Review of first eleven Ofsted inspections of services for children in need of help and protection, children looked after and care leavers, and Local Safeguarding Children Boards

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Executive Summary

This study analyses the initial feedback from inspectors and the local authorities that have been inspected under the new framework evaluating services for children in need of help and protection, children looked after and care leavers, and Local Safeguarding Children Boards (LSCBs) and makes recommendations on how inspections could be strengthened.

There is general endorsement that the new framework is looking at the right aspects of work and so could be a positive factor for encouraging improvement in the sector. However, there is also widespread concern about the demands it puts on both inspectors and local authorities and about the reliability and validity of the judgments reached. As a result, I have made the following recommendations:

1. Ofsted should explore the advantages of using qualitative software to assist data management since the new inspection framework requires the collection and analysis of both more data and more types of data. Such software could improve the transparency of the judgments on local authorities and contribute to increasing the sector's confidence in them.

2. Ofsted should consider increasing inspectors' training in research methods and project management

3. The new judgments involve combining qualitative and quantitative data and there is no algorithm for this. To improve consistency among inspectors, I recommend that Ofsted set up a consistency panel in which all inspectors discuss, review, and seek to standardize their judgments before the final judgment is announced.

4. Ofsted should make the moderation process more transparent to build up confidence in the sector.

5. The contents of Annex A should be scrutinized with a view to appraising the cost-benefit ratio and either considering removing items or encouraging inspectors to make use of them and show the local authority why the data is informative.

6. There should be a narrative paragraph attached to the final judgment that gives more detail about how near the local authority was to an adjacent category

7. The new inspection framework is encouraging desired improvements in the sector but inspections could be more influential by changing the language that they use so that they help to embed the cultural changes being sought. Areas where work on this could be beneficial are:

   (a) Developing more realistic language and clearer recommendations about risk management that avoid the impression that risk can be eliminated by professionals or that they can predict the future with absolute accuracy;

   (b) Undertaking more work on how to discuss practice, avoiding the conceptualization of a sharp process/practice divide that has become widespread and locating some process within practice, showing how it contributes to good outcomes for children.

8. The inspection rightly is concerned with finding out whether children and young people are helped by the services provided but the complicated causal links between professional practice and outcomes make it difficult to make judgments about causality rather than just correlations. More work on how to understand the causal processes and what type of comments can be made about effectiveness could improve the rigour and transparency of inspections. Ofsted should also pay more attention to how the local authority obtains feedback about both the experiences of those using services and the impact in terms of achieving goals and solving problems.

9. Since reform and improvement are such important dimensions of the current work environment, inspectors should consider paying more attention to the local authority's reform plans (or lack of them).

10. In the longer term, as more innovative ways of working are introduced (and the Department for Education's Innovations Programme makes it likely that there will be some radical, whole-system changes) more work may be needed on defining and describing 'good' practice. I recommend that, if such a need arises, consideration is given to consulting the College of Social Work and the Chief Social Worker for Children and Families since they too are concerned with defining 'good' practice.

Introduction

The objective of this project is to review the implementation and effectiveness of the new inspection framework that evaluates services for children in need of help and protection, children looked after and care leavers, and LSCBs (also internally described as the Single Inspection Framework (SIF)) by analysing the

feedback obtained from inspectors and the eleven local authorities that have been inspected, observing how the framework is being implemented, and how the findings are written up in the final report.

The inspection process has a powerful influence on service provision and the recommendations about revisions to it that I made in my review of the child protection system in 2011 are intended to be a key component in encouraging reform. Inspectors are now focusing more on the impact services are having on children, young people and families, so that they are giving more attention to *how* professional tasks are performed besides noting *that* they are performed. All in children's social care should be doing this but, for some, it is a long journey to move from a system that prioritized process to one that fully engages with the challenges of practice. The positive feedback from the sector about the new framework indicates widespread support for these reforms but it is no simple step for either Ofsted or the sector to embed a new way of thinking and working.

The framework was developed following the Chief Inspector's decision in March 2013, that there would be a 'single' inspection of services for vulnerable children and families, subsuming child protection, services for looked after children and care leavers, and local authority adoption and fostering services. The new framework, bringing together four previously separate inspections, poses intellectual challenges: more data is considered than in the individual inspections; there is a greater range of data with more qualitative data being gathered; there is more attention to the connections between data to capture some understanding of children's journeys through the services rather than snapshots at one stage only.

