

# Northamptonshire County Council

## Inspection of children’s social care services

**Inspection dates: 17 June 2019 to 28 June 2019**

**Lead inspector: Pauline Higham**  
**Her Majesty’s Inspector**

<b>Judgement</b>	<b>Grade</b>
The impact of leaders on social work practice with children and families	Requires improvement to be good
The experiences and progress of children who need help and protection	Inadequate
The experiences and progress of children in care and care leavers	Inadequate
Overall effectiveness	Inadequate

Northamptonshire’s children’s services are failing to keep children safe. While some progress has been made since the Ofsted focused visit in October 2018, there remains a range of significant weaknesses in services whose effectiveness is central to protecting children. There are also highly vulnerable children in care who are living in unregulated placements that are unsafe and unsuitable. A small cohort of care leavers are vulnerable and homeless, and services have failed to prevent these young people from remaining in unsuitable and unsafe circumstances.

The quality of support for vulnerable children in Northamptonshire has declined since the last full inspection in 2016.

Northamptonshire has experienced a period of significant instability at senior leadership level for both the council and within children’s services.

There is now a new senior management team in place for children’s social care, which, in a short period of time, has produced some key improvements. There is a permanent management structure in place across the service, the longstanding unallocated cases have reduced, caseloads for social workers are lower and decision-making in the multi-agency safeguarding hub (MASH) is now timelier.

The new senior management team has assessed its services accurately. This includes a clear understanding of current serious weaknesses and of what is required for it to address these.

## **What needs to improve**

- Strategic development of early help services to ensure that children's needs are identified and responded to at the earliest opportunity.
- The identification of and response to risk when contacts relating to safeguarding concerns for children are received into the MASH.
- Timely and purposeful visits to children to ensure that their needs are understood.
- The quality of social work assessments and plans so that they are consistently timely and are effective in improving children's experiences.
- The identification of and response to risk in relation to long-standing concerns of chronic neglect.
- The quality of management decision-making, oversight and challenge.
- Social worker caseloads that enable all children to have an allocated social worker and workers to have manageable workloads.
- The response to children at risk of exploitation to ensure that their vulnerabilities are fully recognised and lead to intervention to keep them safe.
- Sufficiency of placements that meet children's needs.
- Clear reunification plans and support services for children returning home.
- Timely transition planning for disabled children in care to reduce uncertainties and anxieties for them and their families.
- Pathway plans that include clearly defined objectives for young people.
- Proactive intervention and focus for older teenagers disengaged from support services.
- Stability and sustainability of the social care workforce.
- The use of quality assurance activity such as case auditing and escalations to inform and improve practice.
- Action planning in response to the findings of serious case reviews.

## **The experiences and progress of children who need help and protection: inadequate**

1. Children and families are not always offered early help at the right time. Partners do not refer or complete early help assessments early enough. This means that needs and concerns escalate and are not addressed at the earliest opportunity for many children. Waiting lists for some important targeted interventions of up to six weeks cause further delay for children and families.
2. In the MASH, new contacts, screening and information-sharing are completed in a timely way for the majority of cases. Management oversight is evident at key stages, and in most cases thresholds are applied appropriately. As a result, the majority of children receive the right level of service, as defined in the local authority threshold document.
3. However, the cases of a sizable minority of children referred to the MASH who may be at risk of harm are closed without good enough evaluation. This means that these children may remain at risk without the necessary support. Consistent recognition of risk and consistent application of threshold is not fully effective in the MASH.
4. When safeguarding concerns are identified by workers, decisions are made promptly by managers to escalate cases to S47, and strategy meetings are held in a timely way. Actions are clearly recorded and swiftly completed. Where needed, the police work with social workers in response to higher levels of risk, and this is a strength.
5. The emergency duty team is effective and ensures an appropriate response is provided to children at risk of harm during out of office hours.
6. The assessments of the first response team (FRT) are completed within maximum statutory timescales. However, this is not always done in a timely way that addresses children's individual circumstances. To improve this, time checks at 10 and 20 days are being appropriately applied.
7. While children are allocated quickly into the FRT, they are not always seen in a timely way to ensure that their needs are understood. This was an area requiring priority action following the Ofsted focused visit in October 2018 that has not been fully remedied.
8. Assessments across the service do not include enough information about individual children and their lived experience, and this leads to plans which are not effective enough. Most assessments focus only on presenting issues and do not give sufficient weight to the impact of historical concerns and patterns. Some identified needs are not included in plans and this reduces the plans' effectiveness. Better assessments incorporate children's views through direct work, and this provides a powerful

narrative of the child's experiences and the impact of concerns on their lives. However, these assessments are in a minority.

