Ofsted reports – children’s social care early help and local authority leadership

Date 9 April 2015
Author Martin Rogers
LGiU/CSN Associate

Summary

Alongside its recent annual report on children’s social care, Ofsted published two other reports: (i) a thematic inspection report which evaluates the effectiveness of the early help services for children and families provided by local authorities and their partners, and (ii) a good practice report which looks at the ways in which successful leadership in children’s services leads to better practice and improves the lives of children and families. This briefing summarises both reports.

This briefing will be of interest to members and senior officers with responsibility for children’s social care.

Overview

When Ofsted published its recent annual report on children’s social care (see ‘Related briefings’), it published two other reports on key aspects of children’s services:

Early help: whose responsibility?

The thematic inspection report Early help: whose responsibility? draws on evidence from inspections and the examination of cases in 12 local authorities (LAs). The report emphasises the importance of early help services, and recognises that LAs and their partners are focusing increasingly on early help and prevention services for families, with many ‘now establishing a more coordinated and structured approach to this crucial role’. However, Ofsted found that opportunities to provide earlier help had been missed in one third of cases; assessments were of poor quality in more than half of cases; planning was effective in only one third of cases; management oversight was often weak, and was not being monitored by Local Safeguarding Children Boards (LSCBs); and LAs and their partners were not fully evaluating the impact of their early help work. The report’s detailed findings provide not just a critique of short-comings but – both implicitly and explicitly – a useful guide to improving the quality of provision.

Joining the dots… Effective leadership of children’s services

The good practice report, Joining the dots… Effective leadership of children’s services draws on evidence from visits to nine LAs selected on the basis of their inspection judgement history: some had been consistently good for a number of years; others were on an improving trajectory – from ‘inadequate’ to ‘requires improvement’ or from ‘requires improvement’ to ‘good’.
Early help: whose responsibility?

Introduction
The report lists the difficult family circumstances in which over two million UK children live:

- 2.6 million living with parents who drink hazarudoously, 705,000 of whom are dependent on alcohol
- 110,000 adults who were parents or lived with children were treated by the National Agency for Substance Misuse in 2013–14
- 130,000 children are living in families with past or present domestic abuse
- 17,000 children are living with parents with a severe and enduring mental illness.

During 2013–14, there were 657,800 concerns about children referred to children’s social care services – an increase of 10.8% compared with the previous year.

The report cites the Munro review of child protection, the Allen report (Early intervention: smart investment, massive savings), the Tickell report on the early years foundation stage and Frank Field’s independent review on poverty and life chances as identifying a growing body of evidence of the effectiveness of early help for children and their families. Professor Munro recommended that a duty should be placed on local authorities and statutory partners to provide an ‘early offer of help’, but this was not accepted by the government, which considered the existing duty to cooperate set out in sections 10 and 11 of the Children Act 2004 to be sufficient. The 2013 revision of the statutory guidance Working together to safeguard children (a new revision of which was published on 26 March 2015) re-emphasised the crucial role of early help, and placed a duty on LSCBs to ensure that an agreed threshold document was in place so that all professionals are clear when it is their responsibility to help children and families as difficulties emerge. The statutory guidance on the roles and responsibilities of DCSs and Lead Members also says they should take account of the benefits of prevention and early intervention and the importance of cooperating with other agencies to offer early help to children, young people and families.

Research evidence and Ofsted’s inspection findings suggest a number of key issues:

- neglect and emotional abuse are associated with the most damaging long-term consequences for children
- thresholds for intervention are not shared across partnerships
- professionals find it difficult to identify these types of abuse and to decide when a threshold for action has been reached; they often had high thresholds for recognising them, and these forms of harm are rarely acted upon without a trigger incident
- thresholds for access to children’s social care are high, which may deter referrals
- individual skills and knowledge varies, and this is pivotal to identifying early help needs.
Findings from practice

Early help provision

A wide range of professionals working in universal services are identifying additional needs for children and families, and inspectors considered 56 early help cases across a wide range. Findings included:

- opportunities to intervene earlier had been missed in over 40% of cases; factors included:
  - delays in information sharing between agencies
  - delays in providing services following assessment, and parents not being given support when they first ask for help
  - a tendency to respond only in a crisis to families with long-standing identified needs