At the same time, the judgment of 'adequate' was to be replaced with one of 'requires improvement' to replicate the organisational commitment to 'only good being good enough' for all children.

Developing a framework of such significance, with a new judgment structure, new judgment grades and describing 'good' as the new benchmark for all local authorities was indeed a challenge in the timeframe. As I understand it, the conflated consultation activity and the restricted time to pilot and learn from that testing resulted in Ofsted's public commitment to strengthen the quality assurance of the first eleven inspections and to formally evaluate the framework in the same timeframe. I was asked to contribute to that evaluation.

The data that I have collected during this review is listed in Annex A.

The framework of inspection

There is widespread endorsement of the framework: it is seen to cover the right factors as grounds for a judgment about the quality of a children's social care department. This is a major achievement. The concerns that are expressed are about how the framework is used and the reality for inspectors of managing a large and complex inspection.

Data management

The new inspection framework covers the range of local authority services for vulnerable children and families in order to be able to understand children's journeys through the system. Only one person expressed criticism of the notion of combining the previously separate inspections; other comments strongly endorsed the thinking behind this change. However, a major criticism and one that concerned me very much from my readings and observations, is that the new framework creates a much greater problem of data management. It is not just that it requires more data but also more types of data and the connections between the data. The focus on the quality of practice and the impact on children, young people and their families has quite rightly led inspectors to use a range of data collection methods: looking at the local authority's performance data and how they themselves monitor quality, reading records, discussing cases with social workers and their supervisors or line managers, observing practice. They therefore need to analyse both qualitative and quantitative data, keep control of a vast set of data, form judgments, and critically check them.

In my observations of the inspection process I was impressed by the skills shown in collecting data. The interviews with social workers about individual cases, for example, seemed similar to good critical supervision and gave workers a fair opportunity to demonstrate their reasoning and justify their actions. In my opinion, however, the data management methods that were adequate for an inspection with a smaller range and a greater focus on written records are no longer adequate for the new inspections. They do not make is sufficiently easy for inspectors to check hypotheses and judgments across the full set of data and so risk being vulnerable (and, of equal importance, being seen by the sector as vulnerable) to the common biases of human beings as analysts. Human beings have well known limitations as data analysts, including:

- They quickly suffer from data overload;
- First impressions have an enduring impact on how they interpret later evidence;
- The 'availability' heuristic means that vivid, recent data is more readily remembered;
- The confirmation bias leads to more attention being given to evidence that confirms their view than evidence that challenges it;
- They fail to take account of the varied reliability of different types of evidence, tending to treat them as equal.

These problems are well known in research and so we can draw upon solutions developed in that context. The key solution that I consider Ofsted should trial is to use qualitative analysis software. This has transformed qualitative research in the last twenty-five years, allowing researchers to collect more data and analyse it with more rigour and transparency, so that conclusions reached are more compelling.

At present, inspectors report frequently working excessively long hours as they organise and analyse their data at the end of each day. A technical aid to doing this, once they are familiar with it, would reduce the burden considerably.

Software allows the user to code sections of any material, forming hierarchies or groups to organize it further. The process of coding in itself facilitates interpretation, with hunches and questions being readily recorded in memos attached to the coding. Then, when hypotheses are formed, it is easy to run a rigorous check: one vivid example may make you form a hypothesis but, by checking for other relevant data, you will be reminded of instances that do not support your hypothesis. There is less reliance on memory, with its risk of bias, than with the current method. The software also makes it easy to pull out examples of the practice being judged, so it is easy to add them to the final report as illustrations of what is meant by 'good' or 'poor' practice when making evaluative comments. Such vignettes not only make the document more readable but also improve the transparency of the judgments, helping the sector learn more about what inspectors are looking for.

This inspection framework, too, aims to cover children's journeys through the system, so this creates a challenge in bringing together the individual inspections of parts of that journey. Using software and a common coding system would make it easier to look across the sub-divisions and see common findings. This would create the option of the report being structured around themes relating to performance rather than service components. For example, how well does the authority provide reflective supervision?

There are several software packages on the market but I have used NVivo in doing this study since I find it very user-friendly. Annex B of this report outlines a project that would allow Ofsted to explore this option in more depth before making a decision whether to make this change. I understand that hand-written notes are made at present. This does not necessarily have to change since smart pens allow for their electronic capture.