9. All children have a plan, and these plans are reviewed regularly through a core group or child in need meeting, but progress or deterioration are not always added to the up-to-date plan as new or revised actions, and timescales for action are not sufficiently clear. This means that plans are not always effective and it is hard to measure progress for children and their families.
10. Actions formulated in child protection conferences are not sufficiently clear about the objectives and expectations of what is to be achieved to improve children's circumstances. Child protection conference chairs escalate issues, but this is not effective as there is rarely a sufficient response by managers to address the issues raised. As a result, children's situations do not always improve, resulting in poor experiences and increased risk.
11. Some children remain on child protection plans for too long when they are at risk of significant harm in neglectful situations. Social workers and team managers in these cases are over optimistic about change, accept self-reporting too readily in chronically neglectful situations and do not develop alternative plans for children. Escalation and audit are not effective for challenging and improving the practice for these children.
12. Pre-proceeding work under the Public Law Outline (PLO) does not start soon enough for children where there are chronic neglect concerns. This means that children are left in harmful situations for too long, and this has an impact on their well-being and life chances. Once pre-proceeding work is initiated, it is effective for the majority of children. Legal gateway meetings are held when children are likely to come into care. Proposed actions are mostly appropriate, and timely decisions are made based on the child's needs.
13. Although numbers have improved, too many children do not have an allocated social worker, and, as a result, timely actions have not been taken to improve their circumstances. Many of these children have complex needs and their circumstances are not understood sufficiently. There is a duty review system in place for children without an allocated social worker, but it is not sufficiently effective. There is a lack of continuity for children in their social worker relationships, and the local authority acknowledges that this is not a positive experience for children.
14. The capacity of specialist support services is not enough to meet needs. Some support services have been decommissioned or significantly reduced because of budget pressures. Important supportive services for children and families are not always available when they need them. This means that opportunities are missed to improve children's and families' experiences and prevent children's needs from escalating.
15. The voice of the child is not consistently captured by social workers and does not inform all assessments and plans. There is insufficient professional curiosity to explore

beyond what the child self-reports. Very few cases show an understanding of the wider interests and lived experiences of children.

16. Most children at risk of child sexual exploitation in the wider service do not have an up-to-date risk assessment informing interventions and plans for children. This means that risk for these children is not fully understood in order to inform planning and mitigate risk.
17. RISE is a targeted support service for children at high risk of child sexual exploitation, working with children, their families and partner agencies to reduce this risk. Those children referred receive a purposeful, individualised response from this multi-agency team. In the majority of cases, the role of the RISE worker is having a positive impact on reducing risk, building strong relationships with these children with creative direct work.
18. Other forms of exploitation, such as criminal exploitation, that are increasingly prevalent for young people in Northamptonshire are not integrated into the RISE support service, and the pace of addressing wider exploitation has been slow.
19. Although return interviews for the majority of children are timely, recording on return interview forms lacks depth of analysis and it is not clear what interventions may be needed.
20. The approach to homeless young people is not effective, and social workers are not always familiar with young people's right to become looked after, using s20 under the Children Act 1989, and do not always explain this consistently to young people. In most cases, young people are assessed and supported to find accommodation, but this can take several days while they remain vulnerable. There is a lack of sufficient appropriate emergency housing, meaning that too many young people are left in inappropriate arrangements.
21. Where a risk of female genital mutilation is identified, the local authority and partners take appropriate action in a timely way to prevent and protect children at risk. This includes application for court orders for the local authority to acquire parental responsibility, enabling them to make the right decisions for children.
22. Disabled children benefit from strong relationships with their social workers, who are committed to ensuring that their often-complex needs are appropriately met through effective relationships with partner agencies. Social workers know their children well and use a range of communication skills to ensure that, regardless of disability, children's voices are listened to and that they inform plans.
23. A minority of disabled children do not have an allocated social worker. These children are not being seen regularly and there is delay in undertaking children in need meetings for some who are at a period of significant transition into the adult world.

24. Management oversight and decision-making do not consistently provide clear actions and are not sufficiently well recorded on children's files. This does not ensure that children's circumstances improve or that progress is made through child-centred plans and timely action.
25. The number of pupils being home educated has almost doubled in the last four years. Officers meet their statutory duties regarding the documentation required from parents and home visits. They are vigilant for signs that a young person may be at risk of physical or mental harm and they pursue legal action where the education or setting for a young person is not of sufficient quality.
26. The number of permanent exclusions for vulnerable pupils is rising, following a period of decline. For pupils in this position and for those at risk of exclusion, there is a range of alternative provision that is regularly monitored by local authority officers. Pupils on part-time timetables are reviewed weekly to ensure that they are returned to appropriate full-time education as quickly as possible.

