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Dear Ms Underwood

Focused visit to Nottingham City Council children's services

This letter summarises the findings of a focused visit to Nottingham City Council children's services on 4 February 2020. The inspectors were Paula Thomson-Jones, Her Majesty's Inspector, Amanda Maxwell, Her Majesty's Inspector, and Caroline Walsh, Her Majesty's Inspector.

Inspectors looked at the local authority's arrangements for children in need and those subject to a child protection plan, with a focus on children at risk of neglect.

Inspectors looked at a range of evidence, including case discussions with social workers, frontline managers and senior leaders. They also looked at local authority performance management and quality assurance information and children's case records.

Overview

Nottingham City Council children's services were last inspected by Ofsted in November 2018 and were judged to require improvement to be good. At this focused visit, inspectors found that the experience of children in need of help and protection has deteriorated since the last inspection.

Over the last 12 months, despite efforts to increase recruitment, there have been significant shortfalls in capacity, with insufficient social workers and managers to cope with the volume of work. In addition, systemic weaknesses in social work practice across the service have led to risks to children not being understood or responded to. As a result, some children have been exposed to significant risk of harm from abuse and have not been adequately protected.

Areas for priority action

- Address the systemic failures in social work practice to ensure that planning and intervention for children improve their experiences, and that new and emerging risks are identified and responded to.

- Stabilise the workforce and address the significant shortfall in capacity to enable social workers and first line managers to respond effectively to children in need of help and protection.

What needs to improve in this area of social work practice

- The quality of assessments and plans to ensure that they accurately evaluate risk and address the needs of children.

- Management oversight of work to provide effective support and challenge that improve the quality of work undertaken with children and ensure that children are not left at risk of harm.

- Quality assurance activity to make sure that senior managers and leaders have an accurate understanding of the experiences of children, and that this is used to inform service planning that leads to improvement.

- The capacity of senior leaders and managers to set appropriate standards for good social work practice, and their ability to implement effective plans to improve services at the pace that is required for children.

Findings

- Some children who are identified as needing social work assessments, but who are not at immediate risk, are not allocated or seen by social workers quickly enough. Small numbers of children remain unallocated in the children's duty service for up to four weeks. There is insufficient management oversight of these cases during the period prior to allocation. This means that managers are not evaluating children's situations to inform decisions about how long they can wait to receive help.

- Children's needs are assessed, but for many children their assessments are not completed in a timely way. The quality of assessments is not consistently good. Some stronger examples of assessment by individual workers were seen during this visit. However, the majority are overly descriptive, too focused on adults' needs or what adults report, lack evaluation of parents' capacity to meet children's needs, and do not provide enough understanding of what life is like for children.

- The impact of drug or alcohol dependence, or mental ill health, on the parenting capacity of adults is not well evaluated. For many children, there is a lack of

understanding or consideration of their daily experiences. This leads to children being left at risk of further harm for too long before action is taken.

- Weak analysis within assessments leads to poor decisions about the next steps, and children not being responded to at the right threshold. A lack of effective intervention means that too many children are being re-referred to children's social care when their situations do not improve. They then experience repeat assessments, which causes further delay before they receive any help.

- Children are not visited or seen as regularly as they need to be. Children only have limited opportunities to share and talk about their lived life experiences and to build meaningful relationships with workers. The records of visits to children are often basic, and it is not possible to get a clear view of the child's voice or be clear about whether children have been seen alone.

- When it is difficult to contact or visit children, this is not followed up quickly enough. Inspectors saw several examples of children who had not been seen for long periods of time and for whom no decisions had been made to escalate or take alternative action to ensure they are protected.

- Plans are not put in place for most children during the period they are being assessed. Once they are developed, plans are not consistently good. The majority of plans do not include child-centred outcomes or goals, and do not include clear measures or timescales. As a result, they do not provide an effective mechanism to evaluate if children's situations are improving.

- For some children, this results in decisions being made that their circumstances have improved when there is no clear evidence of sustained change. This leads to them continuing to experience harm and also to repeat periods of child protection planning. When children's situations are not improving, the response is too slow. The pace of response is weak and children are left living in neglectful situations for too long before action is taken.

- Children who have child protection plans do have these reviewed regularly at core group meetings. Although many partner agencies contribute to children's planning and participate well in these meetings, this work often lacks a focus on understanding children's lives or measuring the impact for children. The actions taken are not sufficiently focused on ensuring that children are protected.

- Children who have child in need plans do not have their situations reviewed regularly enough. When reviews take place, they are not sufficiently focused on evaluating whether children's experiences are improving. In addition to this, where children are subject to emerging or increasing risks, this is not recognised or responded to. This results in many children continuing to experience neglect and some children being left at risk of harm.

- Despite neglect being a service priority for the local authority over the last 12 months, this has not resulted in a clear approach to responding to children experiencing neglect. For example, during the visit there was little evidence of professionals using any tools to help them understand, quantify and evidence neglect. The local authority and partners have provided some specialist training and have updated the practice guidance. At the time of this visit, approximately one third of social workers had attended this training, many only recently, and the renewed practice guidance has not been issued. As a result, any impact is not evident in work with children.

- Management oversight in a small number of teams has been weak. Until very recently, due to staff vacancies, some managers had been responsible for supervising staff across more than one team. In the majority of teams, there is evidence of regular management oversight on children's files. Records demonstrate some discussion and reflection and often some clear actions. However, these are not followed through, and often actions are not completed, and a lack of progress for children is not challenged and action is not taken to address it.

- Senior managers and leaders do not have an accurate understanding of the quality of practice. The local authority implemented a new framework for learning and improvement in July 2019. The structure of this is clear and there are some useful tools in place. However, this has not resulted in a coherent or consistent evaluation of children's experiences.

- Audits do not consistently focus on the impact of practice on children. Although many audits identify some weaknesses or gaps in practice, these weaknesses are not reflected in the overall evaluation of practice, which is often overly positive. Outputs from audits are often actions to complete tasks rather than any feedback or challenge about the quality of practice. Therefore, they do not support learning and development.

- The local authority self-assessment provided immediately prior to this visit did recognise many difficulties, such as those relating to capacity and staffing. It also acknowledged some weaknesses in practice, such as the poor quality of plans. However, it failed to fully recognise the impact of these on children's experiences or evidence that appropriate action is in place to address this.

- During this visit, inspectors found that the impact on children is significant and we identified serious concerns for a number of them. The local authority accepted these concerns and has acted to ensure that they are providing a more appropriate response to those children.

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

Yours sincerely

Paula Thomson-Jones
Her Majesty's Inspector