

# The quality of assessment for children in need of help

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This report examines the quality of early help and social work assessments for children in need and child protection. It explores the factors that drive or limit the effectiveness of assessment, drawing on evidence from 123 tracked cases from 10 local authorities, including the views of parents, carers, professionals and children.

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## Executive summary

Good-quality assessment for children in need of help is an essential part of keeping them safe.<sup>1</sup> Without it, professionals working with children and their families cannot gain an accurate picture of a child's circumstances. They will find it difficult to identify whether they are suffering, or at risk of suffering, from harm. In turn, this can prevent professionals from taking decisive, effective action to protect children.

In recent years, a number of Ofsted reports, including the social care annual report 2012/13, have identified poor quality assessments across many local authorities, especially in those judged less than good.<sup>2</sup> Inspection evidence has highlighted some common weaknesses, including assessments that do not take sufficient account of family history or fully consider the impact of parent or carer mental ill health on the child.

Her Majesty's Chief Inspector commissioned this thematic survey to gain an accurate, up-to-date picture of how effectively local authorities were carrying out their assessments in early help, children in need and child protection work. It examined whether the quality of assessment had improved and how successful leaders had driven this improvement. In particular, it explored whether assessments were better in those local authorities that had consistently adopted a specific approach, commonly known as a 'theoretical model of practice'.<sup>3,4</sup>

Overall, inspectors found improvement in the quality of assessments in the local authorities inspected. A greater proportion of assessments resulted in children and families receiving the right help and support at the right time. Professionals were engaging more meaningfully with children and families and recording their views more fully than previously reported. In 63% of cases reviewed, inspectors found that children's views on their families' difficulties had been taken into account in the assessment.

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<sup>1</sup> Through assessment, professionals gather and analyse important information about a child and their family to decide whether they are in need of help, are suffering or likely to suffer from significant harm. Any assessment should identify the required services to address these needs to improve their outcomes and make them safe.

<sup>2</sup> *Ofsted social care annual report 2012/13*, Ofsted, October 2013;

[www.gov.uk/government/publications/social-care-annual-report-201213](http://www.gov.uk/government/publications/social-care-annual-report-201213).

*In the child's time: professional responses to neglect*, Ofsted, March 2014;

[www.gov.uk/government/publications/professional-responses-to-neglect-in-the-childs-time](http://www.gov.uk/government/publications/professional-responses-to-neglect-in-the-childs-time).

*What about the children? Joint working between adult and children's services when parents or carers have mental ill health and/or drug and alcohol problems*, Ofsted, March 2013;

[www.gov.uk/government/publications/joint-working-between-adult-and-childrens-services](http://www.gov.uk/government/publications/joint-working-between-adult-and-childrens-services).

<sup>3</sup> Theories and 'theoretical models of practice' can inform social workers of the type of method that is most appropriate to use; [www.mheducation.co.uk/openup/chapters/9780335237784.pdf](http://www.mheducation.co.uk/openup/chapters/9780335237784.pdf).

<sup>4</sup> Some local authorities have adopted specific models of practice such as Signs of Safety ([www.nspcc.org.uk/services-and-resources/research-and-resources/signs-of-safety-model-england/](http://www.nspcc.org.uk/services-and-resources/research-and-resources/signs-of-safety-model-england/)) and Reclaiming Social Work ([www.morninglane.org](http://www.morninglane.org)). These are only examples of theoretical models. Ofsted does not endorse them or any other particular model.

The local authorities that were inspected took their responsibility to support families seriously and offered a range of services to support children and families at times of need. Importantly, in most instances, inspectors found that families did not have to wait for help while assessments were being completed; in four out of five cases reviewed, families were offered help during the assessment.

Inspection evidence underlined the fact that strong, effective leadership in local authority children's services was the key driver in improving the quality of assessments. In those local authorities where the quality of assessment was good, leaders prioritised training and development and supportive supervision. They ensured that caseloads were manageable and put effective quality assurance checks in place. Robust performance monitoring and quality assurance systems enabled leaders to evaluate and improve their assessment practice. Staff morale was high and turnover low.