### **The experiences and progress of children in care and care leavers: inadequate**

27. There are highly vulnerable children in care who are living in unregulated placements that are unsafe and unsuitable. This is the result of a long-term failure to identify and match children to appropriate placements when they present with complex and challenging risk.
28. A small cohort of care leavers remain vulnerable and homeless, and services have failed to prevent these young people from remaining in unsuitable and unsafe circumstances.
29. Too many children come into care in an unplanned way. Children have experienced too many placement disruptions prior to their current placement, and these have impacted negatively on their experience and outcomes.
30. Once in care, the majority of children are appropriately placed in settings that are meeting their needs. For the majority of children, plans are clear and ensure effective progress.
31. Children are seen regularly by social workers within statutory timescales, but the flexibility of visiting does not always match the needs of children. For some children who struggle to form trusting relationships, visiting patterns are not sufficiently tailored to increase visiting frequency to build that trusting relationship.
32. The very newly formed care planning team is undertaking some impressive direct work with children. This is being used to inform these children's current care plans and is conveying their views directly to decision-makers in court.

33. Children who return home from care do not routinely have a clear reunification plan. Appropriate support services or contingency plans are not always in place to ensure their secure transition home and reduce identified risks.
34. The edge of care service, which has been in place for 18 months, provides an effective, flexible, and child-centred service for the cohort of young people it works with, and who are at risk of coming into care. Social care staff build purposeful relationships with young people, meeting with them often and regularly. Use of a variety of direct work tools enables young people to share their experiences and find solutions with their families. This service is a particular strength that makes a difference for children
35. Children in custody are regularly visited and are subject to children looked after reviews. Planning is taking place with partner agencies to develop support arrangements for when these children return to the community.
36. Children's health assessments are regularly updated and considered at reviews. However, older teenagers in care do not have information about their health histories. Children who have mental health needs are not always having these needs addressed.
37. Most children receive appropriate educational provision and their educational needs are supported by education, health and care plans as well as personal education plans (PEPs). The virtual school has improved considerably in the last two years. Effective systems and procedures are in place to monitor the educational progress of each child and young person in care. Key documents, such as PEPs, are increasingly consistent in quality and are well matched to each young person's needs and aspirations. The relatively recent nature of these improvements is not yet fully reflected in the outcomes of pupils. However, the decline seen in the attainment of children in care has slowed or begun to reverse, for example in key stage 2.
38. The children in care council has worked with officers on some important service developments and is a productive, enthusiastic and well-supported group. However, due to budget constraints, children are disappointed that there will be no event this year to recognise and celebrate their achievements. This is clearly much valued, and is a key mechanism in recruiting new children in care council members.
39. Once children come into care, their need for security through permanence is well understood. Permanency plans are in place and are reviewed regularly for the majority of children, with detailed and appropriate actions in place to progress the plan.
40. Once children are identified as needing permanence through adoption, timely and well-considered actions are taken by the permanence team. Children are carefully prepared and are well supported with direct work to understand their history. Children placed for adoption benefit from high-quality life-story work.
41. Family arrangements for seeing birth parents, sisters and brothers are carefully managed and are set at the right frequency level to promote the child's relationships.

42. The fostering service is not able to provide a sufficient number of foster placements, and vacancies in significant posts have made service development difficult. There has been a small increase in local foster placements, but this is not enough to meet demand, resulting in too many children living in residential care and out of county.
43. Staff are not always clear about terms of approval. Some foster carers are experiencing undue pressure to take placements and are not always being provided with accurate information about children's needs.
44. Foster carers are prepared, assessed, approved and supported in a timely way. The quality of assessments is, for the majority, good, and decision-making about foster carers' suitability and ongoing approval is enhanced through independent scrutiny by a child-focused and challenging fostering panel.
45. Some fostering supervising social workers no longer have capacity to facilitate foster carers' support groups because they have too high a workload. This minimises the opportunities for foster carers to feed back issues to the professionals in the service.
46. Adopters are well prepared for the task of adoptive parenting. Assessments are thorough and timely. The quality of reports is strong, and these facilitate safe panel recommendations and decision-making.
47. Pathway plans to help plan for young people leaving care are appropriately detailed and with clear actions. Personal advisers begin working with young people in the year before their 18th birthday to ensure that a relationship is built in the transition from care.
48. Transition planning to adulthood starts too late for most disabled children. This results in uncertainties about future placement and support arrangements, causing anxiety for some children and their families as a consequence.
49. The quality of the service for care leavers is not consistent, especially for the most vulnerable young people. Some important areas of practice have not been sufficiently addressed, such as the effective use of risk assessments, the quality of pathway plans and the consistency and rigour of management oversight and direction.
50. All care leavers have pathway plans, and, in most cases young people were involved in writing them. However, many plans lack specific actions, timescales and clearly defined outcomes for young people. Pathway plans are not always updated when circumstances change for young people.
51. Care leavers are supported to access learning and employment opportunities. Apprenticeship opportunities do exist but plans to expand the range of opportunities that are available are not yet fully developed.

