enough to improve this situation. In 2014–15, 45% of care leavers aged 19 to 21 were either not in education, employment or training (NEET) or their activity was unknown. During 2015–16, the percentage

of care leavers who were NEET rose to 51%, although the proportion of 'unknowns' had reduced to 16%. The rising NEET population of Milton Keynes care leavers compares unfavourably to the national figure for NEET care leavers, which is around 40% and even more so against the 15% of 19- to 21-year-olds in the general population who are NEET. The post-18 education, training and employment opportunities for care leavers are substantially underdeveloped and require significant development in collaboration with the virtual school. For example, the range of apprenticeship, work experience and work placement opportunities is negligible. Seven care leavers over the age of 22 are taking higher education qualifications. (Recommendation)

98. The number of unaccompanied asylum seeking children has grown significantly in the past few years, and the arrangements for their support and development are good. Two asylum seekers have just entered higher education.

99. All young people spoken to were very positive about themselves and their prospects. Care leavers' achievements are celebrated at an annual 'True Triumph' event held in July each year. This is a high-profile, much-enjoyed and generally well-attended event, and guests include senior local authority representatives, local dignitaries and members of parliament. Care leavers are intrinsically involved in organising and presenting the awards event, which this year featured 198 individual nominations. However, one care leaver told us that they were unaware that the event was taking place.

Leadership, management and governance	Requires improvement

Summary

The DCS and senior managers are visible and well-respected leaders and have a clear sense of vision and purpose. The DCS and his senior management team, established in 2015, have worked steadily and purposefully to implement change. Having identified performance issues in services for children looked after, they rightly took robust action to restructure the corporate parenting service and address poor performance. As a result, the pace of change has increased and practice standards have improved.

Political and corporate leaders have made significant investment in children's services, ensuring increased funding in response to rising demand as a result of the significant population growth in Milton Keynes. This investment is making a tangible difference to children's lives, particularly through the very good work that is taking place to support children and families through the CFPs and the FAST.

Despite these strengths, senior managers do not have a direct line of sight on some aspects of frontline practice and were unaware of a number of shortfalls until highlighted by inspectors. The local authority's quality assurance framework, although extensive, had not been effective in identifying these weaknesses.

The local authority's approach to family support, working with some families about whom there are safeguarding concerns via a structured problem solving approach without escalating the intervention into the child protection conferencing system, needs to be strengthened to ensure that risk is managed effectively. Management oversight of child in need plans is insufficiently robust. In some children's experience there was a lack of timely progression to child protection enquiries when risks had increased, indicating concerns about significant harm. Their partner agencies are not sufficiently engaged in critical decisions about escalating concerns through strategy discussions, to ensure shared ownership of risk.

Performance management information and quality assurance activity are not sufficiently accurate or analysed effectively to provide managers and leaders with a clear understanding of practice or to drive improvements. Joint commissioning decisions and arrangements are sound and closely linked to shared priorities. Social work recruitment and retention have been prioritised through increased investment and a coherent workforce strategy and, as a result, the stability of the workforce has significantly improved, and staff morale is high. A comprehensive programme of supervision and appraisal is in place.

Inspection findings

100. Frontline services provided to children in Milton Keynes are too variable, with inconsistencies in practice in some critical areas. Although thresholds are understood well and applied by partner agencies, the application of thresholds by children's social care is inconsistent. In a minority of cases, the response to initial child protection concerns and escalating risk for children in need is insufficiently rigorous. As a result, the response to risk is not consistently effective, and some children receive a service at the wrong level of need. These weaknesses resulted in inspectors referring a number of cases to the local authority during the inspection.

101. Senior managers had not previously been aware of a number of practice shortfalls identified by inspectors. These include visits undertaken to some families by duty social workers in the MASH, to determine thresholds, and pre-assessment visits, to determine thresholds for child protection enquires, without strategy discussions taking place. Further examples include the practice in the MASH of strategy discussions in response to initial child protection concerns recorded in isolation by the police, and the use of bed and breakfast accommodation for vulnerable care leavers without a rigorous assessment of risk. Senior managers accepted inspectors' findings in respect of these concerns and took swift and decisive action to rectify this.