These leaders also worked successfully with other key organisations towards a clearly defined common goal. Effective communication and partnership working between agencies to promote good assessment and support children and families were vital ingredients in successful local authorities.

All 10 of the local authorities inspected used aspects of 'theoretical models of practice' to inform their specific approach to assessment. However, the extent to which these approaches were embedded varied across the local authorities. Inspectors found that using theoretical models of practice improved the quality of assessment. Evidence also showed that assessment was most successful in the local authorities that had fully embedded these approaches over time. In these local authorities, leaders used the models to set clear expectations and a consistent approach for professionals to follow in their assessment work. As a result, professionals were more confident in carrying out effective assessments.

Overall, workers welcomed the new single assessment framework.<sup>5</sup> They told inspectors that they felt less pressurised to produce an assessment with timelines that did not reflect the child's needs. They also said it gave them more time to engage with children and families and reflect their views in the assessment and subsequent plan for support.

However, inspectors identified a number of common improvements needed in the local authorities inspected to ensure consistently good assessment. Too often, social workers did not routinely share written assessments with families or children. Furthermore, the language that social workers used in written assessments and resulting plans was often unclear and used jargon. This made it difficult for families to fully understand decisions and judgements and what needed to change to make things better for children. In many cases, assessments did not fully consider the ethnicity and identity of children or take into account their history. In most of the

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<sup>5</sup> [www.communitycare.co.uk/2012/06/12/ministers-confirm-removal-of-child-assessment-timescales/](http://www.communitycare.co.uk/2012/06/12/ministers-confirm-removal-of-child-assessment-timescales/).

cases tracked as part of this thematic survey, social workers had carried out assessments as a stand-alone process, rarely updating written assessments when new information came to light. As a result, plans to support children and their families were not always based on a comprehensive assessment of need.

Inspectors identified a requirement to improve the way that local authorities use chronologies – historical information about a child’s life experiences – to inform high-quality assessment. In most cases, chronologies lacked clarity and did not include the relevant information needed to inform the assessment and plan for support.

In a quarter of the 123 cases tracked, inspectors found that the assessment had not been timely enough. In some instances, local authority leaders had put too much focus on their own timescales and not enough on the most appropriate timeline for the individual child. As a result, too many children were being left in circumstances where they were at potential risk of harm. Worryingly, in eight local authority areas, there were sometimes significant delays in being able to access Child and Adolescent Mental Health Services (CAMHS).

Despite the overall and steady improvement in the quality of assessment, inspectors found that 21% of subsequent plans for support did not clearly demonstrate the help that children and their families would receive and how the best interests of the children would remain the greatest priority.

## Key findings

**Since Ofsted’s social care annual report 2012/13, the overall quality of assessments had improved in most local authorities visited.**

- Most local authorities provided a range of services to families when a need was identified. In most instances, families received help during the assessment period and did not have to wait.
- In 63% of cases reviewed, professionals were carrying out assessments promptly and in line with the right timeline for individual children.
- In the large majority of cases, workers were using the child’s voice and views to inform their analysis in assessment.
- Assessments better reflected the views of parents, including significant males in families. Parents told inspectors that workers spent more time listening to them than they had previously.
- The views of other professionals were more frequently and consistently included in assessments.
- Inspectors found that, in most instances, using theoretical models of practice had improved the quality of assessments. Staff spoke confidently of the merits of using the models in their assessment work. Inspectors found that using a model was more important than which model was used.

## **Leadership in a local authority was fundamental in ensuring good quality assessments.**

Inspectors found that leaders in high-performing local authorities:

- built strong partnerships and shared information effectively with partner agencies – they saw partnership working as central to good-quality assessment
- ensured robust, reflective managerial supervision and oversight of workers carrying out assessments
- prioritised training and development for workers, including in using assessment support tools and theoretical models of practice to improve children's outcomes
- ensured that workers had manageable caseloads
- were committed to continuity and consistency in workers for children and families
- developed electronic recording systems that supported good practice
- had established effective quality assurance processes.

