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Dear Ms Underwood

Focused visit to Nottingham children's services

Her Majesty's Chief Inspector of Education, Children's Services and Skills is leading Ofsted's work into how England's social care system has delivered child-centred practice and care within the context of the restrictions placed on society during the COVID-19 (coronavirus) pandemic.

This letter summarises the findings of a focused visit to Nottingham children's services on 30 June 2021. Her Majesty's Inspectors for this visit were Rachel Griffiths and Victoria Horsefield.

Inspectors looked at the local authority's arrangements for children in need and those subject to a child protection plan.

This visit was carried out in line with the inspection of local authority children's services (ILACS) framework. However, the delivery model was adapted to reflect the COVID-19 context. This visit was carried out on site, though with video calls for discussions with social workers. The lead inspector and the director of children's services agreed arrangements to deliver this visit effectively while working within national and local guidelines for responding to COVID-19 and meeting the needs of the local authority's workforce.

Headline findings

Nottingham City children's services were last inspected in November 2018 and were judged to require improvement to be good. At a subsequent focused visit in February 2020, inspectors found that the experience of children in need of help and protection had declined, resulting in two priority actions and four areas for improvement being set. Despite the unprecedented challenges of the pandemic, inspectors found evidence of improvements in these areas, albeit from a very low starting point. Leaders are realistic about the progress they have made, and about the large scale of change still required in order to embed workforce stability, raise the quality of

social work practice, and ultimately improve the lives and experiences of children living in Nottingham in need of help and protection.

Areas for priority action

The areas for priority action set at the last focused visit in February 2020 remain. There are no additional priority actions.

What needs to improve in this area of social work practice?

The areas for improvement set at the last focused visit in February 2020 remain. There are no additional areas for improvement.

Main findings

It has been an exceptionally difficult year for Nottingham. The impact of the pandemic has been significant. High rates of infection, prolonged periods of lockdown, and staff at all levels experiencing bereavement and loss have been very challenging. The local authority's response to COVID-19 has been proactive. Staff have adapted to working from home and children who are in need of help and protection have continued to be seen throughout the pandemic. Alongside the management of the pandemic, leaders have pushed ahead with their improvement plans, with some progress evident. However, embedding change and new ways of working with children and families at a time when visits have had to be adapted in response to COVID-19 restrictions has been a challenge, and has had an impact on the pace of change taking place.

The workforce in Nottingham has been stabilised over the last year. Most social work vacancies in the fieldwork teams have been filled. Most team managers are now permanent. There is a reduced reliance on agency staff. While still too high for some experienced social workers, caseloads have reduced, meaning that while some social workers are starting to have more time to spend with children and families, this is not yet the case for all practitioners.

Staff are positive about working in Nottingham. They report feeling well supported by managers and value improved communication with senior leaders via a practice forum. This is enabling them to share their experiences and contribute to improvement plans.

Staff reported positively about the training they have received in relation to relaunched practice standards and Nottingham's chosen practice model. Inspectors saw some effective examples of this training being put into practice. However, this is not yet consistent or embedded across the fieldwork service in order to have a positive impact for all children. The model of practice is not being consistently used in all aspects of practice or in supervision.

Social workers visit children regularly to monitor their welfare and safety. Unless there are exceptional circumstances, visits are always undertaken on a face-to-face basis. Most children now have a consistent social worker, providing greater opportunities for trusting relationships to develop and for children to have someone they can share their worries with.

Although children are being seen regularly, the quality and frequency of direct work being undertaken with them varies. Inspectors saw an example of excellent, creative direct work with a young child, which informed their assessment and plan. However, this is not happening for enough children, resulting in their life experiences not always being understood and their views not being central to assessments, plans and reviews.

The quality of assessments remains variable. In better ones, social workers demonstrated an understanding of the child's experiences and the impact of issues such as domestic abuse, substance misuse and parental mental ill health have on them. Weaker assessments do not fully analyse all needs and risks. Some assessments are not updated when children's circumstances significantly change. Some parenting assessments are significantly delayed, which has an impact on the effectiveness of planning for children.