Having an electronic database would not only help during the inspection but would create a readily accessible combined dataset allowing thematic reviews across local authorities to delve into rich qualitative and quantitative data.

> ***Recommendation:*** *Ofsted should explore the advantages of using qualitative software to assist data management since the new inspection framework requires the collection and analysis of both more data and more types of data. Such software could improve the transparency of the judgments on local authorities and contribute to increasing the sector's confidence in them.*

The greater size of the new inspections also suggests that it may be worth re-examining the training that inspectors are given in research methods and project management and considering strengthening this.

> ***Recommendation:*** *Ofsted should consider increasing inspectors' training in research methods and project management.*

Reliability and validity of judgments

Closely linked to data management are concerns about the reliability and validity of the judgments reached in inspections. There is general endorsement that the inspections are valid in that they are studying the right aspects of work, but considerable concern has been expressed in the sector about the reliability of their judgments.

In written and spoken feedback to me, several comments were made about this. There was concern about poor consistency between inspectors so there was an element of luck in the final judgment. Also, many comments related to aspects of the inspection process. Three authorities complained that it seemed to be a deficit model with inspectors being biased towards looking for poor practice not good.

> *'…the team was looking for things that went wrong and pursued that line ad nauseam. Good practice was rarely if ever explored and if it was it didn't find its way into the final report'* (comment from local authority).

This perception of a bias may be mistaken but it is a common finding in analyses and so would not be surprising. Others complained about discrepancies between verbal and written feedback from inspectors. The way the final judgment was reached was also unclear and so made some feel anxious. Three authorities were highly critical of the moderation process in Ofsted, thinking that it was inappropriate for people with no direct knowledge of their work to make such an influential judgment about them.

There are significant challenges in making reliable judgments about the quality of practice and its effectiveness. The previous inspection framework that focused more on readily observable and measurable aspects of work was probably able to reach a good level of inter-rater agreement (though I do not know of any systematic check on this). However, it had the major weakness of influencing those it was inspecting to prioritise those aspects of their work over the more intangible but more important aspects of communicating well with families, achieving good assessments, and providing effective help. In trying to achieve more consistency and transparency, it is important to minimize the risk of having an adverse impact on practice by over-simplifying the inspection of complex matters.

While still aiming at improving the reliability of judgments, an alternative to reducing complex concepts to simple ones or a tick-box approach is to train people to make consistent judgments by learning through the experience of making them and then discussing how judgments were reached. This approach works well in research where members of the research team are trained to make consistent judgments by going through vignettes and discussing how to rate them. Further training is provided as research data is gathered and interpreted. I have been informed that in the Netherlands, a somewhat similar process is used. All inspectors come together once inspections are finished and moderate each other's judgments to improve consistency. Over time, one can expect the initial

judgments to become more and more consistent and the moderation process adds another check on this. With the first eleven Ofsted inspections, some moderation was undertaken but this was by senior personnel, not the inspectors themselves and such a process will not aid the development of a shared understanding amongst inspectors on how to judge services.

The formulation of the final overall judgment is particularly challenging. It is difficult to see how any algorithm could be devised for doing this because the circumstances are so varied. More group discussion will not only improve consistency but help inspectors articulate to local authorities precisely how the final judgment was reached.

> ***Recommendation:*** *the new judgments involve combining qualitative and quantitative data and there is no algorithm for this. To improve consistency among inspectors, I recommend that Ofsted set up a consistency panel in which all inspectors discuss, review, and seek to standardize their judgments before the final judgment is announced.*

After the inspection team reach a judgment, there is a moderation process in Ofsted to quality assure the reports and the criticisms about this process seem to arise, at least in part, from not knowing how they were moderating the judgments.

> ***Recommendation:*** *Ofsted should make the moderation process more transparent to build up confidence in the sector.*

These recommended changes would mean that local authorities would have to wait to hear their outcome but the benefits could be clearly set out in terms of how it was in their best interests for the judgments and moderation processes to be more transparent and seen to be consistent. The intellectual case for this is persuasive but I appreciate that the emotional case is harder to make. The alternative is to give them a provisional judgment with the major risk of causing distress and anger if it is later moderated downwards.

Impact on local authorities

There were a number of complaints made about the impact of the inspection on the authorities inspected. The previous policy of conducting four separate inspections may have, in reality, made heavier demands but the total may have been less visible to the local authority.