- the quality of early help assessments was too variable, with fewer than half judged good
  - poor assessments: failed to analyse information; were over-descriptive and unclear about strengths and concerns; relied on one parent’s self-reporting, with little input from professionals; did not consider the family’s history nor the significance of current issues; focused too much on the parent rather than the impact of the parent’s difficulties on the child; and contained limited about the father or other partners
  - good assessments were characterised by: seeking the child’s views and experiences; consideration of siblings’ needs individually; the participation and consent of both parents; the family’s history informing findings and decisions; all professionals known to the family contributing; comprehensive information; needs, risks and strengths clearly identified; and sound conclusions based on good analysis of information

- assessments were generally better where a standardised assessment tool was used (eg. Signs of Safety or an ‘evaluation wheel’)

- A common, significant failing was not engaging fathers or male partners living in the household

- effective planning contributing to improved outcomes was found in only just over a third of cases; such planning included regular reviews of plans focused on outcomes and good use of progress tools that attempted to measure and evaluate desired outcomes. Although practitioners could normally articulate verbally that outcomes had improved, this was often absent from written records; some plans did not feature the needs identified in assessments, and a majority were not sufficiently specific or measurable; plans were too often a list of actions that did not identify the outcome to be achieved or how to assess whether it did.

Referrals to the local authority

In order to consider the application of thresholds, inspectors examined referrals to the local authority, including cases that did not progress beyond referral and those that progressed to a formal assessment followed by statutory intervention then ceasing. They spoke to 62 referring professionals and the social work staff who made decisions on the referrals, over a quarter of whom said they struggled to understand and apply local thresholds. Other findings included:

- in just over three quarters of the cases closed at the point of referral, this decision was considered appropriate – but, though statutory intervention was not required, children and
families would have benefited from an early help offer and this opportunity was missed for some

- almost a quarter of cases were closed inappropriately at the point of referral. In these:
  - risk was not well considered and action not taken when it should have been
  - a re-referral for the same issue was made in the subsequent three months that could have been addressed with the information known originally
  - the referral quality was poor and the referral was closed without children’s social care speaking to the referrer to establish the reason for their decision
  - the case was closed without completion of identified tasks

- **good quality referrals** were timely and contained the following features: concerns about the child and a rationale for referral; reference to the local threshold document; clarity about how the concerns affected each child in the family; evidence that concerns had been discussed with parents and consent sought and obtained; context and historical information; a balance between positive factors and risk; a summary of views of other professionals; identification of any language barriers or the need for an interpreter

- almost half of the referring professionals took no further action when children’s social care closed the case, and did not seek to secure early help for the child; in too many cases, children’s social care also failed to secure appropriate support – demonstrating continued confusion about partnership roles and responsibilities

- despite guidance in *Working together* requiring children’s social care to give feedback to the referrer on the decisions taken, this was not done in one third of cases examined – and many referrers had no expectation of feedback and did not seek it

- ‘Our [Ofsted’s] evidence from this inspection indicates that in 30% of cases examined not all children and families with additional needs were given help when they did not meet the threshold for statutory intervention. A question remains about who is responsible in such a scenario?’

### Monitoring and evaluating the effectiveness of early help

#### Management oversight

‘Overall, there were significant weaknesses in the quality and focus of supervision and management oversight of early help cases… inspectors only saw written records of management oversight in just over half of the early help cases… Of those that had a written account of management oversight, fewer than half considered the effectiveness of the child’s plan. Even fewer considered whether the plan was improving the child’s circumstances and experiences. Managers also missed opportunities to challenge poor professional practice.’ Other findings:

- none of the local areas had developed a multi-agency process for the standard of management oversight that should be offered to professionals who contribute early help; LSCBs were often unaware of the level and consistency of management oversight
- practitioners regularly used their peers and professional networks for support
- where early help coordinators existed, they were highly valued

#### Quality assurance

‘The current approach to quality assuring and monitoring the effectiveness of early help is disparate, disjointed and significantly underdeveloped… Local authorities and their partners have
limited information on how early help is improving children’s circumstances... The local authority and/or partners have not developed systems to identify whether success is sustained in the long term for children and their families. Furthermore, analysis by the local authority and/or partners does not yet sufficiently focus on whether the ‘right’ children are receiving early help and whether early help is reducing the numbers of children that require a statutory response... there is no way of knowing whether early help services are targeting the most vulnerable children in the area... Impact for children who receive early help and those who receive a statutory service are often seen separately and in isolation. Improved analysis that encompasses both early help and statutory services is needed to ensure that the ‘right’ children are receiving help when they need it and that the responsibility for help does not fall unfairly on the local authority.’

