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Dear Nicola

## Focused visit to Cambridgeshire children's services

This letter summarises the findings of the focused visit to Cambridgeshire children's services on 10 and 11 March 2022. Her Majesty's Inspectors for this visit were Russel Breyer and Margaret Burke.

Inspectors looked at the local authority's arrangements for children in need and children subject to a protection plan. Inspectors considered the experience and progress of children, the application of thresholds, step-up/step-down arrangements, and children subject to edge of care or pre-proceedings support.

This visit was carried out in line with the inspection of local authority children's services (ILACS) framework. The visit was carried out fully on site.

## Headline findings

At the last inspection of Cambridgeshire children's services in January 2019, the experiences and progress of children who need help and protection were found to require improvement to be good. Since then, the COVID-19 pandemic has presented significant challenges to which senior leaders have responded well. Recent changes in senior leadership have maintained continuity. However, the implementation of a new practice model in February 2020 was affected by the pandemic. This, and continuing challenges in recruiting enough social workers, has meant that improvement has not been made at sufficient pace in services for children in need and those in need of protection.

Leaders recognise this and, supported by well-informed, committed elected members and financial investment, they are taking action to strengthen services. Effective early help arrangements reduce the need for social care interventions. Adolescents are supported effectively by specialist teams, and services for young people at risk of extra-familial abuse are a strength. Comprehensive quality assurance arrangements ensure that leaders are well sighted on the quality of help given to families. However, when there is a need for social care support, the quality and timeliness of

services remain less than good for too many children. While no children were found to be suffering harm, and some children make good progress, the challenge of high caseloads has persisted for a number of years and has not been successfully addressed, despite efforts to recruit more staff. The impact of high caseloads is that social workers and frontline managers focus on the most urgent work to secure children's safety, without sufficient capacity for the follow-up work needed to sustain change within families.

**What needs to improve in this area of social work practice?**

- Social worker capacity to undertake effective direct work with children and their families.
- The timeliness of allocation of social worker in child in need cases, to meet children's and families' needs.
- The time available to ensure high-quality reflective supervision and decision-making for children.
- Managers' and social workers' understanding of the risks of sexual abuse.
- Social workers' capacity to attend relevant training, including induction into the practice model.

**Findings**

The COVID-19 pandemic continues to have a significant impact on Cambridgeshire. Leaders have ensured the safety of children well in the circumstances. The continuing impact of the pandemic on work with children and families and on the workforce has slowed their progress in strengthening services.

Children who need help or protection are identified and most receive a timely assessment of risk and need. In most cases, thresholds for working with children are appropriately applied. However, children do not always receive timely support following identification of need. In a small number of child in need cases, there are long delays between assessment of need and a social worker being allocated to provide longer-term intervention. Circumstances for some children deteriorate in this time, which may be avoidable with more timely allocation.

Once allocated a social worker, most children in need and those with a child protection plan are supported well. Their social workers and children's practitioners can access specialist adult workers within the 'Family Safeguarding' model, and these are engaged quickly to help families when the need is identified. Children's practitioners hold cases that are appropriate to their role, and receive regular supervision. Social work managers make key decisions about cases. The children's practitioners also assist allocated social workers who hold more complex cases.

Many social workers struggle with excessive workloads, with high caseloads predominantly of child protection or complex child in need work. This is unacceptable, as it limits the time workers have available to get to know children and families, and to work with them to address the problems they face.

Plans to recruit more social workers have not been successful in reducing caseloads across the service. Managers are aware of the impact of high caseloads for social workers. They ensure that children are not left at risk by ensuring oversight through regular supervision of staff. They keep children's cases under review and respond if circumstances change.

Visits to families are mostly regular and within timescales. Some social workers get to know children and families well, and directly help them to address problems. However, too many visits lack a purpose or focus, with some visits serving mainly to monitor families. An example was seen where concerns focused on a mother's alcohol misuse affecting her unborn child. The family were visited, but the impact on the existing children in the household was only partially explored as their views were not sufficiently captured.