## **Inspectors found that assessments in early help and statutory work had similar areas for improvement.**

- In eight out of the 10 local authorities inspected, assessment was undertaken as a standalone process that needed to be 'done' to a family, rather than one part of an ongoing process to provide continued support and improve outcomes for children.
- Analysis in assessments did not clearly identify risks and strengths of individual families or indicate the potential for a family to achieve change.
- The language used in written assessment and planning documents was often unclear, over-complicated, detracted from the concerns raised and was unhelpful to families.
- The quality of chronologies in the assessments reviewed varied considerably. Key information to inform assessments and plans was included in only a small number of cases.
- Often assessments did not fully include the views of extended family members, including grandparents, aunts and uncles.
- Professionals undertaking early help assessments and social workers undertaking statutory assessments did not always update assessments to reflect changing circumstances and to inform planning for the child and family.
- Social workers did not always share the findings from assessments with children and their families to help them understand what was happening and the rationale for decisions made. Professionals in early help work shared assessments more readily.
- In a third of the 123 cases tracked, the written plans resulting from assessments were not good enough to drive improvement in children's circumstances.

## Recommendations

### The government should:

- reinforce the critical importance of focusing on individual children's timescales when assessing children's needs
- take account of any recommendations from the children and young people's mental health and wellbeing task force to address the lack of access to services.<sup>6</sup>

### Local authorities and partners should improve the quality of assessments through:

- clear analysis of findings to identify next steps
- reflecting the views of wider family members
- fully considering the ethnicity and identity of children and taking into account the child's history
- developing the effective use of chronologies in assessment work
- sharing assessments with families in a format and language that they can understand, and developing age-appropriate ways of explaining assessments with children
- continuing to assess as new information comes to light and circumstances change so that support for children is always fully informed by the latest information
- ensuring that written plans resulting from assessments focus on the most important needs of children, improve their experiences and include clear contingency plans.

### Leaders in local authorities should create the right environment for high-quality assessment work through:

- reviewing their workforce development programmes to ensure that social workers have appropriate skills to assist them in undertaking effective, comprehensive, analytical assessments that support and protect children
- ensuring that supervision is reflective, challenging and builds on professionals' experience to inform and improve practice
- regularly auditing assessments with a focus on outcomes for children and families
- encouraging workers to use assessment support tools when undertaking assessments to gather the views of children, young people and their families<sup>6</sup>
- ensuring that families have access to the services to support them

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<sup>6</sup> [www.gov.uk/government/groups/children-and-young-peoples-mental-health-and-well-being-taskforce](http://www.gov.uk/government/groups/children-and-young-peoples-mental-health-and-well-being-taskforce).



- reducing the number of different social workers that support a child and their family
- ensuring that the electronic recording system supports workers in undertaking assessments and creating child focused chronologies
- using feedback from families and children to inform practice
- ensuring that child protection chairs challenge the quality of assessments and the progress of children's plans.

## Introduction

1. This thematic inspection was commissioned to examine how well local authorities and their partners were undertaking early help and statutory assessments and to identify the factors that facilitate or hinder good practice. We were particularly interested to get a clearer picture of:
  - the general quality of assessments, including how effectively social workers engage with families
  - the range and breadth of help, support and action taken before, during and after assessment
  - how well leaders in local authorities drive and support good assessment
  - whether using a theoretical approach helps to improve assessment and develop good practice
  - how local authorities evaluate whether assessments are identifying risk and need and resulting in action plans that make a difference to the lives of children and their families.

## Background

2. Ofsted's social care annual report 2012/13 expressed concerns about the poor quality of assessments, but particularly in those local authorities judged to be less than good. Poor-quality assessments were resulting in unfocused plans that lacked clarity, were too generic and likely to fail to improve outcomes for children and families.
3. The statutory guidance '*Working together to safeguard children (2015)* sets out the key functions of assessment as:
  - to gather important information about a child and family
  - to analyse their needs and/or the nature and level of any risk and harm being suffered by the child
  - to decide whether the child is a child in need (section 17) and/or is suffering or likely to suffer significant harm (section 47)
  - to provide support to address those needs to improve the child's outcomes to make them safe.
4. Research has identified a number of features that assessments should include:<sup>7</sup>

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<sup>7</sup> Please see Annex B for detailed referencing.

