Piccadilly Gate
Store Street
Manchester M1 2WD

T 0300 123 1231
Textphone 0161 618 8524
enquiries@ofsted.gov.uk
www.gov.uk/ofsted

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Wendi Ogle-Welbourn
Executive Director: People and Communities
Shire Hall
Castle Hill
Cambridgeshire
CB3 0AP

Dear Ms Ogle-Welbourn

Focused visit to Cambridgeshire County Council children's services

This letter summarises the findings of a focused visit to Cambridgeshire County Council children's services on 13 and 14 March 2018. The inspectors were Mandy Nightingale, HMI, and Margaret Burke, HMI.

Inspectors looked at the local authority's arrangements for children in need and those subject to a child protection plan.

Inspectors considered a range of evidence, including case discussions with social workers and child protection chairs. They also reviewed local authority performance management and quality assurance information and children's case records.

Overview

Corporate and political support is ensuring a continued focus on improving social work practice. Leaders know their service well. The local authority's summary self-assessment report accurately recognises strengths and areas for development, resulting in focused improvement. However, it is too soon to evaluate the impact on children's outcomes of some of the newer initiatives.

Strong partnership working ensures that children in Cambridgeshire are protected. Children's needs are quickly identified and the services provided reduce risks and enable children to remain at home with their families.

Children are seen in accordance with their plan and, where appropriate, most are seen alone. Social workers build meaningful relationships with children and their families.

A reorganisation of children's services 12 months ago to a district-based structure has not yet resulted in a stable workforce that provides continuity of support for children and their families in all parts of the county. High staff turnover, vacancies and absence, as well as significantly high caseloads persist in some areas. Where there are difficulties and delays in recruiting suitably qualified and experienced social workers, some children are not seen regularly enough and they experience too many changes in social workers. Some children's records are not up to date.

What needs to improve in this area of social work practice

- Children's records need to be up to date, fully reflect the work undertaken with families and show how this informs care planning.
- Social workers and managers do not have a clear and consistent understanding of the expected timescales for single assessments and initial child protection case conferences. This needs to be addressed to ensure that children are seen promptly and risks of significant harm are considered by relevant professionals, ensuring timely decision-making and planning.
- Recruitment of suitably qualified and experienced social work staff needs to be more efficient to reduce the unacceptably high caseloads in some areas. When caseloads are too high, children are less likely to receive a service appropriate to their identified needs, and social workers may struggle to provide consistently good quality support to children and their families.

Findings

- Leaders and managers know their services well. They are aware that caseloads are too high in some areas and understand the impact that this has on performance and the quality of social work practice. Action has been taken to address the high number of caseloads in the last three months.
- The current district-based life-long unit model has not been delivered consistently across all districts, making it difficult for leaders to assess its impact for children. Some teams are vulnerable to staff turnover, vacancies and absence. Inspectors saw the impact of this, with significantly high caseloads in some areas affecting the quality of social work practice and outcomes for children. In addition, visits to children in need are mostly carried out in accordance with minimum statutory requirements, rather than as identified by the individual needs of the children concerned. Similarly, many single assessments are completed at or over expected time limits, and supervision and case records are not as up to date as they could be. Consultant social workers, who carry a caseload as well as supervising staff, are particularly stretched in some areas.

- Despite these delays, assessments of children and families are generally of good quality. They set out family histories, identify risks and reflect the voice of the child. They could be improved through more consistent use of research and by being completed within a timescale that is appropriate for the individual children concerned.
- Children's plans demonstrate that a range of professionals are working productively together in families' lives. Inspectors saw practice which delivered positive outcomes for children in most cases. However, many plans are not sufficiently focused and this dilutes their effectiveness. Some plans are not child focused, are process driven and do not contain timescales for actions to be completed. This means that, in some cases, families, professionals and children are not clear about what is expected of them and when.
- The use and quality of safety plans are variable. Better plans are developed with families and have a meaningful benefit. However, some plans are more action-focused, with little evidence of being developed with families. Delay in completing some safety plans means that work with some children is not informed by a full understanding of the risks to them at the time when these risks are first identified.
- Strong and effective partnership arrangements result in consistent joint working and sharing of information to support assessments, planning and ongoing decision-making for children and their families. As a result, children, their parents and siblings receive appropriate coordinated services promptly to address their identified needs.
- Specialist support roles, such as the unit clinicians and the adviser from the sexual behaviour service, have a positive impact on progressing plans for children.
- Disabled children receive an effective social work service which recognises individual needs for support and protection. Children's views are sought using a variety of different approaches, and these inform care planning. The authority's whole-family approach and review process for long-term children in need cases are not fully understood or consistently implemented by staff. This means that not all the needs of brothers and sisters are recognised in care plans or assessments.
- Children are seen and seen alone when appropriate. Social workers engage in direct work with children and their parents to ascertain their wishes and feelings. Social workers speak very positively about children they work with. However, for many children it is not always evident that social workers have a clear understanding of their lived experience. Evidence of direct work with children and parents demonstrates some positive outcomes; however, this is not always promptly uploaded to the child's record.

- Management oversight is evident when decisions are made to commence pre-proceedings work under the Public Law Outline. However, inspectors saw delays for some children in progressing these decisions. While children continue to be seen by social workers and other professionals, this means that outcomes for some children recognised to be at risk of significant harm are not achieved in a timely way. The local authority recognises this as an area of practice that is not strong enough and requires further development.
- Letters informing families of pre-proceedings work are not family friendly and understandable to families; too often they contain too many expectations and are unrealistic.
- Diversity is understood by social workers, with evidence that it is considered to meet individual needs.
- Improved commissioning of advocacy services has resulted in more children participating in their child protection conferences. As a result, children have their voices heard and they influence the design and delivery of future services.
- Comprehensive and effective performance management tools and processes mean that leaders and managers understand performance and can address areas for improvement. Despite innovative actions identified to address poor performing areas, the local authority recognises that it does not always have the staffing capacity to act. As a result, the quality of practice and compliance with statutory requirements are not consistently of a high standard in some areas and the local authority's own expectations are not always met.
- Child protection chairs are rigorous in raising concerns and challenging ineffective care planning for children subject to child protection plans. Escalation of concerns is effective. Tracking escalations is a new process which could be improved by monitoring and analysing trends to further inform learning and performance management.
- Social workers, managers and clinicians are confident and capable and they know children well. They are supported well by consultant social workers and senior managers, with access to a good quality, appropriate training opportunities provided in different formats to meet individual learning styles and availability.

Ofsted will take the findings from this focused visit into account when planning your next inspection or visit.

Yours sincerely

Mandy Nightingale
Her Majesty's Inspector