102. Senior managers provide visible and consistent leadership. They have good knowledge of individual children. An open and reflective approach to service development has been effective in responding to some shortfalls. For example, senior managers rightly took rigorous action in response to performance issues identified in the corporate parenting service. This led to a long period during 2015–16 when there was instability in the service and insufficient capacity to allocate social workers to all children looked after. As a result, children experienced periods without an allocated social worker, supported by different duty social workers and with their cases held in managers' names. A comprehensive and rigorous development plan has resulted in recruitment to vacant posts and increased stability across the service with almost all posts filled at the time of the inspection. Practice improvements are beginning, but too many children have continued to experience disruption because of the instability of the service.

103. Sufficiency remains a challenge for the local authority. The comprehensive placement sufficiency plan 2014–17 for children looked after and care leavers sets out the local authority's response to ensure sufficient accommodation. Since the development of the plan, the number of children looked after has significantly increased. A placement sufficiency project is in place to address the need for local placements for children looked after and accommodation for care leavers. However, targets to increase the number of fostering househlds have not been met. Consequently, not all work streams in the project have made progress, notably fostering. Providing sufficient and suitable placements for

older children in care and care leavers remains a challenge for the local authority.

104. The local authority recognises this, and clear targets have recently been set to remedy this. The local authority recognises that short-term placement stability has increased but does not sufficiently understand the reasons for this and the local authority's decision to suspend the permanency-tracking group has not been replaced with sufficiently effective alternatives.

105. The quality assurance framework draws together a wide range of appropriate activities to examine the quality of practice. These include routine and thematic audits, feedback from children and their families and complaints. An extensive auditing programme is in place, and over 400 audits were carried out in 2015−16, but there is too much focus on process and compliance and a lack of qualitative analysis. As a result, the audits do not provide a consistently coherent approach to strengthening practice or learning, or sufficient evaluation of children's experiences. Audits undertaken for this inspection did not provide sufficient qualitative analysis and were variable in quality. In a number of cases, inspectors either did not support the local authority evaluation or considered that the audits failed to capture significant issues, particularly about the child's lived experience.

106. Performance management meetings chaired by the service director help to identify deficiencies in practice. However, action planning from quarterly audit reports has been limited, with no clear targets to measure success. As a result, performance management meetings have not been effective in driving practice improvements, such as care planning and recording. (Recommendation)

107. Performance reporting is not consistently reliable. Recording onto the information technology (IT) system by staff is not always timely. The local authority struggled to provide accurate data for this inspection, particularly on care leavers and adoption. Monthly performance reports do not consistently include analytical commentary or some information, such as statutory visiting, number of children missing or children at risk of child sexual exploitation, which is essential to frontline practice. This weakens the local authority's capacity to analyse and respond to changes in performance. The local authority had identified this shortfall prior to this inspection and is in the process of employing external expertise to support development in this area. Frontline managers have access to the monthly performance report, but there is no live reporting to support them to track and monitor their day-to-day work. In the absence of readily available performance information to support them, managers use a range of manual spreadsheets to track and monitor performance, but this is time consuming. (Recommendation)

108. The DCS is an ambitious and confident leader who has positively influenced the service. He has a clear vision and understands the strengths and the majority of weaknesses of the service. The local authority has experienced increasing financial pressure in the context of the significant population growth in Milton

Keynes. Despite increasing pressures on the local authority, as a result of the growing population, it has maintained its commitment to supporting children to remain in their families and has continued to invest in early help. The local authority's investment in three locality-based children and family practices and the FAST has led to highly effective interventions for families that prevent problems from re-emerging and are making a tangible difference to children's lives.

109. Recognising the need to increase the impact and effectiveness of the LSCB, the chief executive and the DCS were influential in recruiting and appointing a new chair. Partners are committed to working together and have a vision for improving outcomes for children. The DCS and partners hold one another to account appropriately. There are clear links with the Health and Well-being Board (HWB), the clinical commissioning group (CCG), Safer Milton Keynes and the LSCB. The DCS is an active member of all these groups and partnerships. The leader of the council chairs the HWB. The children and families partnership has been absorbed into the board and has a strong focus on ensuring that children get the best start in life. Further work is underway to reform partnership structures in response to the Local Government Association (LGA) peer challenge of the HWB arrangements.