52. The proportion of young people who are not in education, employment or training (NEET) has declined sharply. Positive relationships with colleges and schools, along with effective careers guidance and well-planned transition arrangements, ensure that there are high post-16 retention rates.
53. Young people who are NEET are supported and enabled to access appropriate opportunities. However, there is a cohort of older teenage males who are disengaged from services and for whom there is little in the way of proactive intervention beyond six-weekly visiting. As a result, very little progress is being made to improve circumstances and life chances for these young people.
54. Children who are unaccompanied and who are seeking asylum are routinely considered as s20 under the Children Act 1989, and appropriate placements are sought for them in line with their assessed needs. These children benefit from having committed social workers, who advocate well for them and support them in securing education and employment opportunities.

### **The impact of leaders on social work practice with children and families: requires improvement to be good**

55. The new children's services senior management team has a comprehensive and credible plan for service improvement. The team is taking a whole-system approach to improving practice by putting the right staff in the right place. Previous initiatives had been using approaches that are piecemeal and have not taken an 'end-to-end' overview of system improvement. The target operating model (TOM) approach seeks to address this, but it is in a very early stage of implementation. Senior managers understand service weaknesses and relative strengths and have produced an accurate self-assessment. Improvement plans have been developed while these are in various stages of implementation, and there has been some impact on improving the experiences of children.
56. Progress has been made in the MASH, with a strengthened management team. Decision-making is now taking place and being recorded in a timely way. However, where children may be at risk of significant harm, thresholds are not consistently applied, leaving a minority of children unassessed, and remaining at risk, without the necessary support. There are not performance management systems in place to consistently identify this significant shortfall in practice.
57. There has been a longstanding turnover of staff, and staffing across the service remains extremely fragile. While vacancies are low, a high proportion of staff are provided by agencies and so are not permanent. The local authority has taken sensible steps and has strengthened its capacity at a senior level to focus on recruitment and retention of permanent social workers.

58. Management oversight is not consistently ensuring effective case progression to improve circumstances for children in a timely way. The fragility of workforce, both in terms of status and practice, does not yet provide an environment in which good social work can flourish. This was an area for priority action from the Ofsted focused visit in October 2018 which has not yet been fully remedied. However, appropriate measures are being taken to improve overall staffing, resulting in reduced caseloads for social workers and a reduction in unallocated cases.
59. Caseloads for social workers have reduced to a more manageable level, and the number of children who do not have an allocated social worker has reduced from 267 at the Ofsted focused visit in October 2018 to 86 at the time of this inspection. However, for some social workers caseloads remain too high, and those children who are not allocated a social worker and who are being supported through the duty system are not receiving consistent support based on a full understanding of their needs.
60. Performance management has improved. There is a high level of data and performance information, which enables better measurement and tracking of practice and performance. However, this is not always used effectively to analyse and identify trends at a strategic level, and exception reports are not always being used by frontline managers.
61. Staff report that morale has improved over very recent months with an increasing confidence in the current senior management team. Cafcass and the judiciary acknowledge the very recent improvements in service responses, and this is a positive base to build on with partners to improve outcomes for children.
62. Early help services have not been sufficiently developed, and the pace of change is too slow. This means that children's needs are not being identified and responded to at the earliest opportunity. Children's needs may escalate, which would result in a higher demand on statutory children's services.
63. The local authority preferred social work model has not been consistently implemented in a timely way, either within children's services or across partner agencies. This absence of a consistent model is undermining the development of effective practice that identifies and responds to children and families in a timely and consistent way.
64. Children's identified needs are not always met through appropriate and stable placements. The local authority sufficiency strategy has not been proved effective, and plans to address this are not yet having an impact in securing the right placements for children.
65. Some key support services have been decommissioned despite children's and families' need for these. This is preventing children and families from receiving timely and appropriate support and is increasing pressure on social workers.

66. The quality assurance framework is an area under development. The depth of current learning from auditing is not driving improvements for individual children. Multi-agency audit activity is not well established. Findings from quality assurance activity identify areas for practice development. However, these are not routinely collated and scrutinised or used to contribute to improved experiences for children.
67. The initial response to the findings of recent serious case reviews was very slow and the resultant plans were of poor quality. This was recognised by the current senior management team, which is addressing this with more robust action planning in order to ensure that learning informs practice within children's social care and across partner agencies to better safeguard children.



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