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Theresa Grant
Chief Executive
Northamptonshire County Council
One Angel Square
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Dear Ms Grant,

Focused visit to Northamptonshire local authority children's services

This letter summarises the findings of a focused visit to Northamptonshire local authority children's services on 17 and 18 October 2018 carried out by Linda Steele and Peter McEntee, Her Majesty's Inspectors.

Inspectors reviewed the local authority's arrangements for managing contacts and referrals in the multi-agency safeguarding hub (MASH) and thresholds for children in need of help and protection. Inspectors reviewed a range of evidence, including children's case records, case discussions with social workers, performance management and quality assurance information, and supervision files.

Overview

When children in Northamptonshire are referred to children's social care, they are not consistently or effectively assessed, supported or protected. Children who have the greatest welfare and safeguarding concerns generally receive a service from the multi-agency safeguarding hub (MASH) which ensures that those families and children requiring intervention are initially responded to. However, subsequent action is insufficiently robust and leaves some children's circumstances unassessed for too long and potential risks unidentified.

Against a backdrop of recent significant financial uncertainty and changes in leadership at corporate and managerial levels, services considered during this visit have significantly declined in the past two years since the single inspection in 2016.

This uncertainty has contributed to significant shortfalls in social work capacity across the service, resulting in unmanageable caseloads and high volumes of unallocated and unassessed work. Senior leaders are aware of these serious weaknesses and have taken remedial action to respond. However, this has not been effective or with sufficient urgency or rigour. Consequently, at the time of this focused visit there was insufficient capacity in the MASH and the first response teams to meet the needs of children and families.

Areas for priority action

The local authority needs to take swift and decisive action to address the following areas of weakness in child protection:

- workforce capacity, by ensuring sufficient numbers of experienced social workers and managers, and by ensuring that all caseloads are manageable, and that oversight is robust
- case allocation and progression, by ensuring that all referrals of children receive a timely evaluation, and that those requiring an assessment are quickly allocated and visited; also by ensuring that good quality assessments are completed in line with each child's needs.

What needs to improve in this area of social work practice

- appropriate application of thresholds for making referrals for statutory social work intervention
- the quality and effectiveness of management oversight and supervision
- social work recording, performance management and quality assurance arrangements
- the timeliness of contacts entered on the electronic recording system.

Findings

- The quality of assessment services to children in need of help and protection in Northamptonshire has substantially declined since the single inspection in 2016. Considerable financial instability across the council has led to government intervention and significant challenges in ensuring workforce sufficiency. Changes in leadership at corporate and managerial levels have impacted on leaders' ability to respond to identified weaknesses. Consequently, there is considerable variability in the quality of intervention for children. The impact of this means that some children are not consistently or effectively assessed, supported or protected.

- The senior leadership team has begun to tackle the identified weaknesses in the service. They have taken some action to strengthen the management arrangements of the MASH and first response teams. A new social care board has very recently been established to focus on the work needed and to ensure sufficient resource in order to support improvements. Partners in practice has been commissioned to provide focused assistance, challenge and support to improve the pace of change.

- Nonetheless, at the time of this focused visit, 267 children in need of a statutory assessment and social work intervention did not have an allocated social worker. Capacity to allocate children's cases has been a longstanding problem since the beginning of 2018. The number of unallocated cases has reduced from 551 in January but has remained stubbornly between 200 and 300. Although senior managers had taken action to review these cases either shortly before or during the focused visit, in cases sampled by inspectors there was no evidence of risk being identified, managed or robustly reviewed. This lack of oversight and poor management leaves children at potential risk of harm.

- There has been very recent work to streamline the MASH, but systems are not yet effective in ensuring that risk and need is addressed, with some duplication evident. While all contacts are assessed by practice managers, decision-making is not consistently timely, nor supported by clear rationales. It takes too long for decisions to be made about many contacts and for these decisions to be recorded on the system.

- When children are referred to the MASH, social workers and managers do not make consistently good decisions regarding thresholds. Some children's cases that require social work intervention are closed prematurely. Other children's cases are progressed to the first response team when the children's needs could be met at a lower level. This level of inconsistency regarding the application of thresholds not only means that children do not consistently receive the right service to meet their needs, but it also leads to additional pressure on the service.

- Not all partners understand or apply thresholds appropriately when making referrals. As part of the MASH recovery plan, the local authority is rolling out a programme of training sessions for partners and local authority staff to develop understanding regarding thresholds and levels of need.

- Social work caseloads in the first response teams are too high, with many social workers responsible for between 30 and 50 children. Social workers reported to inspectors that they were 'overwhelmed' and 'drowning'. As a result, visits to children are not sufficient, and rushed home visits lead to superficial, weak assessments, which results in delays in providing support.

- The voice and experiences of children are not always present in assessments and case recording. Assessments focus primarily on the presenting problem, lacking robust analysis of what this means for children. They fail to assess the impact of

fathers and other significant males in children's lives. As a result, they do not sufficiently address or evaluate all areas of potential risk and need.

- When children are at immediate risk of harm, most strategy meetings are timely, make the right decisions about next steps and include relevant professionals. Records of these meetings vary in quality; some do not contain sufficient information to evidence the rationale for the decisions taken. However, in a small minority of cases, delays in convening strategy meetings result in children remaining in situations of unassessed risk. Child protection enquiries, when initiated, are prompt and most accurately outline risk and protective factors.

- Weak management oversight, supervision and quality assurance processes mean that poor practice goes unchallenged and that children's needs are left unmet. Frequent changes in social workers and managers mean that plans to strengthen the quality of practice lose momentum. Consequently, too many children experience unacceptable drift and delay in having their needs met.

- Senior leaders are acutely aware of the negative impact of an unstable workforce on the quality of support to children. They have taken action to review and re-evaluate pay and rewards for staff and to refocus recruitment. Although this is a positive move in the right direction, much instability in the workforce remains, and it is made more fragile by an over-reliance on agency workers.

- Newly established processes for reviewing the backlog of work and ensuring allocation is not yet having sufficient impact. A significant number of children (267) remain without an allocated social worker and without having their needs unassessed. The majority of these children have been waiting for an assessment for more than seven days and a minority have been waiting for up to four months. Many of these children have not been seen for substantial periods of time and their current circumstances and safety are unknown.

- A lack of compliance in meeting basic practice standards, including manager engagement with the audit process, is evident. Senior managers have not been effective in tackling this important weakness. This work is critical to ensure that social workers and managers are clear about what good practice and good services look like in order to raise quality standards.

- Performance reporting is not consistently reliable. Delays in inputting contacts and allocating work means that it is difficult to be confident about the accuracy of performance information. Recording onto the children's recording system by staff is not always timely. This weakens managers' oversight of practice, preventing them from gaining an accurate insight into whether children are effectively supported and protected.

Please send your action plan responding to the areas for priority action to ProtectionofChildren@ofsted.gov.uk within 70 working days of receiving this letter.

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

Yours sincerely

Linda Steele
Her Majesty's Inspector