- Assessment needs to be seen as a continuous event and appropriate contingencies need to be articulated, should a plan fail to protect or secure improved outcomes'.<sup>8</sup>
- There should be a focus on the experiences and journey of all the children, individually within the household. Past events in the family history need to be explored to understand the child's journey.
- Social workers' knowledge of child development should be applied when exploring how a child's past experiences have had – and are likely to have – an impact on their future development and outcomes. Social work professionals need to utilise their interpersonal skills to interact appropriately with family members to find out key information.
- Professionals should collate and triangulate information from other agencies at an early stage of the assessment.
- The analysis of the information captured during the assessment should focus on what has taken place, the impact on the child and the prognosis on the future.
- In instances of parental mental ill health, substance misuse, domestic violence and parental learning difficulty, assessments of parenting capacity should be separated from the assessment of the child and completed within timescales that reflect the child's needs.
- Recommendations and actions that stem from assessment should be focused on improving the outcomes for children and be timely, specific, realistic and measurable.

## Methodology

5. Inspectors visited 10 local authorities and examined 123 cases as part of this thematic inspection survey. Inspectors also sought the views of children, parents, carers and professionals from each of the 10 local authorities visited and its partner agencies. The areas visited varied in size and included shire counties, metropolitan areas and London boroughs (see Annex A).
6. Five of the authorities were selected for this survey because we understood that they had adopted theoretical models of practice. However, during the visits inspectors learnt that all 10 local authorities inspected had combined aspects of different models that informed their assessment practice.

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<sup>8</sup> *Social work assessment of children in need: what do we know? Messages from research*, Department for Education, 2011; [www.gov.uk/government/publications/social-work-assessment-of-children-in-need-what-do-we-know-messages-from-research](http://www.gov.uk/government/publications/social-work-assessment-of-children-in-need-what-do-we-know-messages-from-research).

7. The thematic inspection considered the impact and effectiveness of assessments for early help, children in need and child protection across an age range of 0-17 years. Inspectors also considered the quality of plans arising from the assessments.
8. Of the 10 authorities visited as part of the thematic inspection, eight had moved to using the single assessment framework and two were still using initial and core assessments. In the three authorities that had most recently changed to the single assessment framework, inspectors also considered the quality of initial and core assessments.

## **Findings from the local authorities inspected**

### **The overall quality of assessments had improved across the majority of local authorities inspected**

9. In most authorities visited, there was a good range of early help services to support families. Services were routinely offered immediately or as soon as the need was identified during the assessment process. This was important in improving the immediate situation for children, instead of them having to wait until the end of the assessment process to receive support. However, local authorities did not always fully evaluate the impact of services in improving outcomes.
10. In 63% of assessments reviewed, the views of the child were recorded and used to inform the analysis in assessment. In 78% of assessments, the views of parents were recorded and used to inform the analysis. Parents consistently told inspectors that social workers had changed their approach and now spent more time listening to parents.
11. Importantly, local authorities have responded to the concerns raised in serious case reviews that the views and influence of significant males were not considered well in assessments. In most cases tracked, inspectors found that workers were ensuring that the views of significant males were reflected.
12. In most of the authorities visited, social work qualified team managers (or their assistants) made appropriate decisions on undertaking assessments. In the majority of cases, this decision-making was clearly recorded on the electronic recording system.
13. In all of the authorities visited, statutory assessments were undertaken by qualified social workers. Arrangements for undertaking early help assessments varied, with some completed under the Common Assessment Framework (CAF), others through the government Troubled Families programme and some using local formats. Early help assessments were often undertaken by other key professionals involved with families, including teachers and health professionals.

14. Families have often been critical of services when professionals undertake further assessments and previous information has to be repeated. Local authorities using the single assessment framework have found that it has reduced the need for families to provide information again.

