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Dear Ms Smedmor

Focused visit to Suffolk children's services

This letter summarises the findings of the focused visit to Suffolk children's services on 16 and 17 September 2025. His Majesty's Inspectors for this visit were Margaret Burke, Monique Lindsay and Michele Henry.

Inspectors looked at the local authority's arrangements for the front door.

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

Headline findings

Since the last inspection, there have been significant changes in the senior leadership of children's services. The director of children's services took up post in July 2024, followed by the appointment of her leadership team, most of whom have been in post for less than a year. Despite this, the practitioner workforce has remained stable, and morale is high, helping to maintain consistent relationships and minimise disruption to front door practice. The new leadership team in accepting the previous inspection findings have responded through strengthened oversight, investment in quality assurance and a commitment to external challenge. This has fostered a culture of learning and practice development, with early signs of improvement beginning to emerge. Work to address practice deficiencies is underway. However, the changes implemented in the front door have had limited impact. Shortfalls in timeliness, threshold application, responses to repeated contacts and gaps in multi-agency collaboration are still evident and continue to result in delayed and fragmented responses for children and families. These findings were not a surprise to leaders; they had more recently identified that these challenges were entrenched and required 'back to basics' strategies. They have more recently shifted focus to create sustainable changes which are also aligned with the Governments' children's social care reforms and aim to create joined-up structures that deliver timely and responsive services.

What needs to improve in this area of social work practice?[1]

- The timeliness of responses to request for help from front door services. (outcome 1, national framework)
- The consideration of cumulative harm for children when multiple or repeated requests are made for help or services for children and their families. (outcome 3, national framework)
- The accuracy and use of data to support management oversight of the quality and effectiveness of front door services. (enabler 2, national framework)
- The consistency and appropriateness of decision-making regarding thresholds. (enabler 3, national framework)

Main findings

Children who are referred to front door services and identified as at risk of harm receive a prompt and appropriate response. These request for help contacts benefit from strong oversight, clear identification of risk, and swift multi-agency collaboration, with well-documented strategy meetings. As a result, children in these most urgent circumstances are safeguarded quickly, and families are supported to reduce immediate harm. However, when the request for help for children and their families is determined to be less urgent and are RAG rated amber or green, they do not consistently receive a timely response. Delays in processing the request for help, decision-making and information-gathering mean that children may remain in vulnerable situations or without help for longer than necessary, with risks and need sometimes escalating before support is provided.

The current monitoring systems do not reliably flag delays, particularly when the contact/request for help can often remain in 'in-trays' for up to five days before being RAG rated without triggering any alerts. This lack of responsiveness can result in missed opportunities to intervene early, leaving children exposed to unassessed risk and families without timely support.

Consultant social workers' management oversight is evident, but it does not always lead to timely action. Threshold decisions are not consistently applied. The inconsistent exercise of professional curiosity means that risks are not always fully explored, and some opportunities to understand the child's lived experience are missed. Contacts that result in No Further Action (NFA) sometimes involve risks from neglect or domestic abuse that are not consistently triaged with sufficient curiosity or with the consideration of cumulative harm being fully explored. Repeat referrals are not always reassessed with fresh scrutiny. Therefore, patterns of concern are missed

[1] The areas for improvement have been cross-referenced with the outcomes, enablers or principles in the Children's Social Care: National Framework. This statutory guidance sets out the purpose, principles for practice and expected outcomes of children's social care.

and not addressed. For children with additional needs, including those awaiting health diagnoses, these needs are not always recognised in order to ensure they receive the help they require, despite parents actively seeking support. For some children, these delays can compound their difficulties and increase family stress, leaving children in environments without appropriate support.

The quality of assessments in the front door varies. Some assessments within the front door demonstrate strong multi-agency collaboration. Where this works well, children benefit from coordinated responses and timely safeguarding action. However, co-location of services does not consistently result in timely checks or consideration of all children in the household. Delays in receiving police history or health checks for children, particularly for those under five, creates delay in gaining a full understanding of risks or need. Schools are not routinely consulted when this would add value. Practitioners therefore miss opportunities to understand vital information about children's day-to-day well-being, or to share information which can ensure that additional support is made available within the school.

While some front door assessments are detailed and some include relevant history, others lack key information such as ethnicity, health checks and the voice of the child. These gaps limit practitioners' understanding of the child's identity, needs and resilience. Fathers are not routinely consulted, and when parents are excluded from decision-making, a clear rationale is not consistently provided. The new parental conversation approach is not yet embedded, to ensure that families feel heard and supported to engage with services. Without this full picture of the child's experience, some front door decisions and plans are not sufficiently tailored to the child's needs or effective.

Contact outcomes are inconsistently recorded. Some are marked as 'advice and information given', without any evidence of this being provided. There is insufficient curiosity and challenge about the number of multiple contacts, ending in NFA. While there is a system for reviewing high numbers of repeat contacts, it is not consistently applied or monitored to provide leaders with an understanding of compliance or impact of this practice. This has resulted in a small number of children being exposed to ongoing risk without escalation or intervention.

The recent involvement of Family Support Practice Managers in front door services is a strength. Their oversight promotes consistent threshold decisions and enables prompt transition to and from Early Help. Where this works well, families are supported early, and children benefit from timely intervention. Early implementation indicates that more work is required to ensure that referrals to Family Support from the front door are robustly scrutinised and safeguarding needs are adequately assessed before step-down decisions are made. While this is in its early stages, the involvement of the Family Support Practice Managers has enabled these families to be quickly stepped back up when their needs require statutory intervention.

Parental feedback reflects the impact of these delays. While some parents report positive experiences once they get ongoing support, others express frustration at the

time taken to receive help. For some parents it was evident that delays have eroded trust in services and reduced engagement, ultimately affecting children's access to the support they need.

Staff consistently spoke positively about their experience working in Suffolk. They report high morale, strong peer and managerial support, and regular supervision. This stability has helped maintain continuity for services, even during leadership changes. Managers are visible and accessible, and staff feel their well-being is actively supported. There is a clear sense of team cohesion and mutual respect among colleagues.

While staff feel supported, concerns were shared by some about increased workloads and system ineffectiveness. Cumbersome processes and added tasks are creating pressure, leading to delays in decision-making and support for children. Additional resources have been allocated, but these have not fully addressed the current strain on services.

Training and development opportunities are routinely made available, with staff accessing peer support, optional and mandatory training, and postgraduate modules. Workers value these opportunities and feel they contribute to developing their skills and confidence.

Quality assurance processes and framework have been strengthened, with more work in the process of being completed. Auditing is well established and now routinely involves practitioners. Audits are providing leaders with a broadly accurate line of sight to frontline practice. Staff view these audits as constructive and helpful, supporting reflective practice and service improvement. Leaders have welcomed external reviews on services, including the front door services and are acting on these findings.

The whole council's support for and investment in children's services is clearly evident. While there are early signs of progress, further work is required to ensure that improvements are sustained and that all children benefit from a consistently high standard of front door services which offer a timely and responsive range of services to children and their families in Suffolk.

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

Yours sincerely

Margaret Burke
His Majesty's Inspector