Cost:

Chief amongst them were complaints about the heavy demands for time, resources, and data that had a negative impact on services for children. One Link Person reported the demands made of them:

> *From Working Day 1 to the end of Working Day 15 (when this report was completed) as the Link Support Person I committed the following time solely to supporting the Single Inspection:*

> • *Continuously worked days: 21 continuously worked days (this will end up being 25 continuously worked days following the conclusion of the Single Inspection period);*
> • *Person hours committed to Single Inspection support: 178 person hours (against contracted hours of 108 hours, and not including other hours spent on post responsibilities related to the Link Support Person's other non-Children's service areas).*

Others questioned whether the demands were reasonable when the public sector is dealing with major cuts in funding and is asked to show value for money for all its activities.

In particular, there was some questioning of whether some data was of sufficient value to the inspectors to justify the cost to the authority of providing it. Annex A to the framework lists the documents and data that authorities are asked to supply. Some of this is straightforward and readily available. However, some of the data is not requested by the national data gathering exercise and so requires special action to obtain it. I was told that authorities have been spending thousands of pounds in creating new data collection mechanisms. This cost varies depending upon their existing IT system and the nature of the contract with the provider that determines the cost of making changes.

Reading the final reports with the additional data requests in mind, I was unable to see any evidence that it was adding significantly to the inspection judgments. It may be that it is drawn upon when analysing data from records and interviews, but it is not visible in the discussion of judgments. This raises the question of whether the data is not needed, and so should not be collected, or whether inspectors *should* be making use of it because it provides good evidence about the quality of help being given.

Clearly, inspection is bound to have some impact and this is warranted because of the importance of the task and the relative infrequency of inspections every three years. However, several questioned whether the current demand is proportionate.

> ***Recommendation:*** *the contents of Annex A should be scrutinized with a view to appraising the cost-benefit ratio and either considering removing items or encouraging inspectors to make use of them and show the local authority why the data is informative.*

Human impact

Inspections are inevitably and rightly challenging but it seems that they are now experienced as extremely stressful by most. Many respondents spoke of staff feeling fear during the inspection process and being demoralized if the final judgment was less than good. There were also comments on its impact on service users, for example, time given to the inspection reduced the time available to work with them. Anxiety about the inspection was said to trigger more activity on cases but whether this is desirable or not would require further study.

This level of emotional impact is worrying. I can only speculate about its causes. One significant factor seems the scale of negative response to a poor judgment. Local and national media provide harsh commentary (while paying little attention to higher grade judgments). Within the authority, the response is very negative too. Many DCSs have been sacked because of an 'inadequate' judgment. There is emerging evidence that Chief Executives and local politicians are now treating the third grade judgment 'Requires improvement' that was formerly called 'Adequate' as equally damning as the worst judgment of 'Inadequate'. This suggests a failure to understand why the name was changed: to indicate higher aspirations for children and young people, a very desirable change. With so much riding on obtaining a 'good' or 'outstanding' judgment, it is perhaps not surprising that inspections are daunting.

This blame culture is very counter-productive. Of course, no-one wishes to condone poor practice at any level in the organisation but it is important to recognize that improvement in children's social care takes time and so it is not helpful to sack a DCS who is leading a major programme of reform just because the expected improvements are not appearing quickly. The issue of a blame culture is discussed further in the section on 'Managing uncertainty and risk'.

One might consider that staff in a good authority should have the confidence to face close scrutiny with little anxiety. However, a factor that acts against this is that several reported low confidence in the reliability of the inspectors' judgments and so were not sure they would receive the rating they believed that they deserved. I addressed this issue of the reliability and validity of the judgments in an earlier section.

The overall judgment is one of four options and several authorities would welcome more information about where they came within the range for a specific judgment, i.e. how close they were to the thresholds for the adjacent categories. This would help them in local discussions and in leading improvement, particularly when they have received one of the two lower judgments. It seems to me that the text should convey much of this kind of detail about the subsidiary judgments, both when reporting an area of weakness and in listing priority actions. However, since the computation that produces the overall judgment is opaque, it would be helpful if there were more narrative about how it was reached and this would convey more detail of how close they were to reaching the next category.

> ***Recommendation****: there should be a narrative paragraph attached to the final judgment that gives more detail about how near the authority was to an adjacent category.*

Local Safeguarding Children Boards

While all of the above text has relevance to the inspection of LSCBs, there were some specific comments made on how they were inspected.

