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David Watts  
Interim Director for Children's Services  
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Dear Mr Watts

### **Focused visit to North Northamptonshire children's services**

This letter summarises the findings of the focused visit to North Northamptonshire children's services on 18 and 19 October 2023. His Majesty's Inspectors for this visit were Lisa Walsh and Kendra Bell.

Inspectors looked at the local authority's arrangements for the 'front door'.

This visit was carried out in line with the inspection of local authority children's services (ILACS) framework. Inspectors looked at a range of evidence, including case discussion with social workers and managers. They also looked at local authority performance management and quality assurance information and children's case records.

### **Headline findings**

Since the previous full inspection in October 2022, Northamptonshire Children's Trust (NCT) has continued to deliver children's social care and targeted early help services on behalf of West Northamptonshire and North Northamptonshire councils.

Since the previous inspection in October 2022, when the overall effectiveness of the service was judged to be requires improvement to be good, senior leaders have maintained a firm focus on improvement through external reviews, quality assurance processes and a realistic improvement plan.

Leaders know their front door service well. They understand the services strengths, specifically: an increasingly stable workforce, improvements in the quality of social work interventions and assessments.

Leaders are also acutely aware that there is much more to do in terms of: the consistency of the whole partnership's understanding and application of thresholds, decision-making and management oversight in the multi-agency safeguarding hub (MASH), initial responses in the MASH to children at risk of exploitation and those

who go missing from home, responses to children out of hours, the development of early help provision, and the effectiveness of current IT systems. Actions to address these weaknesses are underway but are not yet complete or evidencing impact. As a result, help and protection for some children is not provided at the earliest opportunity.

### **What needs to improve in this area of social work practice**

- The quality and effectiveness of decision-making and management oversight in the MASH.
- Initial responses in the MASH to children who go missing from home and who are at risk of exploitation.
- Responses to children in need of help and protection out of hours.

### **Main findings**

The MASH receives a high number of contacts, the majority of which do not meet the threshold for statutory intervention. The quality of contacts from partners is inconsistent, placing an additional burden on social workers to determine the level of risk and need. Senior leaders are aware of the impact this places on the service and are implementing clear plans to support partners to better understand threshold.

Most partners obtain parental consent for information to be shared with the MASH, with the exception of the police. This creates additional work for social workers who have to contact families before being able to progress work. Contacts do not consistently obtain details of children's ethnicity to inform their decision-making.

The majority of contacts are reviewed in a timely way by team managers, providing a rationale for further action. Partnership working in the MASH is mostly effective, and when children appear to be at risk of immediate harm, the response is timely, and the application of thresholds are mostly appropriate. When further information is required, proportionate agency checks, as well as the consideration of children's histories, are used by social workers in the MASH to inform the next steps.

Management oversight does not consistently provide a clear rationale for future action or ensure timely progression of contacts through the MASH, when risk of harm is not immediate. A small number of children wait too long to receive support, and for some, the impact of accumulative neglect is not always recognised. This contributes to delays in effective intervention being provided to improve children's circumstances.

Children at risk of exploitation are not consistently responded to at the earliest opportunity in the MASH. Some children experience repeated contacts prior to intervention to assess risk and provide protective intervention. Service responses do

not take sufficient account of how risks outside the home might impact on children, particularly those who go missing from home.

When outcomes of MASH enquiries result in no further action, social workers and team managers do not consistently consider whether the family could be supported through early help services.

For some children, there is a lack of professional curiosity and over optimism from social workers and team managers within MASH, which results in no further action being taken without the appropriate information to inform an analysis of risk. This can lead to repeated contacts and children's needs not being met at the earliest opportunity.

When a strategy meeting is required, they are mostly timely and consistently involve appropriate partners. Information provided to strategy meetings appropriately reflects the risks to children. Actions focus on immediate protection, as well as considering wider issues. For a small number of children these meetings are delayed, meaning that plans to safeguard children are not implemented in a timely way.

When initiated, child protection enquiries are mostly timely and thorough. Social workers see children, though not always as promptly as they should. Social workers implement interim safety plans. The quality of plans could be improved to include partners and provide clarity as to who is doing what to safeguard the child.

When children go missing from home, the majority receive timely return home interviews. This enables workers to have a better understanding of why children go missing and informs planning to reduce further risk. Despite this, MASH responses to children going missing or who are at risk of exploitation are not yet robust enough. Decision-makers are not consistently analysing all information and providing a clear rationale for next steps. Some children experience repeated contacts prior to intervention in order to assess risk and provide protective intervention, but an evaluation of risk is not routinely evident in records about the places and spaces where children are going missing from home. Therefore, plans to reduce risk are not always occurring at the earliest opportunity.

Children do not consistently receive an effective safeguarding response from out of hours services. Children are not always seen by social workers when this is needed, and parental safeguarding actions are not always appropriately verified.

When children transfer from MASH to the duty and assessment team (DAAT), team managers allocate children's cases promptly and provide social workers with clear guidance. Children are seen quickly, and immediate safety planning is usually completed with families. This means that there is a clarity as to mutual expectations and understanding of what they need to do to prevent or minimise risk for children. Collaborative, strengths-based social work practice is having a positive impact for many families. Assessments are informed by purposeful direct work with

children to fully understand their experiences, leading to appropriately focused plans. A small number of assessments continue to fail to analyse children's full histories, the experiences of all children within a family, and their unique characteristics.

Social workers feel that caseloads are manageable within the DAAT, allowing them to have the opportunity to build meaningful relationships with the children and families with whom they work.

Social workers across front door services are very positive about working for the NCT. They describe a supportive, strengths-based culture. They report feeling highly valued by managers and leaders at every level. Staff are motivated, and like their leaders, they are committed to improving the lives of children in North Northamptonshire.

The positive culture described, alongside a successful workforce strategy, has resulted in the workforce in the front door being more stable than it has been in years. Leaders remain focused and determined to build on this stability even further.

A range of quality assurance activities, including the use of collaborative reflective practice discussions with social workers, are providing leaders with a line of sight of the quality on impact of social work practice. Leaders are fully aware that there remains more to do to improve the quality and consistency of the collaborative reflective practice discussions, and to demonstrate how this activity is improving social work practice and children's experience. Leaders have recently refreshed their quality assurance processes in response to an external review, but it is too soon to see the full impact of this.

Current electronic systems are too complicated. Social workers in the MASH have to navigate through seven different systems. This is burdensome and time consuming for very busy staff who are dealing with high numbers of contacts each day. Leaders have taken action to respond to this. New IT systems are in the process of being procured. This, as well as the front door improvement plans and early help strategy, demonstrate leaders' aspiration to ensure that children receive a consistent and proportionate response from all front door services.

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

Yours sincerely

Lisa Walsh  
His Majesty's Inspector