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

Dear Mr Macilwraith

Monitoring visits to Cumbria local authority children's services

This letter summarises the findings of 10 monitoring visits to Cumbria local authority children's services undertaken between July 2015 and June 2016.

The local authority is making expected progress to improve services for children and young people in Cumbria.

The local authority was inspected in March 2015. Overall effectiveness and services for children looked after were judged inadequate. Services for children in need of help and protection, adoption and services for care leavers were judged to require improvement.

During the monitoring visits, inspectors looked at practice in all districts of the county. Detailed feedback was given to senior managers in the local authority at the end of each visit to assist improvement planning. Three summary reports were produced for the improvement board. In addition, Ofsted and the local authority jointly delivered a seminar of findings and lessons learned to managers from children's social care and senior partners from health services and the police.

Areas covered by the visits

During the monitoring visits, inspectors focused primarily on reviewing progress made in respect of the services for children looked after and a more limited review in the area of help and protection. This reflected the balance of concerns found in the most recent inspection in March 2015. Inspectors considered a range of evidence, including electronic case records and supervision notes. They also held discussions with social workers, team managers, independent reviewing officers (IROs) and case auditors.





The work was carried out in four phases. Phase one, from July to September 2015, focused on case tracking. Phase two, between October 2015 and January 2016, concentrated on the impact of the IRO service and on the quality assurance arrangements that check on the progress of children and young people. Phase three, between February and April 2016, re-visited case tracking, enabling inspectors to consider the degree of progress made. Phase four was a paper-based review of plans and reviews for children looked after, as well as six audited cases of children with complex needs.

During phase one, inspectors looked at 18 cases. Overall findings by inspectors were similar to the local authority's own findings from audits of the cases. This was an important indicator for the local authority that internal auditing had helped them to understand and address weakness in practice and to build on strengths.

Key findings from the phase one monitoring visits

- The local authority was not monitoring the progress of permanence plans for all children looked after to ensure that these were on track.
- The impact of IROs was not strong enough to address drift and delay in plans for children looked after.
- The quality of children's case records, particularly the chronologies of key events in their lives and records of their views, was very variable. Some good cases were seen but many required improvement.
- Some social workers and managers had a good understanding of permanence planning but this was not true for all of them. However, by the end of phase one staff and managers were able to describe recent advice and training on permanence they had received to help them to improve their practice.
- The relocation of middle managers in the districts was reported by staff to be a significant improvement. The accessibility and oversight of middle managers was assisting quick decision-making regarding case direction and accessing resources.
- Inspectors noted offices to be considerably calmer and observed productive case discussions. All staff reported increased confidence in senior managers, and increased visibility and good communication from the senior leadership team.

The second phase of the work focused on the quality of case file auditing, with inspectors testing oversight and challenge of cases from the IRO service. Local authority managers observed and audited child protection conferences and reviews for children looked after. An audit tool was also developed to enable IROs to reflect on their own performance. Together, these activities enabled the authority to assess the quality of planning and decision-making for children and young people.

Similar issues to those identified in phase one were found, but this was expected given the widespread deficits found at the inspection. However, some better practice was seen that was benefiting some children.



Key findings from the phase two monitoring visits

- Staff did not always consider the experience of the child or take into account the child's wishes and feelings when making decisions or plans about them during meetings.
- Reports were not always shared with family members prior to meetings.
- Professionals from partner agencies, particularly police and health, were not always attending key meetings. These issues were raised at the improvement board, resulting in a commitment from the police and health representatives to review practice and address concerns.
- The quality of plans continued to be variable.
- There was a stronger focus on promoting permanence for children and addressing historical issues of delay and drift.
- There was more evidence of challenge from the IROs but progress for some children was too slow. However, the recently appointed permanent IRO manager demonstrated a good understanding of areas in need of development in the service. A plan was in place to strengthen this service further.
- Deficiencies in practice identified on previous monitoring visits were rectified, and some good- quality assessments were seen.

The third phase of the work mirrored the case-tracking activity of phase one. Eighteen cases in total were audited, with similar judgements made by the local authority's auditors and the inspector. The narrative within audits had improved with clearer explanations for the audit findings. Inspectors were encouraged to see the local authority had taken action to address the internal audit recommendations prior to the monitoring visit.

Key findings from the phase three monitoring visits

- Some children looked after had up-to-date comprehensive assessments of their needs that were informing planning and reviewing but this was not evident for all of them.
- There was evidence of some assessment tools being used, although this was not widespread.
- The quality of case summaries on children's files was improving but there was more to do to ensure that they were all of good quality.
- Management oversight on cases was variable, but more cases had written advice and directions for social workers about what future action was needed.
- Progress was being made in training and recruiting social workers but some children were still experiencing changes of social worker.
- More IROs were using the self-reflection audit tool to help them review their own performance to improve their contribution in progressing children's plans.



