Aviation House
125 Kingsway
London WC2B 6SE

T 0300 123 1231
enquiries@ofsted.gov.uk
www.ofsted.gov.uk

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Mr John Macilwraith
Corporate Director for Children's Services
The Lonsdale Building
The Courts
Carlisle
CA3 8NA

Dear Mr John Macilwraith

Monitoring visit of Cumbria local authority children's services

This letter summarises the findings of the monitoring visit to Cumbria children's services on 13 and 14 October 2016. The visit was the eleventh monitoring visit since the local authority was judged inadequate in March 2015 and the second letter to be published. The inspectors were Ian Young HMI and Shabana Abasi Seconded Inspector.

The local authority is continuing to make progress in improving services for its children and young people in relation to the areas that were the focus of this monitoring visit.

Areas covered by the visit

During the course of this visit, inspectors reviewed progress made in the area of help and protection, with a specific focus on thresholds for intervention. Previous visits had mainly considered the children looked after population because this was the area that the local authority's performance had been judged as inadequate on inspection. The purpose of this visit was to monitor progress on tackling aspects of a help and protection offer that was judged to require improvement at the inspection in March 2015.

The visit considered a range of evidence, including electronic case records, observation of social workers undertaking referral and assessment duties, and other information provided by staff and managers. In addition, we spoke to a range of staff, including managers, social workers, other practitioners and administrative staff.

Summary of findings

- Management oversight of cases stepping up to and down from thresholds for intervention has improved through developments in the multi-agency

safeguarding hub (MASH), and the recent introduction of early help and family support panels (EHFSPs).

- Case auditing to a good standard remains a strength of the organisation, and inspectors agreed with managers' insightful findings on all audits of tracked cases.
- Cases offered as good practice examples demonstrate that the foundations of good quality early help work are in place.
- Social workers often use terminology associated with a nationally accepted model of good social work practice, and this augurs well for its rollout as the county's model of choice.
- Social workers spoken to had manageable workloads, and this supports assessment and planning processes that are generally timely.
- Regular supervision of social workers by team managers is in evidence on children's files, although the high turnover of team managers does not promote consistency in this area.
- Children's cultural and religious heritages are recognised early in any involvement in families' lives and interpreters are used judiciously, although more thought could be given in assessments and plans to the impact of the children's heritage on their unique identity.
- Children are seen and seen alone by their social worker and what they say is recorded. However, the impact of this on assessments and plans is not always made sufficiently clear.
- Thresholds for intervention are not consistently well understood and implemented across the multi-agency partnership or within children's services itself.
- Independent Reviewing Officers (IROs) are not sufficiently vigilant in ensuring that plans are measurable enough to support rigorous monitoring against targets when cases are stepped up to or down from child protection plans.
- Some services that might assist social workers in stepping plans up or down across thresholds for intervention were absent from cases reviewed. These services include child and adolescent mental health services (CAMHS), family group conferences (FGCs) and intensive family support services.

Evaluation of progress

Based on the evidence gathered during the visit, inspectors identified areas of strength, areas where improvement is occurring, and some areas where progress has not yet met the expectations in the local authority's action plan.

Cases reviewed by inspectors evidenced that management oversight has improved, because effective use has been made of management processes. These processes include accurate and well-presented bespoke performance reports, a robust auditing process, and the recent introduction of EHFSPs. These improvements, alongside improvements made in the MASH, mean that managers are now more confident of their oversight when cases step across thresholds for intervention. Senior leaders are now appropriately putting in place further measures to assure themselves that robust practice in this area becomes standard. Through time, they are confident that by

establishing firm processes to step up to social work intervention through MASH and step down through EHFSPs, they will embed consistent practice. To achieve this transparently, the local authority accepts that meeting notes should detail more clearly any management decisions made by EHFSPs. Further consideration is also being given to building upon existing good practice in early help assessments and plans with the introduction of intensive family support. This is designed to improve partners' confidence that transitioning between plans is being securely handled and can be safely undertaken. It is too early to judge the impact of these more recent developments. Their effectiveness will be considered at a future monitoring visit.

Several positive developments support cases stepping either up or down across thresholds for intervention. Social workers are broadly conversant with a national model of social work practice that is being rolled out across the teams to help them concisely identify risk and protective factors in children's lives. Social workers are generally competent at recognising children's cultural heritage and at engaging with children, although they could be better at drawing this information together into impact statements on what it means to be each individual child living in Cumbria. Social workers have manageable caseloads of on average in the low twenties and this means that they generally get things done on time. They are supervised regularly, but would benefit from a lower turnover of team managers as this would aid consistency of decision making at the front line.

At this visit, inspectors found that cases are consistently and appropriately stepping up to social work intervention. Monitoring of this has improved senior leaders' assurance that developments in the structure and functioning of the MASH have raised the standard of practice. Robust workflow processes suitably support a dedicated multi-agency workforce, and this ensures a timely and proportionate response in most cases seen.

Thresholds for intervention are not currently well understood or implemented by professionals, and this has a number of negative consequences, including child protection plans that are stepped down too quickly. This is often because social workers take an over-optimistic view of parents' willingness to engage. Inspectors saw examples of children with the same plan regardless of whether it was a child protection or child in need plan. Children are therefore on plans for prolonged periods of time, moving between levels of intervention without a clear focus on the outcomes needed to improve their lives.

IROs do not routinely ensure that child protection plans include specific and measurable targets to promote children's safety. This exacerbates the problem of children frequently moving between plans without clear outcome measurements put in place for their conclusion. Social workers do not make good use of FGCs to avoid frequently making decisions to step plans up or down across thresholds. Social workers are aware of the potential benefits, but the technique is not in general use. The level of involvement by CAMHS in the lives of children who are in need of specialist emotional support is not always timely. Inspectors reviewed a number of

case files and found that, despite a high level of need, CAMHS had not been involved. As a result of the concerns raised by this monitoring visit, Ofsted's regional director has written separately to the independent chair of the local safeguarding children board regarding the absence of CAMHS intervention on the cases reviewed during this monitoring visit.

Inspectors found that senior leaders are using strong performance information and existing robust audit processes to improve systems and processes that contribute to keeping children safe. This includes conducting a longitudinal audit of children's cases to identify the blockages preventing cases safely and securely achieving closure. It also includes reviewing the workload of the managers in the MASH to ensure that there is sufficient capacity for them to continue to manage all referrals within agreed timescales. These areas will be the subject of audits to improve the management of thresholds by the time a future monitoring visit takes place.

I am copying this letter to the Department for Education. This letter will be published on the Ofsted website on 14 November 2016.

Yours sincerely

Ian G Young
Her Majesty's Inspector