Where children's wishes and feelings are sought, these do not always influence the work done with them. In one case, a child was visited at school when he had expressly requested that this did not happen.

Plans for most children are clear and SMART. Plans are regularly reviewed in multi-agency meetings to check that actions are completed. Supervision for social workers also reviews actions, but the focus is too often on completion of identified actions rather than updating a plan to respond to changing circumstances. This means that some plans do not respond flexibly or quickly enough to changing need, so children make less timely progress.

Experienced independent chairs provide consultation outside of review meetings and alert managers when progress is not being made. Meetings are well attended by families and professionals, who contribute to the plan for the child, so that broader needs are met.

Most children are stepped down from child protection to child in need plans appropriately, so they receive a service at the right level. For a few, however, progress is not sustained and children return to child protection plans where this could have been avoided with better decision-making.

Child in need cases are stepped down to a well-resourced Early Help service when appropriate. Families are contacted swiftly, introductions help the work to get off to a good start and families experience a seamless service.

Management decisions about children at risk of sexual abuse are not informed by a good enough understanding of risk by managers and social workers. Appropriate

assessments or plans are not always made when children at risk go to live with extended family members, or when children themselves may present a risk to others.

Children who need the protection of a legal framework are tracked effectively by service managers who ensure that referrals are made and timely support is provided. Managers are aware where delays occur, and they act to address them. Risk is reduced enough for some children in pre-proceedings to be able to exit the process.

Young people at risk of entering care are well supported by workers in Adolescent teams, who build effective relationships with them and their families, and who access a range of resources to help. This work is characterised by persistence, good partnership working and an effective problem-solving approach. Caseloads in these teams are much lower than in other services.

Children and young people at risk of extra-familial exploitation benefit from support from specialist adolescent workers, a joined-up approach with partner agencies, and effective strategic oversight. Services in this area have helped to reduce incidents of gang-related violence.

Disabled children are supported well by workers who take timely action to ensure that they are safe and their families helped. For some children, this is by taking timely court action, for others by supporting the family to make changes. The child is held at the centre of the work. Workers have skilled communication techniques and are able to present the child's voice clearly to inform decisions.

Overall, parents are treated fairly and are helped to make progress. However, some families experience work at the first point of contact, and some social workers as blaming. Their view was that this set intervention off on the wrong foot. This may make it more difficult to engage families in work to bring about change. Parents felt that some workers in 'front door' teams do not have time to understand their children, and do not accurately represent their views. Better relationship-based work takes place in Family Safeguarding and Children with Disability teams, where workers engage families effectively and build trusting relationships.

Staff are well supported by a stable and experienced management group whose members are available to their workers and who provide regular supervision. However, frontline managers are responsible for too many children, which leaves them too little time to provide reflective supervision which considers what life is like for the child, or to think through with workers what might make a difference, especially in complex cases. Supervision is overly task- and process-focused. This can avoid delay, but means that plans do not reflect children's changing needs or different approaches are not tried, so that the help given to families is less effective.

Management decision-making is inconsistent in too many children's cases. Decisions are sometimes changed without a clear rationale being recorded. Decision-making can be incident-reactive rather than based on reflective consideration of risk factors.

Not all workers receive a thorough or timely induction. Some workers do not have a good understanding of the Family Safeguarding model, and are unable to make full use of its benefits. High workloads mean that some workers are not able to attend important training. There were also delays in practical matters, such as securing laptops for new starters.

Quality assurance processes are comprehensive and detailed. A programme of performance meetings ensures lines of sight, accountability, and learning at all levels. A rolling audit programme, with caseworker involvement, helps workers to take immediate learning from the exercise. This is supplemented by a responsive programme of thematic audits.

The format for assessments and other records does not enable the reader to easily understand the child's journey. Information is repeated for siblings on the same form, making it hard to draw out needs of individual children.

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

Yours sincerely

Russel Breyer
**Her Majesty's Inspector**