110. The DCS also acts as the director of adult services. The local authority's decision to combine the DCS and the director of adult services role has been subject to a rigorous test of assurance by a senior partnership panel led by the LSCB chair. The DCS is a member of the LSCB and has a close working relationship with the chief executive of the council, which helps to ensure prioritisation of children's issues.

111. The lead member and the chief executive have a well-informed overview of developments and improvements in children's services and express a high level of confidence in the DCS and the senior management team. There is strong ambition from corporate and political leaders to produce service improvements and better outcomes for children, demonstrated in the significant additional financial investment in children's services. For example, following the cultural and community services review, the local authority has maintained 17 children's centres.

112. The corporate plan (2016–2020) sets out the key priorities for children, aligns effectively with the joint strategic needs assessment (JSNA) and health and well-being strategy and is driven by the starting well partnership, a sub group of the HWB. Vulnerable children are a high priority, including children looked after and those affected by domestic abuse, homelessness and mental health problems. Service plans set out the priorities for the year. An established annual appraisal cycle is in place, with staff appraisals focused on objectives linked to the priorities of the service.

113. The local authority has implemented the vast majority of the recommendations from the 2012 safeguarding and looked after children inspection. However,

there is still more to do to ensure that strategy discussions consistently take place in response to child protection concerns, and that chronologies are robust and of a good quality to be a useful tool to social workers and managers. (Recommendation)

114. Commissioning arrangements are effective, and careful attention is given to planning service developments. Commissioning processes are monitored for contract compliance by the joint commissioning board through, for example, membership of regional consortium for residential placements. This is ensuring good-quality placements for children looked after. A joint commissioning review of CAMHS has recently reduced waiting times from 28 weeks to six weeks. However, some children had waited too long to have their emotional and behavioural needs assessed by CAMHS. A plan is in place to develop a joint commissioning post and to jointly commission tier two and three CAMHS services.

115. Senior managers have strengthened recruitment and retention strategies with a sharper focus on career pathways and swift recruitment in response to difficulties in recruiting social workers. A detailed workforce strategy has helped to bring about a reduction in the turnover of staff, and only seven social workers have left the local authority in the last 12 months. This strategy is beginning to evidence impact, with 142 of 150 posts filled on a permanent basis. Additional agency staff fill shortfalls in capacity in response to identified need.

116. Social workers are positive about working in Milton Keynes. They report that managers are available and visible. They feel well supported in their work through regular supervision, which includes the much-valued offer of clinical supervision. Social workers are well trained and have manageable caseloads and their interests are well represented by the principal social worker. The pathway for social workers to access the assessed and supported year in employment (ASYE) is well structured, and there are good links with local education providers. Managers deal with poor performance effectively, including when they consider that the work of agency staff falls short of expected standards.

117. The principal social worker effectively supports the organisation's learning. Regular lunchtime seminars and direct one-to-one support with social workers and frontline managers support their development. Briefings and lunchtime learning sessions ensure that staff are aware of learning from serious case reviews. Despite these sessions, inspectors found that some social workers did not demonstrate learning from recent serious case reviews. Commissioned training takes account of evidence-based practice to ensure that workers can undertake their roles effectively. However, a recent training audit of the corporate parenting team identified that personal advisers had engaged in little or no training between September 2015 and March 2016. (Recommendation)

118. The corporate parenting panel meets regularly, and there is good attendance of elected members. During the last year, the panel has scrutinised services provided by children's homes in Milton Keynes, meeting with children's home managers and reviewing inspection outcomes. In November 2015, the panel held a major enquiry into child sexual exploitation, hearing from a range of partners to ensure that arrangements for local work to protect children from the risks of child sexual exploitation are effective. Inspector observation of the panel demonstrated diligent and probing questioning, with a focus on the impact for children and, at times, significant appropriate challenge to the LSCB chair.

119. The member-led corporate parenting panel takes a clear interest in the progress of children looked after and care leavers and celebrates their achievements. Members have received training to support them in their work to ensure that they understand their responsibilities. Member work has shown some effective challenge, for example, in waiting times for children to receive a service from CAMHS and work experience opportunities for children looked after. Children from 'Our Voice' told inspectors that, although they have regular contact with the DCS, they do not know members of the corporate parenting panel. The chair of the corporate parenting panel acknowledged that members are not sufficiently engaged with children looked after and care leavers who are not members of the panel. (Recommendation)

120. Partnership work with police, health and education has been extensive in developing awareness of, and services for, children at risk of child sexual exploitation, with some effective practice to share information about vulnerable children and to disrupt patterns of activities. A dedicated post within children's services links directly with other agencies. Direct work undertaken by the child sexual exploitation project is particularly effective in reducing the risks to children.