### **Leadership was a fundamental factor in ensuring good-quality assessment**

15. Ofsted's good practice report *High expectations, high support and high challenge* made clear that local authority senior leaders played a crucial role in ensuring organisational cultures were characterised by high expectations, strong support and effective challenge.<sup>9</sup> It highlighted that being well supported by their leaders gave frontline staff more confidence about the risks they were managing and more focus on engaging families in child protection plans. They felt more able to do their job well to support children and families.
16. In this thematic inspection, inspectors also found that leaders played a crucial role in creating an environment in which assessment practice could improve. They identified a number of characteristics of effective leadership that enabled good assessment, as set out below.

### **Theoretical models**

17. All authorities visited as part of this inspection used elements from various theoretical models of social work practice, complemented by assessment tools to support their engagement with children and families. Some of these authorities had only recently adopted the models of practice and it was too early to see the full benefits of these changes, but the thematic inspection identified some improvements.
18. Staff and partner agencies in authorities that were using theoretical models of social work practice well had received extensive training and had access to a range of support materials. Local authority staff and their partner agencies' staff had a good understanding of the models at all levels, ensuring that practice was more consistent. Inspectors found that, in most instances, these models were improving the quality of assessments. Staff spoke confidently of the merits of using theoretical models, complemented by the use of assessment support tools, and acknowledged the impact on their practice, especially in improving engagement with families and children.

In Southwark, all staff spoke positively to inspectors about the 'Signs of safety' model and were confident in using it. Staff spoke positively about parental participation and inspectors saw good use of genograms to clarify issues of family history and composition.

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<sup>9</sup> *High expectations, high support and high challenge*, Ofsted, February 2012; [www.gov.uk/government/publications/support-for-staff-working-in-child-protection](http://www.gov.uk/government/publications/support-for-staff-working-in-child-protection).

## Partnership working

19. Implementing a theoretical model of practice was not the sole factor that had generated improvements in the local authorities inspected. Progress in assessment work was also being achieved through strong partnership working.
20. Effective partnership working with key agencies, including police, health and education and good communication to support children and families, were vital ingredients in successful organisations promoting quality assessments. In many of these authorities, leaders saw partnership working as central to ensuring good assessments.
21. Inspectors found that good communication between all agencies working with a family helped to ensure that assessments and plans considered a broad range of relevant information to give a fuller picture of the family and child's needs.

## Workforce development

22. In those authorities where the quality of assessments was better, staff turnover was relatively low and training and development were prioritised. Where agency staff were used, they were employed for longer periods to provide greater consistency of worker for children and families.
23. The majority of local authorities visited had addressed workforce issues to improve the quality of assessments. This included significant investment in training and development on the single assessment framework but also on important factors to be considered, such as learning from serious case reviews.
24. However, despite local authorities' commitment to continuity and consistency, inspectors found a high turnover of staff in too many of the 123 cases reviewed, with families having numerous workers in 12 months. In one case, a family had four different workers in 12 months.
25. In all local authorities visited, inspectors found a leadership commitment and investment in registering workers with various workforce development agencies such as 'ccinform', 'Research in Practice' and 'Making Research Count' or through the College of Social Work.<sup>10</sup> These give access to the latest research, developments and standards in social work practice and other services. In some cases, social workers used these resources effectively in their assessments to inform and validate their analyses.
26. Those authorities in which inspectors found good quality assessment offered a range of effective training to staff in early help services and support workers. The workforce development plans recognised the importance of developing a

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<sup>10</sup> The College of Social Work (TCSW) was set up in 2012 to improve standards in social care. However, in June 2015, it announced its closure in September 2015; [www.tcsw.org.uk/membership/](http://www.tcsw.org.uk/membership/).

skilled workforce through a focus on development and supporting unqualified staff into further training.

A good example of training to support staff in their work was the use of motivational interviewing techniques for early help workers in Gateshead. Workers told inspectors that this had been invaluable and had enabled them to engage more effectively with some harder-to-reach families.

