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Dear Ms Wilshire

Focused visit to West Northamptonshire children's services

This letter summarises the findings of the focused visit to West Northamptonshire children's services on 18 and 19 October 2023. His Majesty's Inspectors for this visit were Rachel Griffiths and Naintara Khosla.

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 discussions 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 that inspection, 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 service's strengths, in particular, an increasingly stable workforce and 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 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 who go missing, responses to children out of hours, the development of early help provision

and the current IT systems. Actions to address these weaknesses are under way but are not yet having an 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 and who are at risk of exploitation.
- Responses to children in need of help and protection out of hours.

Main findings

The MASH receives high numbers of contacts, the majority of which do not meet the threshold for statutory intervention. This, together with the inconsistent quality of information provided in the contacts, means that social workers must spend more time than should be necessary trying to understand the information received, to analyse risk before making informed decisions.

Social workers in the MASH promptly consider the contact information they receive to inform next steps. They do not, however, consistently obtain details of children's ethnicity to inform their decision-making.

Parental consent is increasingly being sought by most partners before a referral is submitted to the MASH. There is, however, an exception for the police, for whom there is an agreement that this is not required. This places an additional burden on busy social workers who must then seek consent before doing wider checks. Team managers appropriately overrule the need for consent if children's safety requires this.

When risks of harm are immediate, social workers act quickly, with prompt multi-agency checks being undertaken by MASH partners to inform the next steps.

Partnership working in the MASH is mostly effective. When further information is required to inform the next steps, proportionate agency checks, as well as consideration of children's histories, are undertaken to inform decision-making. The records for decisions made by team managers or social workers, do not always provide a clear rationale for the next steps or explain why an alternative response would not be more appropriate.

In some instances, social workers in the MASH do not fully recognise the cumulative impact of neglect. A lack of professional curiosity and overoptimism can lead to no further action being taken. In some instances, this leads to repeat contacts and children's needs not being met at the earliest opportunity. Additionally, when the outcome of MASH enquiries is no further action, social workers and team managers

do not consistently consider whether the child and their family could be supported by early help services to prevent smaller problems escalating into bigger ones.

When children are at risk of harm, strategy meetings usually take place promptly. Effective information-sharing between partners at these well-attended meetings results in appropriate outcomes that are proportionate to the assessed level of risk. For a small number of children, MASH staff do not consider strategy meetings soon enough, or they are delayed. This means that plans to safeguard children are not always implemented at the earliest opportunity.

When initiated, child protection enquiries are mostly timely and thorough. Social workers see children, though not always as promptly as they should do. Social workers implement interim safety plans. However, the quality of these could be improved to provide clarity as to who, including those in the wider partnership, is doing what to safeguard children.

Since the previous inspection, more children who go missing are benefiting from timely return home interviews. These are helping workers to understand the reasons for children going missing. Positively, the numbers of children having repeat incidents of going missing are reducing in West Northamptonshire.

Despite this, MASH responses to children who go 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 to assess risk and provide protective intervention. An evaluation of risk is not routinely evident in records about the places and spaces where children are when they go missing. Therefore, plans to reduce risk are not always drawn up at the earliest opportunity.

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

When children’s cases transfer to the duty and assessment team (DAAT), social workers are promptly allocated to complete an assessment of children’s needs. Team managers provide workers with clear guidance at the start of these assessments and in subsequent supervision sessions, with a focus on time frames and the specific areas that need to be considered in assessments.

This guidance has assisted with the improvement in the quality and consistency of assessments since the previous inspection. Assessments are timely and most analyse the views of children, parents, wider family networks and the professionals involved. Collaborative, strengths-based social work practice is having a positive impact for many families. 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.

Having a manageable workload means that social workers in the DAAT teams can build positive relationships with children. Many skilfully do this. Creative direct work undertaken by some social workers enables them to develop a good understanding of what life is like for children. Children's views are generally included in their assessments and plans.

Social workers across front door services are very positive about working for 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 West Northamptonshire.

The positive culture described, alongside a successful workforce strategy, has resulted in the front door workforce 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 experiences. 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 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 acted in response 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, demonstrates leaders' aspirations of ensuring that children receive a consistent and proportionate response from all front door services.

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

Yours sincerely

Rachel Griffiths
His Majesty's Inspector