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Dear Lesley,

Focused visit to Northamptonshire children's services

This letter summarises the findings of a focused visit to Northamptonshire children's services on 24 April 2018. The inspectors were Dawn Godfrey, Her Majesty's Inspector, Rachel Griffiths, Her Majesty's Inspector, and Carolyn Spray, Ofsted Inspector.

Inspectors looked at the local authority's arrangements for children in need or subject to a child protection plan, with a focus on early assessment and planning. This included the transfer of work from the first response teams and the application of thresholds, as well as the effectiveness of step-down arrangements when children may no longer need monitoring through a multi-agency child protection plan but still require support.

Inspectors also evaluated the effectiveness of management oversight, supervision and quality assurance in progressing plans and improving practice.

Inspectors looked at a range of evidence, including case discussions with social workers, as well as local authority performance management and quality assurance information and children's case records.

Overview

Senior leaders have a good understanding of how services are performing and the challenges that remain in continuing to improve the quality of social work practice. Managers are having a positive impact on staff morale and staff feel safe and well supported by them. Social workers identify the social work academy as a major source of support that enables newly qualified social workers to feel well prepared

for the challenges of social work and helps them to make a safe transition from qualification to full-time practice.

While no children were found to be at immediate risk of harm, the quality of early assessment and planning remains too variable, resulting in children and families too often experiencing delay in receiving the right support. There is a clear service improvement plan underway, and encouraging progress has been made. Managers now need to strengthen their challenge to improve the quality of work to ensure that all children benefit from consistent social work practice that improves their circumstances in a timely way.

What needs to improve in this area of social work practice

- The quality of assessments and plans is too variable. Assessments often lack depth, and sometimes miss consideration of wider risk factors.
- Initial plans often lack any detail and are not always clear about how children or families are going to be supported.
- Supervision is not always taking place regularly or is not always prioritised. Management oversight and direction is not always reflected in the case record and does not sufficiently drive progress.
- Caseloads remain too high. This is impacting negatively on the quality of practice in some teams, and there is a risk that children in need work is overlooked in those teams.
- The quality assurance framework is too complex and audit activity is not reliably providing the right information to help drive improvement. Managers need to know what 'good' looks like consistently and need to be helped to challenge more effectively when practice is not good enough.

Findings

- Senior leaders are working hard to change the culture of social work in Northamptonshire and to create a positive environment for staff to continue to improve their practice. The introduction of positive initiatives such as 'cakes and compliments' and the social work awards are helping to create an atmosphere of high challenge and high support. Political support for children's services continues to be strong, and the whole-system transformation plan that is underway is clearly focused on addressing capacity issues and supporting the retention of social workers.
- The quality of children's assessments is not yet consistently good enough. In the majority of cases, the single assessment is timely and of sufficient quality to decide about threshold. However, too often single assessments lack depth. This, coupled with lack of consideration of wider issues of potential risk, results in further assessment following transfer, which causes delay and means that children and families do not always receive the right support at the right time.

- Assessments often lack consideration of absent parents, and extended families are not well engaged. This results in gaps in knowledge of children's family backgrounds.
- Identity and diversity needs are poorly considered and are often not recorded at all. Where a child is part of a larger group of brothers and sisters, their individual needs are not well articulated and only cursory attention is given to those presenting as low need.
- Most assessments have multi-agency input and stronger assessments reflect the child's voice and their day-to-day experiences to inform analysis and planning. There are some positive examples of older children attending review child protection conferences or planning meetings to directly inform their plan. This is not consistent, though, and there is sometimes an over-reliance by social workers on parents' views and self-reporting to inform assessments.
- Positive examples of pre-birth assessments are clear on risks, use history well to inform analysis, and result in swift, effective action to safeguard new-born babies.
- Child protection and child in need written plans need further improvement. Frequently, plans do not reflect what services are going to be offered to a family to assist and sustain change, and there is an overemphasis on parental action without clarity on how they will be supported. This makes it difficult for families to understand what needs to change and by when.
- Contingency plans are too generic and do not give sufficient attention to a family's individual circumstances. Parents are not always clear on consequences if risks do not reduce and change is not sustained.
- Adolescent risk management plans are better quality, with a stronger multi-agency approach, and children are central to their own risk planning. Better child in need plans have a clear outcome focus, with clear timescales to achieve.
- The vast majority of social workers spoken to know their children and families well, and see children regularly and alone. Social workers' verbal feedback often shows more insight into what children need and the risks posed to them than written records.
- Decisions about whether a child requires further support from the safeguarding teams following a first response assessment are appropriate and proportionate. There remains, though, a lack of challenge about the quality of assessments both within and of the first response teams.
- When child protection plans end, the step down to child in need planning is not always effective. At times, there is a discrepancy over what is agreed at the review child protection conference and what actually happens. This means that families do not always get continued support to sustain positive change, and in some cases, concerns escalate again, resulting in re-referral.
- The local authority is introducing signs of safety as its preferred model of social work intervention, and most permanent staff have been trained in this. While staff are broadly positive about this approach, it is yet to become established practice and there is wide variance in its application across the county. There are no common templates for recording, with some social workers making up their own

templates, and others not using signs of safety at all. This is not assisting consistent practice and hinders progress in driving up quality.

- Caseloads are becoming more manageable, but continue to impact negatively on the quality of practice, particularly in Northampton. Consequently, some child in need work is being overlooked and requires concerted management oversight to ensure that risks are managed effectively.
- Social workers do not always receive supervision regularly, and it is not consistently reflected in case records. In some teams, recent supervision has used signs of safety methodology and this is supporting better quality direction and reflection.
- The quality assurance framework is detailed, with a high number of different audit tools in place. This level of sophistication is not assisting managers to focus on impact and outcomes sufficiently, or to challenge effectively. Audit tools are too long and do not link with signs of safety. There is a level of over-optimism in several audits, and there is a lack of consistent moderation.
- Within the audit process, there is an overemphasis on compliance and a lack of focus on quality. Audits are too descriptive and lack analysis, with a lack of focus on the impact of intervention on a child's life. Actions arising from audits are basic and some are poor, and follow-up is not evident. This means that it is difficult to see how this process is helping to drive up practice standards and assist leaders in identifying themes for improvement.

Ofsted will take the findings from this focused visit into account when planning your next inspection or visit.

Yours sincerely,

Dawn Godfrey
Her Majesty's Inspector