121. The MARMM takes action to ensure that plans are in place to safeguard highly vulnerable children identified as being at risk of sexual exploitation or missing episodes. Recent learning (July 2016) from a thematic audit of missing children led to decisive action by senior managers to introduce 'missing month', to raise awareness, audit and strengthen practice in response to children who go missing from home or care and to emphasise the importance of return home interviews.

122. Relationships between the local authority, the courts and the Children and Family Court Advisory and Support Service are strong, with regular meetings and engagement through the local family justice board. The local authority is highly regarded by the courts, with evidence of high-quality work during the Public Law Outline process and high-quality assessments and evidence prepared as part of court proceedings. The family drug and alcohol court (FDAC) pilot has been effective. Of 25 cases in Milton Keynes, 28% of children returned to their parents' care, 64% to kinship arrangements and 8% to long-

term foster care. The local authority is currently changing from an FDAC pilot to a permanent programme.

123. The local authority has a strong process for learning from complaints. Most complaints are resolved quickly. The complaints and compliments annual report is comprehensive and includes performance data and outcomes. The local authority recognises that a low number of complaints are from children. The participation officer and the newly commissioned advocacy service are actively working to raise awareness in children more effectively, and there is some early indication of engagement, with two complaints received from children in the last month.

124. The local authority's commitment to ensuring that the voices of children and families effectively influence service development is a strength. Milton Keynes has embedded children's and families' participation in service development through a routine consultation process. There are examples of effective consultation to inform specific projects.

125. 'Our Voice' (children in care council) requires more support from the local authority to improve its influence. The group is enthusiastic and supported by a participation officer. It meets regularly, but very small numbers of children looked after attend. The separate group for care leavers has recently been re-launched. Children looked after placed outside the area are not enabled to attend or have their voice heard in this group. (Recommendation)

The Local Safeguarding Children Board (LSCB)

The Local Safeguarding Children Board requires improvement

Executive summary

A diagnostic undertaken following the appointment of the experienced independent chair in July 2015 identified a number of significant weaknesses, particularly in respect of the board's performance management functions and its ability to evidence what impact it was having in terms of outcomes for children. Since the chair's appointment, considerable work has taken place to strengthen the board's ability to evaluate the effectiveness of the arrangements in place across the partnership. However, the board is not yet able to consistently demonstrate its effectiveness in scrutinising frontline practice despite these improvements. Although the board has access to a range of partners' performance information, it has more to do to evaluate and understand what the data means in terms of the experiences of children and to strengthen its quality assurance function.

The effectiveness of the Milton Keynes Safeguarding Children Board (MKSCB) levels of need and the Milton Keynes family support models, while broadly understood across the partnership, is not robustly tested. The board has had sight of the work underway across the partnership to support children and families through early help intervention. To date, although a range of quality assurance review and audit activity takes place in relation to testing and assuring the Board as to the effectiveness of the MKSCB levels of need and the Milton Keynes family support models, the board has not held regular multi-agency case file audits of practice in relation to this. It has scheduled a review for the fourth quarter of 2016/17. The board has not had sufficient oversight of the effectiveness of protection to children looked after, care leavers and children who have disabilities.

The board's monitoring of agencies' section 11 self-assessment returns or its coordination of single and multi-agency audit activity is not strong enough. The board has taken action to address this shortfall, bringing in new processes to ensure a more rigorous approach going forward, but this has not yet resulted in the board being able to rigorously evaluate the effectiveness and delivery of safeguarding services to children across the partnership.

Considerable work has taken place to strengthen the quality and effectiveness of the board's learning and improvement framework, and there are some early signs of improvement, including an increase in take up of training. However, there is still more to do for the board to be confident that training and dissemination of learning, particularly from serious case reviews, are appropriately integrated into operational practice and improve services delivered to children.