## Supervision and management oversight

27. Inspectors found that management oversight and reflective supervision were key factors in sustaining good practice and improving weaker practice.<sup>11</sup> The support and challenge from managers at all stages ensured that good assessments focused on the needs of the children and were completed within appropriate timescales for individual children.
28. Some local authorities that adopted theoretical models of practice were using reflective supervision and group supervision effectively to support staff to improve how they undertook assessments, particularly their analysis of findings.<sup>12</sup>
29. Supervision of casework was more apparent within the statutory assessments than in early help. This was because the local authority was not always the lead professional in early help cases so was unable to provide inspectors with evidence of the impact of supervision and management oversight in early help assessments.
30. Inspectors found some good examples of supervision.

Southwark local authority has introduced a practice group model in which advanced practitioners hold regular group discussions on all cases. These discussions are shared with more senior practice group leaders. The groups aim to ensure accountability, and provide challenge and consideration of further options for working with families.

31. In all of the authorities visited, guidance and expectations for management oversight and supervision were clear but practice was sometimes variable. Staff told inspectors that they welcomed the challenge and support of managers and especially the opportunity for group supervision to support and develop good practice.

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<sup>11</sup> Reflective supervision: individual management of practitioners that enables practitioners to be both challenged and supported to think about their strengths and areas for development and overall make their practice with families more effective.

<sup>12</sup> Group supervision: groups of social workers meeting with a manager to maximise learning about what works most effectively for children and families.

32. Where the single assessment had been introduced, most authorities had incorporated checkpoints (with managerial oversight and challenge) at around 10, 28 and 40 days. This differed from the previous procedural checks that were driven by statutory guidance and used as performance criteria. It appropriately informed decision making as to where and how the assessment would proceed.

### **Performance monitoring and quality assurance**

33. Inspectors also found that the use of robust performance monitoring systems helped all of the local authorities to understand the effectiveness of assessment work.

In Gateshead, a workshop involving 80% of the social work workforce looked at the tools and methods for ascertaining and collecting children's views. Teams shared good practice and assessment support toolkits were introduced to engage with families more effectively. In addition, managers set up a 'voice of the child' email address to collate the information captured about children's views to ensure these could be used to influence service design and improvements.

In Torbay, the senior management team organised a peer reflection week, during which professionals reviewed 15 cases as a group. The aim of the reflection week was to consider the child's journey in children's services. This included reflecting on the views of children, parents and carers to identify and promote good practice.

34. In addition to the expectations for managerial oversight, audits of case files were the main mechanism that enabled managers to assess the quality of practice at service and individual case level. Findings from audits were routinely considered in the discussions at all levels and taken forward in individual performance meetings/supervision and team meetings. This helped managers improve practice and thus outcomes for children.
35. It was pleasing to see that senior managers used a range of both quantitative and qualitative performance monitoring systems to understand the effectiveness of assessment work. This included the review of auditing processes, data analysis and trend analysis (for example, referral rates and child protection plan timescales) alongside service user feedback, surveys, learning from complaints and the observation of practice.
36. In too many assessments, performance monitoring systems were too focused on measurable processes and were not always used well to identify and improve practice to secure better outcomes for children and families.



## Delivery of services

37. The seven local authorities with a Multi-Agency Safeguarding Hub (MASH) or multi-agency referral arrangements had a good basis for effective communication to inform the assessments. The development of MASH and multi-agency referral services had widened the skill and qualification base of the workforce, resulting in a more holistic view to assessment. With many local authorities managing increasing levels of domestic abuse notifications, the knowledge of specialist domestic violence workers within MASH was welcomed by social workers and promoted effective good practice.
38. Three of the authorities visited had recently changed how staff worked with children and families to provide support and services through the introduction of the single assessment. These authorities, working with LSCBs, had also updated and re-launched their 'thresholds document', providing up-to-date information and their expectations for intervention and support of all agencies working with children and families.
39. Overall, social workers welcomed the new single assessment framework. They said that they felt less pressured to produce an assessment within set timescales. The new framework gave them more time to engage with families and undertake direct work to ensure that the views of children could be incorporated into the assessment.
40. In authorities that had recently adopted the single assessment framework, there had been significant investment in changing how staff work to provide continuity and consistency. While it was too early to fully assess the impact of this, most children and families welcomed the changes and appreciated not having to repeat information to different social workers.
41. Inspectors found the shortest period for social workers to remain working with children and families was until the end of the initial child protection conference (ICPC) and first core group meeting at approximately six weeks. In four authorities visited, workers remained involved, where necessary, through to the completion of care proceedings. The benefit of a consistent worker meant that families had the opportunity to have a relationship with their worker. They did not have to repeat information repeatedly to different workers. This also meant that families had less opportunity to conceal important historical information.

