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Mr John Macilwraith
Corporate Director for Children's Services
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Dear Mr Macilwraith

Monitoring visit of Cumbria local authority children's services

This letter summarises the findings of the monitoring visit to Cumbria local authority children's services on 24 and 25 January 2017. The visit was the twelfth monitoring visit since the local authority was judged as inadequate in March 2015. The inspectors were Sheena Doyle HMI, Shabana Abasi Seconded Inspector and Lorna Schlechte HMI designate.

Areas covered by the visit

During the course of this visit, inspectors reviewed the progress that has been made in help and protection services. The focus was on the following areas:

- The arrangements in the multi-agency safeguarding hub (MASH), including staffing, decision-making, information gathering and timeliness of responses were considered.
- Seven cases were selected in order to track the local authority's arrangements for responding to referrals to children's social care, the quality of statutory assessments and the quality of safeguarding enquiries under section 47 (Children Act 1989). These cases were audited by the local authority. One case followed up progress of a child whose case was sampled at the last monitoring visit.
- Seven cases were sampled in order to explore the appropriateness of the application of thresholds and arrangements for the transition of cases between levels of intervention.

The visit considered a range of evidence, including electronic case records, supervision notes, observation of some of the staff in the safeguarding hub undertaking referral, information gathering and assessment duties and other

information provided by staff and managers. In addition, we spoke to a number of staff, including managers, social workers and independent reviewing officers.

Evaluation of progress

The practice seen on this visit is still too variable, and there is not consistently good practice across the whole of Cumbria. The MASH continues to work well within its defined role. The pace of improvement in early help services is too slow. The MASH benefits from the co-location of staff from an appropriate range of agencies, who work well together. The MASH includes specialist teams that deal with domestic abuse, children at risk of sexual exploitation and children who go missing. All contacts for advice, help and support pertaining to children's welfare are routed through the MASH. Staff and managers are vigilant in ensuring that matters are progressed within timescales that are appropriate and specific. They are supported well by the electronic recording system, which, for example, flags contacts that are exceeding expected timescales. This assists management oversight of the workflow. However, inspectors found that workflow is poor at the point of transfer. Many steps are required in order to convert a contact to a referral and to send the referral to the district social work teams. This makes the process time consuming. Inspectors were satisfied that managers are fully aware of this issue and that actions are underway to streamline arrangements, but these measures were not in place at the time of this monitoring visit.

At the time of this monitoring visit, the police allocated to the MASH were not co-located with other MASH staff, but were based separately. This is a temporary measure caused by the urgent relocation of the MASH service for reasons of health and safety. The police staff will re-join their colleagues once computer cabling has been completed. Consequently, this monitoring visit did not sample any of the activities undertaken by the MASH police staff. Staff in the MASH explained the value of having police colleagues co-located with them under normal circumstances and described how this facilitates information sharing and decision-making. The separation of staff at the time of the monitoring visit means that informal case discussions are not occurring, although liaison via telephone and email is evident.

The MASH concentrates on the immediate review and triage of incoming information to determine an appropriate immediate response and the gathering of multi-agency background information, when necessary, before a child's case is passed to the team or service that can best support the child. These arrangements meet the needs of the county. Staff in the MASH also provide information and advice to callers for non-urgent or general enquiries. The staff do not currently convene or attend strategy meetings, undertake any statutory assessments or plan any interventions. Their duties cease once the contact has been dispatched to early help or statutory children's social care services in the districts. Within this context, 12 pieces of work were sampled with a variety of staff. The sampled work demonstrated that all of the verbal analyses and written activities undertaken by the staff were appropriate.

Workers are efficient, and this is supported by the electronic system's prompts and gateways, which ensure that key tasks have to be completed before next steps can proceed. One worker functions as the 'lead' worker by sending out requests to other colleagues in the MASH to check their agency's databases and reports accordingly. This works well. In the work sampled, responses were prompt and the information provided was relevant. The overall collation of this information by the 'lead' worker is generally good and includes succinct synopses and analyses of the multi-agency involvement that has taken place so far in the child's life. This supports decision-making on next steps, and its effectiveness was seen in the tracked cases. All tracked cases show timely referral from the MASH to district social work teams and generally prompt allocation to social workers. Records of concerns and issues are clear and appropriately rated: red, amber or green. Letters to referrers regarding outcomes and closure letters to parents and other professionals were seen on all tracked cases, which is evidence of good communication.

Social workers in the MASH are able to close down or redirect contacts if the seriousness of presenting issues is judged by them to be below the level of statutory intervention. This means that decisions regarding children who are deemed to require a less rapid or serious intervention, such as a referral to early help services, are not overseen and agreed by a manager. In contrast, all decisions to progress a contact to statutory services are overseen and agreed by managers. Although the local authority advises that it has a range of mechanisms, such as audits to test the appropriateness of decision-making in the MASH, this arrangement is not sufficiently robust and means that there is insufficient management oversight of all decisions made in the MASH.