The board has made significant progress in monitoring and raising awareness across the partnership, to identify children at risk of child sexual exploitation and female genital mutilation. This progress includes the provision of accessible

information and guidance to parents, carers and children on the MKSCB website. Partners have access to appropriate risk assessment tools, procedures and relevant information to support coordination of safeguarding activity.

Recommendations

126. The board should ensure that it has effective oversight of frontline safeguarding practice across the partnership for children who have disabilities, children looked after and care leavers.

127. The board should seek assurance and monitor the effectiveness of early help levels of need pathway, with particular focus on outcomes for children identified at risk of neglect.

128. The board should undertake a comprehensive evaluation and needs analysis of training, in order to demonstrate the impact of learning on frontline practice.

129. The board should take action to implement regular multi-agency audit activity in relation to the effectiveness of multi-agency threshold decisions, including thresholds for convening strategy discussions and child protection enquiries. The board should seek formal written assurance from police regarding the actions taken to reduce delays in screening domestic abuse notifications and regarding whether they are effectively safeguarding children.

Inspection findings – the Local Safeguarding Children Board

130. MKSCB requires improvement to be good. Despite significant improvements brought by the appointment of the experienced and knowledgeable independent chair in July 2015, the board is not yet able to demonstrate its effectiveness in scrutinising frontline practice and influencing outcomes for children. A new learning and improvement framework, supported by an outcome-based accountability model, while approved across the partnership, is too recently implemented to evidence impact.

131. Following her appointment, the chair completed a thorough diagnostic on the effectiveness of the board in January 2016. This has provided the impetus for change, leading to a suitable shift in the board's governance structure. This gradual step change supports the board to have strategic accountability and oversight with suitably diminished operational activity. The chair's diagnostic exercise has resulted in a focus on three key areas of priority. The three priorities drive an ambitious business plan for 2016−2017 and an overarching three-year strategic plan that promises 'high support and high challenge' to everyone working with children and their families.

132. The chair's recent membership on the HWB, alongside annual scrutiny by the children's select committee and regular meetings with the chief executive, lead member and the DCS, provides a clear structure of governance and accountability of the board. However, progress has been slow in two significant

areas: the board's performance and quality assurance function and its effectiveness in driving learning and development.

133. The board's performance and quality assurance sub-group has revised its terms of reference and appropriately re-invigorated partner representation. This sub-group is the springboard for driving forward the implementation of the learning and improvement framework, but it is too early in its creation to demonstrate any significant improvements. Performance information is available to the board, but there has until more recently been insufficient focus on developing a coherent evaluation of performance activity. As a result, quality assurance and audit activity has been informed by limited intelligence and evaluation, which is insufficiently multi-agency in its nature. This has hindered the identification of board priorities that are rooted in intelligence about performance, the impact of safeguarding activity and the quality of outcomes for children's lives.

134. Although the board has had oversight of frontline practice through audit activity, it has not been sufficiently effective in coordinating the range of audit activity across the partnership. A multi-agency audit on missing children, completed in July 2015, received a poor response from schools, and health data could not be matched to other partners' data, so the impact and effectiveness for children was not measurable.

135. An audit of the MASH reported in September 2015, without a focus on outcomes for children, could not demonstrate whether partnership working is effective in leading to improved outcomes for children. The audit identified significant gaps in information sharing between the MASH and schools, whose request for early notification of domestic abuse incidences is not yet in place, and plans that were not progressed quickly enough.

136. The board had been unaware of a very small minority of critical issues identified through the inspection process, including delays in police screening of domestic abuse notifications and pre-assessment visits without strategy discussions taking place. The board does not always have enough assurance across all aspects of safeguarding practice that it is sufficiently effective, and that children are therefore consistently effectively safeguarded. (Recommendation)

137. The board has published an access to services document on its website, which promotes a family support approach, reinforced and understood across the partnership. While a range of quality assurance review and audit activity takes place in relation to testing and assuring the board as to the effectiveness of the MKSCB levels of need and the Milton Keynes family support models, the board has not held regular multi-agency case file audits of practice in relation to this. It has scheduled a review for the fourth quarter of 2016/17. (Recommendation)

138. The board does not understand the reasons for the increase in child protection plans (from 57 to 92 in March 2016) or the predominance of children with child protection plans under the neglect category (80% at March 2016). Partners'

understanding of these changes is based on hypothesis and unverified reasons, rather than on an analysis of performance information.