Roles and responsibilities

‘The evidence on this inspection indicated that current statutory powers do not provide a sufficient focus for any one agency or partners collectively to give early help the priority that it requires... Evidence further showed that children’s needs were sometimes left unmet and no agency had overall responsibility to provide help... This thematic inspection demonstrated significant variability in the effectiveness of local shared accountability and coordination of early help services... In many areas, a disconnect remains between statutory service provision and an early help offer for children.’ Other points include:

- not all partnerships had yet developed a shared early help strategy, and none had scrutinised the effectiveness of the delivery of their strategy and its impact on improving outcomes for children at the earliest point or reducing the need for higher cost more coercive help
- many JSNAs fail to focus sufficiently on and prioritise potential child protection issues (eg. the prevalence of parental mental ill health, drug and alcohol misuse or domestic violence), and few routinely identify the number of children affected by such issues
- whilst Working together requires LSCBs to publish a threshold document that includes an outline of early help assessment and the type and level of services to be provided, there is no requirement to evaluate the effectiveness of the application of the threshold document
- Working together identifies specific groups of children who would benefit from early help (eg. children who are disabled or have specific additional needs or special educational needs, young carers, those showing signs of engaging in anti-social or criminal behaviour, those in a family situation presenting challenges to the child, and those showing early signs of abuse and/or neglect), but professional awareness of and about such vulnerable groups was very low – possibly preventing them from identifying and providing early help to families
- LSCBs indicated that specific focus on early help training was underdeveloped; no LSCBs could confirm whether all those who needed to be trained on early help had received appropriate training, and only a quarter had developed processes for monitoring and evaluating the impact of training (thus failing to take sufficient account of their statutory duty to do so set out in Working together).

Learning from serious case reviews

Research on SCRs of children’s cases during 2009–2011 identified that 42% of cases were receiving a service from children’s social care at the time of the incident and 23% had previously been known to children’s social care – which suggests that some cases were being closed
prematurely. In a further 14% of cases, referrals were received but not accepted for assessment. The research noted that thresholds to children’s social care were set too high, particularly when neglect was the primary concern.

A sample of recent SCR findings which relate to early help reflect the findings of this thematic inspection, confirming that insufficient attention is given to SCR findings and how these inform and improve practice. Issues arising from these cases include: a lack of focus on the child; thresholds not understood across partnerships and set too high; adherence to procedures over common sense protection of children and young people; poor communication and inter-agency working; delays in early help services being provided and a lack of follow-up if a child did not take up the use of a service; a lack of satisfactory management oversight of practice in relation to early help; a lack of critical analysis and accepting information at face value; risks from fathers/partners not sufficiently considered. Reflecting findings from SCRs, inspectors asked professionals about training they had received to support their work with families who are reluctant or resistant to engage; whilst two thirds had received some training, one third had not – and many commented that it would be helpful.

Conclusion
Evidence from Ofsted’s ‘SIF’ inspections of LAs and from this thematic inspection shows clearly that the offer of help to families when concerns first arise is increasingly prioritised by LAs and their partners, so more children are benefiting from better focused and coordinated support earlier. However, the quality and effectiveness of early help services remains too variable between areas and within the same services. Planning is not informed by robust needs assessments, and evaluation of impact is not well developed.

There is a lack of clarity about statutory roles and responsibilities for the provision of early help, and ‘the recommendations from this thematic inspection should be urgently considered by government so that the costs and poorer outcomes of later intervention can be avoided.’

Recommendations
The report includes recommendations for the government, LAs and partner agencies and LSCBs. Those for LAs and LSCBs can be readily anticipated from the findings about practice; the two recommendations for government are that it should:

- strengthen and specify the roles and responsibilities of local authorities and statutory partners, setting out that they must secure sufficient provision of local early help services for children, young people and families and require that an annual plan is published by the partnership and aligned with the local joint strategic needs assessment
- require LSCBs to evaluate the quality and effectiveness of early help services and to publish their findings in the annual LSCB report.

Joining the dots… Effective leadership of children’s services
‘Leadership style was found to be a critical feature in the local authorities visited. Although not all leaders possessed the same qualities, the style in which they engaged their staff, partners and local community was central to their success in driving change and improvement. Their approach was open, honest and collaborative. They were driven by a strong moral base informed by solid professional knowledge. These successful leaders modelled expected behaviour and set clear expectations for staff. They were credible and highly visible, and inspired staff to perform well.'
They set high standards for workers and developed a culture which was supportive and challenging while acknowledging risk and the need for clear accountabilities.’