The local authority describes its early help services as being on a journey of development. Families are encouraged to engage with services by dedicated staff located in the MASH as well as by specialists in the districts. The function of the district early help panels is being revamped. As a result, they now review cases that have become 'stuck' within the early help service, and they help to identify situations in which alternative approaches may be more successful. However, this change is very recent, so it is too early to see the impact of this new role of the early help panel.

The local authority does not have a mechanism by which it can assure itself of the quality of early help assessments and the progress of early help interventions. The integrated children's electronic system is not fully up to date, so MASH staff may miss notifications of ongoing involvement from early help services, which are recorded on a separate electronic system.

Among the local authority's strengths are its robustness and its realistic audits of cases, which strongly converge with inspectors' assessments of casework practice. These strengths have been evident on every previous monitoring visit. Disappointingly, on this visit, the local authority's audits judged four out of six cases

to be 'inadequate' and two to 'require improvement'. This is not consistent with the overall pattern of practice seen on recent monitoring visits, when the standard has been better overall. Inspectors agree with the judgements made by the local authority auditors against the key elements of performance seen in these audits. The quality of audits shows that the auditors, who are drawn from the workforce's management team, understand the principle and practice that underpin good social work. It is worrying that at this monitoring visit a higher proportion of casework is judged to be inadequate. However, the timescale under consideration is approximately a year for each case and, in some of these cases, there are recent examples of stronger and better practice.

This visit also focused on thresholds and the appropriateness and timeliness of children being 'stepped up' or 'stepped down' between levels of services, including between statutory and early help services. Overall, we found that practice is too variable. Some 'step up' cases show that the child and their family have remained too long at the level of early help intervention. In several cases, early help support appears ineffective in addressing long-standing parenting issues linked to mental health, domestic abuse and/or substance misuse. In at least three cases, family functioning deteriorated over time, and children's emotional and behavioural issues increased. Consequently, attention and effort were focused on the child's behavioural problems rather than on addressing the underlying causal parental behaviours. In some cases, children and families were worked with for too long at the child in need (CIN) level without there being sufficient consideration of escalating the case to child protection, despite clear evidence of a lack of progress. In other cases, there was appropriate escalation from CIN to child protection services, but even this could have been carried out sooner. On a positive note, some cases that were sampled show improvements once child protection procedures were initiated.

A number of cases were closed because of poor parental engagement rather than this very issue being considered as a good reason to consider escalating matters. The local authority should review how well its arrangements support children in families in which there is poor or no parental engagement with services.

'Step down' practice is too variable. Social workers spoken with by inspectors were unclear about the pathways and criteria for early help services. In two cases that were stepped down from CIN to early help, positive progress was made. Three other cases were prematurely closed to statutory services without any referral to early help. In all these cases, further referrals and statutory assessments occurred when concerns and incidents continued to emerge. The local authority is addressing this urgently in order to improve 'step down' arrangements. Greater care is also required to ensure continuity of support when cases are being closed to statutory services. In two cases, referrals to other support services, including child and adolescent mental

health services, were appropriately made, but the cases were closed before the referrals were accepted and actioned. This led to gaps in support for the children.

Children's case records and discussions with social workers confirm that the importance of ascertaining and representing the views of children is clearly understood across the workforce. This has been an important and appropriate development in the local authority and is an area that has been reported positively on previous monitoring visits. Some cases show that children's views are sought, direct work is completed and children's presentation is noted. In other cases, the direct work that is undertaken is poorly recorded, there is little evidence of tools being used and the work is not reflective of the work described to the inspector. Recording of the presentation and environment for pre-verbal children is poor. Casework shows evidence of regular and detailed supervision and management decision-making, although the quality of these records is also variable.

Statutory activities, such as home visits, conferences and core group meetings, are generally timely. In cases that require strategy meetings to be held, the meetings are timely and attended by relevant professionals, including the police. There continue to be gradual improvements in case recording, as seen at previous monitoring visits, but more work is needed to ensure that recording is consistently good. Most cases include a case summary, but the quality of recording is variable. The use of chronologies continues to improve; there is evidence of them on all cases, although not all of them are up to date. Social work assessments vary in their quality and depth of analysis. Some are very good, but not all of them consider historical issues sufficiently. Some are too superficial. This needs to be addressed so that children benefit from thorough and timely assessments of their needs. Statutory plans are in place, although those that were seen lack timescales and contingency arrangements. One case needed to be referred to another local authority, but there is no clear audit trail to detail what information was shared between this local authority and the other local authority. Some cases lack evidence of the application of recognised assessment tools, such as those used to evaluate domestic abuse, and consideration of family group conferences, where appropriate. This hampers the social workers' ability to properly assess and respond to risk.

Senior managers in the local authority, together with partner agencies, continue to demonstrate their commitment to improving services for children. Their willingness to work together to achieve this is clear. Leaders are aware that practice across Cumbria remains inconsistent and are working to address this. Some strengths noted in previous monitoring visits continue to be seen, such as robust auditing, embedding the importance of direct work with children and recording the voice of the child. However, social work practice on the six audited cases, for example, is not as positive as practice that has been seen on previous monitoring visits. This shows

that in some parts of Cumbria practice is weaker and highlights the areas of practice that require further improvement.

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