139. When sub-groups have been consistently chaired and well led, and the Board has exercised strong governance and consistent oversight, the pace of change and improvements is recognisably quicker and developments are more effective. The chair of the child sexual exploitation sub-group also chairs the MARMM that collates information and intelligence to assist in providing partnership oversight of child sexual exploitation risks in the local area. This provides expertise at both a strategic and operational level and effective information sharing. More recently, it has also included data on missing children and those missing education, to ensure that all children at risk are recognised and that appropriate support is put in place.

140. A child sexual exploitation strategy and action plan is effectively providing continuous identification of developments needed to promote and safeguard children at risk of sexual exploitation. These include vigilant monitoring of attendance of targeted groups for training. A child sexual exploitation audit undertaken by the LSCB and reported to the board in July 2016 demonstrates a much-improved audit methodology that provides information with a clear focus on what the expected outcomes are for children, with action plan timescales for delivery. Performance data identifies low prevalence of males at risk of child sexual exploitation. This appropriately prompted a response from the sub-group and resulted in a change in the poster campaign image from female to male.

141. The board has extensive oversight and is the driver for awareness raising and monitoring of female genital mutilation across partner agencies. A data and intelligence led priority since 2015, the female genital mutilation task and finish group has successfully created a multi-agency panel to oversee partner referrals of concern, to identify those children at potential risk of female genital mutilation practice. This has resulted in 60 referrals to the panel since November 2015. Agencies seek and follow advice and escalate to the MASH if safeguarding concerns are evident. Appropriate tools and guidance to support staff are easily accessible on the board's website, alongside plans for funding of a community engagement coordinator to support awareness raising in communities.

142. Partnerships across the board are strong. Partners welcome proposals for change, have commitment and drive for improvement. These include endorsement for designated safeguarding hubs in localities to promote and engage education in the board's functions. The engagement of education partners across primary and secondary schools has historically been weaker than other partnerships. Proposals to designated safeguarding leads in a 'keeping children safe in education' conference in October 2016 outlined the board's expectations for change. The board has been successful in achieving representation on the board, from across all areas of education, including academies and colleges, to support the reach of safeguarding activity.

143. The main partner agencies are required to complete section 11 self-assessments of the effectiveness of their arrangements for safeguarding children. Historically, section 11 returns vary in quality, with 20% of partners being non-compliant in the completion of action plans. Until recently, mechanisms for quality assurance were not in place for the board to challenge partners or follow up implementation of plans. The board intends that a revised electronic section 11 tool will streamline the process, and increase availability of data to support monitoring of future returns. The chair has appropriately challenged the process of biennial submissions and all partners are expected to produce annual returns.

144. The board does not have sufficient oversight of the effectiveness of service provision for children who have disabilities, children looked after and care leavers. Limited monitoring of children looked after in out-of-area placements and an absence of a structured governance arrangement or accountability between the board and the corporate parenting panel do not give partners satisfactory assurance of the effectiveness of the safety of children looked after. This also reduces the board's opportunity to challenge practice that may negatively impact on children looked after. (Recommendation)

145. Strategic analysis, reporting and awareness about the protection of children who have disabilities are weak. There is limited board scrutiny of frontline work across partner services and in children's social care. The service for children who have disabilities is appropriately represented on the board's e-safety task and finish group, the learning and development and participation sub-groups, to ensure that the needs of children who have disabilities are considered. The trackers used by the designated officer do not include categories to support collation of disability data, so the board, when scrutinising the designated officer's annual report, cannot identify any patterns, trends or shortfalls in reporting allegations involving children who have disabilities. In recognition of this, the board has a revised focus on children who have disabilities, planned for the next annual conference.

146. The board completed a wide-reaching children's survey on internet safety between October and December 2015. This survey provided a wealth of important research data and information on safeguarding and internet risks to children in Milton Keynes. Two thousand, five hundred children responded to the survey that identified significant concerns for children's welfare online. Consequently, recommendations for further action are to be taken forward by the internet safety task and finish group. Findings significantly raised awareness of the increased vulnerability of children who have special educational needs and/or disabilities and those identifying as lesbian, gay or bisexual.