- Staff had a better understanding of the importance of accurate, up-to-date case recording. This was evidence of a clear message from senior managers being cascaded and having an impact on frontline staff.
- Social workers and managers knew the children well and gave a clearer account of the child's progress than could be seen from their file. More cases included case summaries and some included useful chronologies but not all files captured progress or recorded the child's story well enough.

The fourth and final phase of monitoring activity focused on two areas: children and young people who have complex needs and disabilities and a review of plans and review meetings for children looked after. With regard to the children who have disabilities sample, inspectors largely agreed with the findings of the local authority audits.

Key findings from the phase four monitoring visits

- Not all eligible children benefited from advocates and independent visitors.
- Assessments and plans for children looked after were of variable quality. Shortfalls included not considering the individual needs of some children in sibling groups, insufficient consideration of the impact of parental difficulties on children and insufficient consideration of identity and diversity for some children.
- Local authority audits correctly identified that too many children who have complex needs and disabilities had not been seen on their own enough and that, overall, practice was variable and ranged from very good to inadequate.
- Some families of children who have complex needs and disabilities had several professionals allocated to different children in the family, which created unnecessary confusion and duplication for both staff and the families.
- Partnership working with providers was not always effective and transition planning for young people who have complex needs and disabilities did not always start early enough in their lives. The local authority was aware of the areas for development and had plans in place to address this.
- Some cases showed improved IRO oversight and evidence of challenge.
- The local authority was taking swift and appropriate steps to review social workers' practice where concerns about their risk assessment skills had been identified.
- Improved practice for children looked after was addressing historical concerns attributed to previous poor practice.
- Good examples were seen of social workers and other staff listening to children to inform plans and provide support for the child.
- There was a strong focus on permanence planning, with good consideration of the various routes to achieve permanence.



Evaluation of progress

The senior leadership team and elected members have consistently emphasised their determination to deliver effective services that improve the lives of vulnerable children and their families. Engagement with Ofsted has been positive from the outset. It has been characterised by openness, careful attention to detail, and high quality professional dialogue about how to secure improvements in service provision most effectively. This continued throughout the disruption caused by the extensive flooding in December 2015. The local authority has sought to integrate advice and external challenge from a range of stakeholders and to learn from their findings in order to improve services for children and young people in Cumbria.

Senior leaders have accepted the historical failings within the authority and have taken prompt steps to change and strengthen leadership within children's social care services, including a significant increase of middle managers. One immediate benefit was the oversight and accessibility to senior managers from staff in social work teams based away from Carlisle, which ensured that decision making on children's cases was able to proceed more swiftly.

There has been increasing evidence of the value and impact of audit tools being used by the local authority and the difference these have made to social work practice and to some children. The audit tools cover a suitable and wide range of performance measures that focus on the quality of engagement with children and their families. In the majority of cases, local authority auditors have been thorough. The tools encourage auditors to consider to what extent the child is 'centre stage' in meetings that are held about them and the extent to which the child's individual needs are being considered.

The local authority promptly addressed all concerns found through their audits and additional concerns identified by inspectors on individual cases. Learning from cases has informed strategic developments, for example, in the deployment of managers, staff training and improving guidance for staff.

Case auditing activity undertaken over the past year has led to many managers becoming increasingly confident and skilled in auditing cases. The local authority has promoted professional discussions within the managerial group about what 'good' looks like regarding social work practice. Inspectors have encouraged this approach so that case audit and review are established as part of mainstream management activity. This has strengthened internal quality assurance as well as performance management arrangements. These provide an additional 'check and balance' to the quality assurance/performance management role of social work practitioners and managers across the county. Social workers spoken to understood the importance of their work being subject to scrutiny and audit by managers. They could provide examples of how actions taken following audits had improved their practice and led to better outcomes for some children. Inspectors have also found evidence where findings from case file audits have been used to address deficits on individual cases



and where good practice was seen, this was shared with workers to support their learning.

The local authority has identified the recruitment and retention of good quality staff as key challenges and fundamental to the success of its improvement plan. Inspectors have met staff who have been recruited, including some who have come through the local authority's social work academy. While this has not been an area of detailed enquiry during monitoring visits, there have been no significant gaps in staffing and management seen in the districts and teams visited.

The inspection in March 2015 identified that some progress had been made since the previous inspection in 2013 when services for children and young people looked after were inadequate. However, based on the evidence tested during these recent monitoring visits, inspectors are satisfied that the local authority has shown steady improvement in line with its improvement plan. Senior leaders and managers have an increasingly detailed understanding of strengths and areas for development, can evidence the steps taken to address key areas of weakness, and are actively monitoring progress with sufficient rigour. The local authority is therefore making expected progress to improve services for children and young people in Cumbria.

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

Yours sincerely

Sheena Doyle

Her Majesty's Inspector