One theme in the comments related to differentiating strategic and operational roles, with some concern expressed that Ofsted inspectors were expecting the Independent Chairs to have too much operational knowledge. The roles of the Independent Chair and the partner agencies also need clear demarcation so that any criticism is correctly focused.

Comments on the communication between the inspection team and LSCBs were generally favourable, with two expressing a wish for more chance to discuss the findings. Of the six who commented, five thought that the grade descriptors were good and one considered them 'unhelpful and counter-intuitive'.

How inspection can encourage good practice

The new inspection framework is an important part of efforts to reform the sector, following my review (Munro, 2011). It is playing a powerful role in driving cultural change so that the sector focuses more on helping children and less on compliance with prescriptions about the processing of cases as a goal in itself. There are a number of areas where this influence is visible and where I think it could be even more influential.

Managing uncertainty and risk

While it is understandable that we all want children to be safe and to flourish, it is also important to acknowledge that we cannot guarantee this. We have limited knowledge about what is going on in other people's lives and limited ability to predict the future. In child protection work, decisions on actions are usually in circumstances where all available options carry some strengths and some dangers. The decision to remove or leave a child or young person in their birth family is based on a calculation of which option is *likely* to have the best benefits for the child. However likely it is that the outcome will be good, the *unlikely* can occur. Therefore a bad outcome does not imply bad professional practice. Conversely, a good outcome does not imply good practice.

The public and the media have been counterproductive by setting unachievable standards of knowledge and prediction. This has contributed to a defensive, blaming culture where people have been reluctant to own up to mistakes or weaknesses for fear of punishment. This inhibits learning and skews priorities away from a focus on the safety and welfare of children and young people. Defensive practice, in this context, usually means choosing the option that best protects the worker or agency, not the child. The reported increase in activity on cases during an inspection may be due to such defensiveness. Improving risk management requires a fair culture where people have realistic goals and can

talk about problems or mistakes, reflecting critically on their own practice without feeling personally attacked.

In the final inspection reports, I saw some good examples of realistic language about managing uncertainty and risk. For example, one authority was praised for assessing and *reducing* risk (not the unattainable 'eliminating' risk). However, the language varies and there are many examples where the reports still convey an expectation that authorities can work miracles. For example, one says of children identified as in need of protection that 'professional staff … work well together to ensure they are kept safe and well'. This seems a risky assertion for an inspector to make. Besides being a generalization about all cases based on a sample, the judgment is over-confident in what professional practice can achieve. However good the protection provided, the unlikely or the unexpected can occur and a child can experience harm. If a child dies, the public may quite reasonably criticize Ofsted for making such an inflated assertion.

The word 'ensure' appears frequently in saying what the authority needs to improve. This can be achieved in some simple tasks but it is not possible to 'ensure', for example, that sufficient adoption placements are available for children with disabilities and complex needs. Calculations need to be made about the *probable* number of placements needed. One family of eleven children can upset the calculation.

> ***Recommendation:*** *Ofsted should develop more realistic language and clearer recommendations about risk management that avoids the impression that risk can be eliminated by professionals or that they can predict the future with absolute accuracy*

Learning about how the service is functioning

A better culture around risk management is necessary not just to improve children's safety but also to reduce the defensive culture and so make it more possible for authorities to focus on learning and improvement. Ofsted, in asking me to carry out this evaluation, is setting a good example by showing the sector that it is willing to learn and change. Realistically, in view of our limited ability to cure all the human miseries in families, this is a context in which continual learning is essential.

In my review of child protection, I stressed the importance of services finding out what impact they were having on children, young people and families as key information in learning how well they were operating. However, establishing a causal connection between professional activity and family outcomes is complicated; a great deal more is going on in families' lives than their contact with formal services. In many instances, formal empirical studies are needed to make strong causal claims. At a local level, observations can show correlations between services and outcomes, but a causal connection is only speculative, albeit with varying degrees of plausibility. The inspection reports contain many claims about effectiveness and I am concerned that these may be going beyond the evidence. How, for instance, can one confidently say that early help provided

to one family *prevented* the escalation of their problems? More cautious language is needed in talking of causality, but valuable learning about impact is possible.