## Areas for improvement in assessments

42. In 20% of the cases seen, inspectors believed that the assessment took too long. In some instances where there were staffing and other pressures and insufficient management oversight, there were delays in completing assessments, detracting from the prompt consideration of the risks to children.
43. Despite the improvements seen in the quality of assessments, inspectors found that staff did not consider some important factors in their analysis. For example, in one case seen by inspectors, the worker did not consider within the

assessment the impact of an Indian woman marrying a Pakistani man, converting from Hinduism to Islam, the impact of estrangement from her family and the consequences for her and for the children. As a result, the findings from assessments did not always provide a holistic view of children's and families circumstances.

44. As Professor Jay made clear in her report into the serious failings in Rotherham Council, chronologies are essential elements of assessment work and inform decision making and planning to safeguard children.<sup>13</sup> Yet the quality of chronologies reviewed in this survey varied considerably. In only a small number of cases were chronologies clear, analytical and providing a good history of the family. Some chronologies were system generated from the electronic recording system. As a result, they were not analytical and listed events in the order that they were recorded, rather than when they happened. Chronologies were not used to inform targets and timescales for working with families.
45. Inspectors found that chronologies were not routinely used as an indicator of the family's capacity to change. In addition, where there were a number of children in one family, inspectors found some examples of multiple chronologies, which made it difficult for social workers to get a full sense of the family history.
46. Assessments were not shared routinely or consistently with parents, although inspectors found that early help assessments were generally shared more often than statutory assessments. Social workers did not share assessment findings consistently and constructively with children. Workers regularly reported that they had given verbal feedback of the assessment to parents and children but had not provided a copy of the written report. Therefore, the assessment process lacked transparency. Often families and children said that they did not understand the decision-making process that resulted in the subsequent plan.
47. In addition, in only a small number of cases were the assessments provided in a format for parents who may have a learning disability or for those who had English as a second language or who did not read English.
48. Assessments need to be clear, straightforward and easy to understand. However, in some assessments inspectors found that workers tried to 'over-professionalise' their written work and consequently did not communicate their thoughts and findings well. The language they used in written assessments often contained professional jargon that detracted from and minimised the concerns and severity of some situations. For example, an assessment may refer to 'three previous instances of domestic abuse' but the level of abuse

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<sup>13</sup> *Independent inquiry into child sexual exploitation in Rotherham 1997–2013*, Alexis Jay OBE, August 2014; [www.rotherham.gov.uk/downloads/file/1407/independent\\_inquiry\\_cse\\_in\\_rotherham](http://www.rotherham.gov.uk/downloads/file/1407/independent_inquiry_cse_in_rotherham).

could range from a verbal altercation to a serious physical assault. If the worker had explicitly described what the abuse comprised this would have more impact. Minimising concerns in this way can make it difficult for children and families to understand the assessment decisions and can make it difficult to progress any plans and actions.

49. Inspectors found that single assessments were 'stand-alone' and generally undertaken in response to specific significant events occurring for children and families, with any updates being triggered by further significant events. This meant that the impact of some important but not significant changes in circumstances might not be fully considered within an assessment. In only two authorities was there a clear expectation that assessments were an ongoing process. In others, there was an expectation that assessments should be updated within a specified timescale, usually 12 months. Consequently, new information, which may be important to the assessment and planning, may not be acted on in a timely manner.
50. Most services could be provided promptly but for others, such as CAMHS and perpetrator programmes for domestic abuse, there could be significant delays. In some instances, this could be a delay of six months or more, reflecting the variability in provision of these services nationally. Given the risk and complexity of some cases, these delays could have a significant negative impact on outcomes for children.
51. Where there were gaps in service provision, some local authorities commissioned local services to meet demand.