In an initial evaluation of the first 11 ‘SIF’ inspections, common leadership characteristics were identified in the ‘good’ LAs:

- senior leadership investment in the professional environment enabled social work to flourish
- senior leaders monitored casework, and management oversight focused on quality of work as well as volume
- leaders kept staffing vacancies under review and used local knowledge and effective strategies to help retain and attract staff
- supervision and training were effective in retaining and developing staff
- managers understood and managed caseloads; they knew children and care plans well
- principal social workers positively influenced practice and provided the professional voice in senior management teams.

This good practice thematic inspection explored these findings further, drawing on evidence from visits to nine LAs selected on the basis of their inspection judgement history: some had been consistently good for a number of years; others were on an improving trajectory – from ‘inadequate’ to ‘requires improvement’ or from ‘requires improvement’ to ‘good’. The line of questioning and methodology was also informed by work done in 2010 and 2011 by the (then) National College for Leadership of Schools and Children’s Services (now National College for Teaching and Leadership) and Virtual Staff College in (respectively): Resourceful leadership: how directors of children’s services improve outcomes for children and National Leadership Qualities Framework for Directors and Senior Leaders of Children’s Services.

The report does not readily lend itself to summarising as it largely comprises brief case studies (which really need to be read in full) and observations and quotes from the fieldwork under a series of section headings. However, key points are highlighted below.

Leadership style

This was a critical feature in the LAs visited. Not all individuals had the same qualities, but the leadership teams all shared a common set of complementary talents and behaviours, and the style in which they engaged their workforce, partners and communities was the key element in driving improvements.

- an effective and strong leadership style was necessary to develop a clear vision for the improvement agenda. This was a particular challenge for leaders who had stepped into poorly performing authorities. Staff were often unmotivated, and felt deskilled and undervalued. Leaders, especially DCSs, spent time building and maintaining relationships with staff
- several local authorities visited had established a collaborative leadership approach. This led to ownership of improvement plans across the organisation. In several authorities task and finish groups involved people throughout the organisation on an equal footing
- modelling the behaviour expected from staff was a powerful way of ensuring that staff were carried along with the overall vision
- leaders in these authorities did not become complacent. They understood that, despite ongoing improvements, they needed to ensure that they kept doing the basics well.
How successful senior leaders oversee safe and effective professional practice

- senior managers took decisive action when necessary and staff trusted their ability to do what was right for children. They encouraged creativity, while ensuring that there were consistent approaches. Leaders supported a model of reflective supervision and provided challenge in a supportive and structured way
- all authorities had introduced decision-making structures to ensure that, where appropriate, decisions were overseen by a middle or senior manager. These enabled a frank discussion and social workers told inspectors that, as a result, they understood the rationale for decisions and what they needed to do to progress cases
- the emphasis for most senior leaders in developing safe and effective practice was on relationship-based work and listening to what children and young people were saying. This behaviour mirrored that modelled by senior managers in their work with partners, other leaders and staff. This strength in building relationships enabled good practice to flourish and encouraged families to fully engage in work
- the importance of good, effective and reflective supervision was recognised in all the authorities visited… [they] were continuing to work on ensuring that reflective supervision was not only offered as standard, but that supervision records demonstrated how discussions had influenced practice.

Workforce overview
Challenges remained in many authorities in recruiting and retaining a skilled and competent workforce. Leaders were developing innovative strategies and ways of overcoming these challenges including succession planning, ‘growing their own’, an emphasis on learning and development, protecting budgets and caseloads and allowing workers space to do their jobs effectively and efficiently. Some LAs encouraged students to take up placements; many encouraged agency workers to attend training in the same way as permanent staff, and encouraged those assessed as effective to apply for permanent positions. It was critical that LAs invested in the workforce so that workers had manageable caseloads.

Performance management
In the early stages of the improvement journey establishing effective performance management was a challenge. The elements of leadership style outlined earlier were crucial in ensuring that staff felt part of the improvement process and did not feel ‘blamed’ for the overall previous poor performance. DCSs and other leaders used many methods to keep a strong ‘grip’ on the front line to make sure that necessary improvements were being made, including: scrutiny and analysis of performance information and data; examination of audit findings for themes and areas for development; using inspection findings and action plans; listening to staff, service users, partners and complainants – and acting swiftly on what was heard.

All of the LAs had processes to ensure that they became learning organisations, learning from local and national SCRs and from everyday practice and sharing learning through bulletins, short guides and aide memoirs to help with practice.