There are two areas of feedback that seem particularly relevant to inspections. First, impact covers not only the longer term effects of service involvement but also the quality of the experience of receiving a service. There is an ethical argument for being concerned about this but also a practical one: professional behaviour can encourage or discourage co-operation and motivation to solve problems. This issue is particularly salient in relation to the experiences of children and young people themselves. Many of them have been maltreated and so it is particularly important that professional contacts are respectful, reliable, and caring. Getting feedback from looked after children is a well established tradition but many local authorities are now developing ways of getting feedback from all families with whom they have had contact. Inspection can encourage such developments.

Secondly, impact covers the longer term effects on the child and family's lives. While I have cautioned against seeking to make strong claims about effectiveness, establishing a correlation is in itself a valuable achievement since it requires a focus on checking whether intended goals have been reached. This encourages workers to have clear goals whose attainment can be ascertained, irrespective of what their contribution has been to causing the improvement. Since vague goals or goals that are not clearly communicated to families are a widely reported defect, this can be a very desirable influence. The data that a local authority chooses to collect for performance management and auditing of cases will affect their ability to learn about impact. A predominant focus on task completion will not reveal deficiencies in practice. For instance, checking that child protection plans have been completed does not, in itself, tell you whether the plans have specified clear goals and how they are to be achieved.

A greater focus on what is happening in families would also contribute to gaining a richer picture of what aspects of the service were correlated with good outcomes. It surprises me that the Ofsted reports contain relatively little comment on specific family problems, such as domestic violence and substance misuse. Yet the work of, for instance, the Early Help services will have varied results depending on how difficult it is to tackle the problems.

Reading the reports has made me conclude that the topic of effectiveness needs further work by Ofsted to help inspectors examine the practice rigorously and give well-evidenced judgments about the impact of the services.

> ***Recommendation:*** *the inspection rightly is concerned with finding out whether children and young people are helped by the services provided but the complicated causal links between professional practice and outcomes make it difficult to make judgments about causality rather than just correlations. More work on how to understand the causal processes and what type of comments can be made about effectiveness and organizational learning about effectiveness could improve the rigour and transparency of inspections. Ofsted should also pay more attention to how the local*

authority obtains feedback both about the experiences of those using services and the impact in terms of achieving goals and solving problems.

Overall, in terms of obtaining feedback, I hope that the sector will one day become rigorous enough in the way that it is monitoring itself that the inspection process will need to do less basic data gathering and more testing whether the self-monitoring is accurate.

Practice and process

In learning about how the service is functioning, one change that is sought is a greater focus on the impact the service is having on children's safety and welfare, reducing the focus on process as a sufficient indicator of good practice. This seems to be challenging, with both the sector and the inspectors continuing to talk of a process/practice divide, a division that arose from the audit culture's focus on records and professional tasks, without direct evidence about children.

> *'There seems to be a tension between what is process and what is practice – so where inspectors may see themselves as focusing on practice issues, e.g. involving the police at a strategy meeting or discussion, the LA views this as a focus on process'* (comment from inspector).

One danger from the process/practice being seen as alternatives is that process becomes less valued as practice is more valued. Some process needs to be seen as a part of practice, with the emphasis being on how it contributes to improving outcomes for children. Records should be kept primarily because they contribute to case management. They do this in a number of ways. They provide a history for the child or young person concerned about when and why the major decisions about their lives were made; they show the cumulative understanding of the impact of difficulties in children's lives, and chronologies of events and incidents that are drawn on in supervision and in writing reports, e.g. to family courts; and they help others take over the work if an emergency arises. It is also important to remember that they are available to families and so some of the detail of reflection on how to understand what is going on may not be recorded or only available in notes on supervision.

Some process issues are not related to case management and some indeed seem to have an adverse effect on case management. For instance, the process of accessing and using case management software can be efficient or unduly time-consuming.

The Ofsted final reports vary in how well they integrate process into practice and convey some account of what is happening to children and young people as well as the tasks being carried out by staff.

> ***Recommendation:*** *Ofsted should undertake more work on how to discuss practice, avoiding the conceptualization of a sharp process/practice divide that has become widespread and locating some process within practice, showing how it contributes to good outcomes for children.*

Defining 'good' practice

The current inspection framework, handbook and evaluation schedule provide a multi-dimensional account of what a good department looks like. However, these documents quite properly do not say how this good performance can be achieved. A local authority is responsible for deciding what managerial and practice methods to implement and more prescription or guidance from Ofsted would run the danger of limiting their flexibility.