There is a lack of consideration of some children's culture and heritage and how their specific identity needs can be met within assessments and plans, thus missing analysing crucial aspects of their lives. This is something leaders are aware of and, in consultation with the practice forum, plan to address.

Assessments in respect of children who are suffering from neglect are improving. Use of a recently launched neglect toolkit is helping staff to better analyse the impact of neglect. It is also helping parents to better understand the concerns and what needs to change. This is a relatively new development and it is too early to see the full impact of this for children who have been subject to long-term neglect.

Children's plans continue to vary in quality. Many have actions that are vague and not specifically targeted. As social workers tend to update plans, rather than rewrite them when actions have been completed or things have changed, it is difficult to see who is doing what, and what needs to change, by when.

Previously used 'contracts of expectations' have been replaced with the use of safety plans, with an aim of working with families to agree a way to protect children. While this is a positive development, safety plans are not yet being consistently written in partnership with families and they are not always updated to reflect progress and change.

Child protection reviews, core groups and child in need reviews are held regularly, with good attendance and information-sharing between professionals and parents. Although scaling is used in child protection reviews to measure children's progress

against their plans, this is not routinely happening in core groups and child in need reviews. Consequently, progress or decline in relation to children's experiences is not being fully captured. Minutes of meetings are not always shared promptly with parents. A parent spoken to during the visit advised that as a result, it is hard to have a clear understanding of what is required of them, and by when, to help ensure that their child's life improves.

Too many children in Nottingham continue to be the subjects of repeat or long periods on a child protection or child in need plan, often for the same reasons. Interventions in these plans have not been successful in bringing about sustained positive change for some children, resulting in them living in neglectful situations for too long. Leaders have now recognised that long and repeat plans are areas that need more robust management oversight. In response, a pilot panel, chaired by the head of service, has been established to review children on repeat plans or plans exceeding 15 months more thoroughly to prevent drift and delay. It is too soon to see the impact of this.

When risks to children increase, and children become subject to the Public Law Outline (PLO) process, service managers and the head of service closely monitor their progress in this process to protect them, and prevent any further delay for them. A recently developed electronic performance reporting system is due to go live in respect of PLO cases to enable more robust analysis of the quality and impact of pre-proceedings work and to help inform development and improvement.

When children's circumstances do improve and their child protection plan ends, the majority of children then become subjects of child in need plans. While children continue to be seen by their social worker regularly in these circumstances, their plans are not always adapted to reflect the change in status. This means that it is unclear what work will be undertaken with children and their families and how progress will be evaluated after stepping down from child protection plans.

All social workers now receive regular supervision and those spoken to were largely positive about this. Supervision records are, however, largely descriptive, and lack reflection and challenge. Actions on cases are often repeated without exploration of what the barriers are to completing them, or reflection of how things could be done differently. This does not drive case progression. In respect of assessments and plans, managers review and authorise these but do not routinely record any constructive feedback as to the strengths and areas for development, thus missing an opportunity for learning.

Quality assurance systems have been developed since the last focused visit. There is now an embedded audit process that includes collaborative audits, moderation and dip sampling. This is enabling senior leaders to have a better understanding of the quality of practice. Leaders recognise that there is more to do and are now focusing on improving the quality, consistency and impact of audits to help drive

improvements. Leaders also plan to seek more feedback from children and families to inform their improvement journey.

Having sufficient capacity in relation to quality assurance has been a resource challenge for the local authority and in response to this, support from a neighbouring authority has been welcomed and used with positive impact. It is not clear that there is sufficient internal capacity to maintain the necessary momentum in quality assurance work, once the current external assistance ends.

Ofsted will take the findings from this focused visit into account when planning your next inspection or visit. I am copying this letter to the Department for Education. It will be published on the Ofsted website.

Your sincerely

Rachel Griffiths
Her Majesty's Inspector