147. Partners demonstrate some challenge and the board rigorously seeks assurance in response to identified concerns. Examples of the board's robust oversight include regular updates and reporting of the CAMHS transformation and regularly seeking assurance of safeguarding and restraint practices at Oakhill Secure Training Centre.

148. While staff and partners value the quality and range of multi-agency training available, 52 training events were cancelled in 2015–16, and 40% of places were not taken up. There has previously been limited challenge by the board of partner non-attendance. The board's revised draft learning and development strategy, while not yet fully embedded across the partnership, incorporates the new learning and improvement framework. The strategy is already showing impact on attendance at training. In September 2016, five training events hosted by the board had 96% take up of 140 places, in comparison with 60% in 2015–2016. (Recommendation)

149. The board publishes and disseminates learning bulletins to all partners. Bulletins are user-friendly and concise, with appropriate focus on learning themes, including child sexual exploitation and serious case reviews for child A and child M. The board cannot yet demonstrate whether learning from the bulletins reach frontline staff or how improvements from this learning are used to improve practice and to better support children and families.

150. The board has effective procedures and pathways in place between the child death overview panel (CDOP) and the serious case review sub-group. The appointment of a dedicated CDOP coordinator post for Milton Keynes and a robust tracking system have considerably reduced waiting lists and improved quality and compliance from partners adhering to CDOP procedures. Identification of learning and promotion of safeguarding campaigns jointly promoted with the board, including recent safer sleeping and smoking in pregnancy campaigns, have identified the need for future deep dive audit activity and are now based upon improved data.

151. Implementation of the serious case review and learning review toolkit introduced in September 2015 is effective. Partners use this toolkit to improve the transparency of decision-making for serious case reviews. Inspectors saw an example of partners having used this new process effectively to identify the need for a thematic review in response to the chair's decision not to carry out a serious case review in response to a serious incident.

152. The chair brings an ambitious drive that is tenaciously focused on delivering good outcomes for children. Increasing participation and the voice of children in the board's work is a priority for the board, and this is becoming increasingly visible throughout the work streams. The chair's reflective question at the end of board meetings asking partners to think about what they have done today to make a difference to a child's life gives a powerful message.

153. The annual report provides clear reasoning and evidence to identify the board's priorities for 2016–2017, purposefully aligning with the board's business plan and overarching strategic plan 2016–2019. The report has some deficits in its ability to evaluate strengths and areas for development, due to the lack of performance information available, and, whilst it is beginning to demonstrate challenge to partners, is not yet sufficiently robust.

Information about this inspection

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

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

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

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

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

The inspection team consisted of seven of Her Majesty's Inspectors (HMI) from Ofsted.

The inspection team

Lead inspector: Donna Marriott HMI

Deputy lead inspector: Linda Steele HMI

Team inspectors: Nick Stacey HMI, Anne Waterman HMI, Natalie Trentham HMI, Nick Crombie HMI, Julie Knight HMI.

Shadow inspectors: Dawn Godfrey HMI, Pauline Higham HMI

Senior data analyst: Peter McLaughlin

Quality assurance manager: Jeremy Gleaden Senior HMI

Any complaints about the inspection or the report should be made following the procedures set out in the guidance 'Raising concerns and making complaints about Ofsted', which is available from Ofsted's website: www.gov.uk/government/publications/complaints-about-ofsted. If you would like Ofsted to send you a copy of the guidance, please telephone 0300123 4234, or email enquiries@ofsted.gov.uk.

The Office for Standards in Education, Children's Services and Skills (Ofsted) regulates and inspects to achieve excellence in the care of children and young people, and in education and skills for learners of all ages. It regulates and inspects childcare and children's social care, and inspects the Children and Family Court Advisory and Support Service (Cafcass), schools, colleges, initial teacher training, further education and skills, adult and community learning, and education and training in prisons and other secure establishments. It assesses council children's services, and inspects services for looked after children, safeguarding and child protection.

If you would like a copy of this document in a different format, such as large print or Braille, please telephone 0300 123 1231, or email enquiries@ofsted.gov.uk.

This publication is available at www.gov.uk/government/organisations/ofsted.

Interested in our work? You can subscribe to our monthly newsletter for more information and updates: http://eepurl.com/iTrDn.

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