This is a period where reforms are widespread, triggered both by my review of child protection and by the austere economic environment. There seems scope for inspections to make more comment on the improvement strategies that are being adopted and how the implementation is progressing. Reference is indeed made in reports to reform strategies but I found them disappointingly sketchy. The feedback from the eleven authorities also indicates widespread dissatisfaction with the level of positive comment on their reform efforts. The level of reform being sought inevitably takes time to achieve. Building up the expertise of staff and shifting the culture to being more concerned about what is happening for the children and young people than compliance with bureaucratic processes are big challenges. Indeed, improvement should be a continual aim even in a local authority that receives a judgment of 'outstanding', since our ability to solve human problems is limited. Acknowledgment by Ofsted, when appropriate, that they were making a good effort would be appreciated. This was achieved in one report and can readily fit into the section on leadership and governance.

> ***Recommendation:*** *since reform and improvement are such important dimensions of the current work environment, inspectors should consider paying more attention to the local authority's reform plans (or lack of them).*

Plans for reform vary in scope but we are likely to see more examples of radical reforms in the way that local authorities fulfil their duties. Specific practice theories are being adopted, such as the Reclaiming Social Work model and Signs of Safety, that are changing long-established patterns of case management. Local authorities' direct provision of services may diminish through increased contracting out. There is a difficult line for Ofsted to tread between specifying what they consider to be 'good' practice, to prevent an 'anything goes' culture, and overly restricting providers' choices.

> ***Recommendation:*** *in the longer term, as more innovative ways of working are introduced (and the Department for Education's Innovations Programme makes it likely that there will be some radical, whole-system changes) more work may be needed on defining and describing 'good' practice. I recommend that, if such a need arises, consideration is given to consulting the College of Social Work and the Chief Social Worker for Children and Families since they too are concerned with defining 'good'.*

Conclusion

Inspections have acquired such an influential role in the sector that it is important to use that power to drive improvements in practice and not to have negative impacts. The new inspection framework in widely endorsed as looking at the right aspects of practice and it is doing so by using a wide range of appropriate data collection methods. There is emerging evidence that it is having a beneficial influence on priorities for reform in the sector. However, there is dissatisfaction with the inspection process itself. It makes heavy demands on inspectors and on local authorities. There is also widespread concern about the reliability and validity of the judgments reached. The recommendations in this report seek to address these problems.

Reference:
Munro, E. (2011). Munro Review of Child Protection, Final Report: A child-centred system. London: Department for Education.

Annex A: Data collected

During the course of this work, I have undertaken the following:

- Read and analysed the seven evaluation forms of the inspections completed by inspectors, with sections completed by the local authority and Local Safeguarding Children Boards (LSCBs);
- Read the background documents: the framework, inspection handbook, evaluation schedule numbers, and seen examples of the process documents – the inspectors' notebooks and the SEA;
- Read the eleven final inspection reports;
- Read feedback from local authorities and LSCB chairs, and articles from ADCS on the new framework;
- Meetings to discuss the inspection framework and process with Ofsted staff, including the Director and Deputy Director of Social Care, the National Leads, QA Managers, and inspectors;
- Meetings with two lead inspectors and my research assistant to discuss how data is managed and analysed during the inspection;
- Meeting with senior managers from all eleven local authorities that have been inspected under the SIF;
- Shadowed inspection in one local authority for two days.

Annex B: Piloting qualitative software

I strongly recommend considering using software to help with the increased data management challenge of the SIF but any tool is not just a passive addition

but changes the tasks required of users. It is therefore important not only to consider what it could, in theory, contribute but also how it could be included in the inspection process in the most constructive way. I therefore suggest a pilot in which both these issues could be addressed.

The first task is to obtain an overview of what data is collected, by whom, how it is analysed, and how combined with other findings to inform judgments. Documents can provide much of this information but it would also be helpful to observe the process to understand better how the technical solution of software can be constructively added to it. Key stages of data management are: the production of the PIB, the preparation work of the Lead Inspector, the data gathering of individual inspectors, team meetings where findings are shared and analysed, the feedback meetings to the local authority.

Developing codes for data can be done in two ways: prior to reading the data or generating them from the content of the data. The eighty-seven evaluation criteria provide an obvious set of pre-specified codes that would be common to all inspections but later generation should be facilitated too since it allows for creative developments.

A small scale use of software could involve a researcher shadowing an inspection and piloting an analysis of some part of the process, e.g. the team meetings, for staff to see whether and how it added value. Once the findings are known, further planning could be done on extending its use.