Listening to children, young people and their families
Senior leaders proactively sought feedback from a variety of sources and acted on it. Some LAs were developing creative approaches to systematically gather the views of children and families.
about their experiences. In all the authorities visited, the senior leadership team (including elected members and the chief executive) invested time visiting children and young people, getting to know the cases, and were passionate about doing their best for families. LAs routinely dealt with complaints and regularly collated the outcomes, recommendations and learning. Complainants were given time and attention and were seen as a valuable learning tool.

**Leadership and management structures**

Management structures varied between authorities, depending on size, geography and history but the common, critical theme was that there was clarity of role, accountability and responsibility. Chief executives saw their role as being supportive – fostering the right environment for the director and senior management team to undertake their roles successfully. Elected members supported and challenged, providing scrutiny and opportunities for reflection. All leaders kept a firm ‘grip’ on the quality of practice. All of this was underpinned by the use of data, feedback, intelligence and a balance of styles between leaders.

In several authorities, the improvement journey had begun with training and support for existing middle managers, coaching and guiding them and promoting their development so that they could effectively performance manage more junior staff. Strong strategic oversight underpinned leadership and management arrangements… The support of the chief executive and the lead member, as well as other elected members, was critical too.

All DCSs stressed the importance of a strategy that spanned the whole of children’s services from early help to care leavers. ‘Twin hatters’, who also managed adult services, saw this dual responsibility as a positive and said that it helped them to expand these strategies to include vulnerable adults who were also parents, as well as services that children would use when they reached adulthood. They also said that their dual role enabled them to emphasise the importance of the children’s agenda in arenas such as the Health and Wellbeing Board and the Adult Safeguarding Board.

**Local partnerships**

Leaders told inspectors that effective partnerships were based on developing strong relationships. They took a proactive approach and spent time getting to know the leaders of their partner agencies and the services that they provided. Building relationships was crucial in enabling partner agencies to become fully involved in the improvement agenda. Many partnerships had invested time in ensuring that there was a common language so that everyone understood what was being said. A shared data set added another layer of scrutiny to frontline practice.

**Relationships between politicians and professionals**

The key to successful relationships between politicians and professionals was clarity of roles and responsibilities. Mature, trusting relationships led to constructive scrutiny and challenge. In some authorities young people met elected members regularly to discuss issues relating to being looked after. Elected members built up a picture of what life was like for families and their increased understanding led to better questioning of data and information and more in-depth and knowledgeable scrutiny.

In all the authorities visited, the elected members had protected budgets, social work caseloads and services for children and families. This was in the context of overall budget reductions. In several authorities budgets had been raised in order to invest in recruitment and retention, to
protect caseloads and ensure capability and capacity within the organisation. In almost all of the authorities inspectors visited, elected members were seen as champions of children’s services.

**Readiness for innovation**

Inspectors saw a variety of innovative and creative ways of working… What was common was that many of these authorities were proactively seeking out new ways of working. Innovation was easier to facilitate in authorities that were already performing well. Those local authorities at an earlier stage in the improvement journey were concentrating on getting the basics right. There was a clear recognition and acceptance in the local authorities visited that when innovating, things were not always going to work. As a result, workers felt permitted to try things out and felt that they would be supported. They felt that the risks were not entirely theirs, but shared, and that there would be no blame if things did not work.

**Comment**

Unsurprisingly, there are many clear echoes in these reports of the ‘SIF’ inspection reports on LAs, of which more than 40 have now been published. Assessments, planning, reports and management oversight are frequently criticised – what are referred to collectively here as ‘getting the basics right’.

Professor Eileen Munro’s review of child protection highlighted that ‘preventative services can do more to reduce abuse and neglect than reactive services’ – and of course, if effective, this brings both greater benefits for children and families and significant savings for LAs. It is encouraging that, in difficult times, LAs are reported to be increasingly prioritising early help, and further progress in this direction seems not only desirable but necessary to maximise the benefits derived from scarce resources.

Ofsted is emphatic – in its observations and recommendations for government – on the need for greater clarity in statutory guidance on roles and responsibilities around early help. It is also refreshing to see that Ofsted appears to think that currently the burden falls unfairly on LAs. At the heart of this issue is clarity about thresholds and their application – another regular feature of SIF reports.

Both of these reports offer much potentially useful learning for LAs.

**External links**


Ofsted [Joining the dots… Effective leadership of children’s services](http://www.gov.uk/government/publications/joining-the-dots-effective-leadership-of-childrens-services)

**Related briefings**


For further information, please visit [www.lgiu.org.uk](http://www.lgiu.org.uk) or email [john.fowler@lgiu.org.uk](mailto:john.fowler@lgiu.org.uk)