The Adolescent Support Unit (ASU) service in Blackburn with Darwen provided a range of services to children and families, addressing complex needs and challenging behaviours. Children could access this service despite not meeting the criteria for referral to CAMHS services.

### **Inspection evidence identified a number of other potential barriers to good assessment**

52. One of the principal barriers to working with families was the stigma of statutory intervention. Workers and families reported better working relationships in early help interventions, where a family's involvement with a social worker was voluntary.
53. Local authorities told inspectors that the electronic recording systems for children's casework did not always help staff to record and update information. In some local authorities, there was limited access to electronic recording systems for early help assessments, which could hinder practice where cases were escalated for statutory social work input or de-escalated from statutory work. This also limited the extent to which early help practice could be monitored by managers.

54. Other barriers reported to inspectors included:
- work load pressures
  - the complexity and volume of case work
  - a lack of experienced workers and timely resources
  - limited access to information from other agencies.
55. The diverse populations in some authorities created barriers to effective working due to a lack of understanding by the local authority staff of the cultures of some minority ethnic groups. There was also an occasional reluctance by certain groups to engage with statutory agencies.
56. Other barriers to effective working were the increasing levels of poverty and need and high levels of referrals for domestic abuse. Both had a significant impact on resources for some authorities, affecting their ability to respond and provide services to support families.

### **The written plans resulting from assessments were not good enough to drive improvement**

57. The written plans for children did not always reflect the assessment findings. Although the views of children were increasingly recorded in assessments, plans did not consider 'how it feels' for the child (the lived experience) and what needed to change. Plans seen by inspectors did not appropriately focus on the essential needs of the child but instead often focused on the priorities of the agencies involved. For example, in the case of a child being scruffy and dirty in school, the plan prioritised the child being in clean clothes and arriving promptly for lessons. However, it did not consider how the child felt or how professionals were going to support the child to make friends and reduce the instance of isolation and bullying.
58. In most cases, workers recorded children's cultural, religious and ethnic identity in the assessment. However, they did not always analyse or consider the importance of children's culture, religious and ethnic identity needs in the planning process.
59. In a small minority of assessments, social workers did not sufficiently analyse risk and protective factors, which meant it was unclear if their decisions were robust and therefore how effective plans would be.
60. Plans were not always up to date. They did not always consider changes in family circumstances. Workers told inspectors that changes in circumstances were often discussed in Team around the Family (TAF) or core group meetings

and plans were consequently updated without the full consideration and analyses of an updated assessment.

61. The important role of child protection chairs to ensure the quality of assessments and the progress of children's plans was unclear.<sup>14</sup> Inspectors highlighted many instances where plans lacked clarity and direction, but these issues had not been challenged by the child protection chair.
62. Social workers did not record contingency arrangements in plans well. Often the plan identified the contingency as being a discussion with the line manager or escalation to the Public Law Outline (PLO) process. This would lead to a 'letter before proceedings' being sent to parents, explaining that the threshold for proceedings has been met and this was a final attempt to achieve the necessary change before considering removing a child.
63. This lack of clarity sometimes resulted in limited transparency for families and children and detracted from the potential serious consequences if actions in children's plans were not met.

### **Research publications feedback**

We are interested in finding out how useful you have found this publication.

Are you thinking of putting these ideas into practice; or already doing something similar that could help other providers; or are you just interested? We would welcome your views and ideas. Complete our survey [here](#).

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<sup>14</sup> A child protection chair is accountable to the Director of Children's Services. They assure the quality and performance of child protection work in children's social care. Where possible the same person should:

- chair subsequent child protection reviews
- be a professional, independent of operational and/or line management responsibilities for the case
- meet the child and parents in advance to ensure they understand the purpose and the process.

## **Annex A: local authorities contributing to the thematic inspection**

Blackburn with Darwen

Durham

Ealing

Gateshead

Hackney

Kirklees

Telford & Wrekin

Torbay

Southwark

West Berkshire

Derbyshire County Council (piloting of the methodology)

## Annex B: References to Ofsted reports and other statutory guidance and research

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## **Annex C: Acknowledgements**

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