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Mr Andrew Dempsey
Director of Children's Services
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Dear Mr Dempsey

Monitoring visit of Torbay children's services

This letter summarises the findings of the monitoring visit to Torbay children's services on 14 and 15 December 2016. This is the second monitoring visit to the council since Torbay children's services were judged inadequate in January 2016. The inspectors were Emmy Tomsett HMI and John Roughton HMI.

The overall findings from this monitoring visit is that the local authority is making appropriate progress in improving services for children and young people in need of help and protection in Torbay.

Areas covered by the visit

During the course of this visit, inspectors reviewed the progress made by the local authority to ensure that services to help and protect children are effective.

Inspectors focused on the quality and timeliness of children's assessments and considered the effectiveness of child protection and children in need plans in achieving improved outcomes for children. In addition, inspectors focused on the effectiveness of management oversight of case work and the quality and timeliness of decision making, information sharing between professionals and the voice of the child.

The inspectors considered a range of evidence, including the local authority's electronic case records, supervision records, observation of social workers and senior practitioners undertaking their duties. In addition, the inspectors spoke to a range of staff including managers, social workers, other practitioners and administrative staff.

Summary of findings

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Children are seen regularly and are seen alone by social workers who know them well. The views of children and young people are identified and reflected well in assessments and care planning arrangements. However, social workers are routinely seeing children during school hours. Whilst this is with the permission of the school staff, children are thus missing lessons which has the potential to adversely affect their educational outcomes.

Timeliness of social work visits to children as part of a Section 47 child protection investigation has declined in the last 6 months. Performance data shows that in November 2016 only 56% of children and young people were seen within a day of the initial strategy meeting. The local authority are monitoring this and have attributed the decline to a recent increase in child protection investigations.

The frequency of social work visits to children subject to a child protection plan has improved significantly. 88% of children are now seen by a social worker every 10 days, an improvement from January 2016 when only 55% of children were seen by a social worker within this timescale. A clear management directive and closer management oversight ensures that most children, on a child protection plan, are seen every 10 days as a minimum.

Direct work to engage children and young people is a key strength in Torbay.

Engagement with children is well embedded in practice and is effective. Social workers routinely use a range of tools, for example, Wishes and Feelings, and the Three Houses model to ensure that they gather the experiences and wishes of children effectively. Evidence collected from these sessions is well recorded and used in assessments and care plans to help inform decisions about children and young people.

The quality of assessments of children remain too variable. While some good examples were seen by inspectors, the quality of analysis within most assessments is poor. The quality of assessments does not easily enable effective child protection and children in need plans to be developed.

Assessments are routinely updated following significant events in the lives of children and young people. Assessment timeliness is an improving picture and 80% of assessments are now completed within 45 days having been at 72% in January 2016. The local authority recognise that timeliness is inconsistent across the social work teams. Senior managers continue to focus on this area.

Assessments of children are not routinely signed off by managers and as a result, managers are not always able to make informed decisions for children based on evidence and analysis within comprehensive assessments. Assessments now contain the signs of safety template to support better analysis and planning by social workers. This approach is mirrored in child protection conferences and the recording of minutes.

Parents are involved in the assessment and planning process and their views are well recorded in case records. The Signs of Safety model is engaging parents in the child protection conference process more effectively.

Social workers demonstrate sustained and proactive attempts to engage absent fathers in the assessment and planning process and this has contributed to more positive outcomes for children. For example, the involvement of fathers in family group conferencing has enabled them to better understand the needs of their children and contribute more fully.

While most strategy meetings are held in a timely manner, these do not result in a clearly recorded and robust action plan. It is not clear from these plans who will do what by when, or what contingency arrangements are in place to protect children and young people.

Strategy meeting records do not record which professionals attend meetings or the contribution they make to the discussion. As a result, there is a lack of clarity amongst professionals when progressing Section 47 child protection investigations.

Social workers and managers within the safeguarding teams are not always clear about the purpose of strategy meetings. For example, a number of social workers and their managers described the primary function as decision making on whether to hold an initial child protection case conference rather than a discussion to consider the child's welfare and safety. Senior managers have issued guidance to support staff in achieving a better understanding of the process and have implemented a robust monitoring system to track the progress made.

Child protection and children in need plans are not sufficiently specific or measurable. Most plans are difficult to understand and do not explain clearly enough what parents need to do to change their behaviour, by when, and the consequences of not sustaining any change. Whilst plans are reviewed in a timely manner they do not consistently contain contingency arrangements for children.

Core group meetings are generally timely and well attended by partners. However, participating partners do not use these meetings effectively to develop child protection plans and, as a result, some key needs for children are not prioritised sufficiently.

Child protection case conferences are mostly well attended and information shared by partner agencies at these meetings is improving both in quality and timeliness. Partners contribute to decision making processes and are reported to welcome the Signs of Safety approach which enables them to consider the risk and protective factors more effectively.

The timeliness of initial child protection case conferences, although improving, is not yet sufficiently consistent and the local authority continues to focus on this area of practice to ensure that performance improves.

The number of children subject to a child protection plan for a second time within two years has been identified by the local authority as showing a steady increase from six children in November 2015 to 17 children currently. As a result, a themed audit is planned by the local authority to ensure that thresholds are understood and applied consistently and that the quality of child protection planning is robustly protecting children.

There is inconsistency in the way professionals apply the scale of risk factors within child protection case conferences. For example, decisions made whether to make a child subject to a child protection plan do not always match the risk grade descriptors supposedly used as part of the decision making process. This is confusing to both parents and young people and does not provide a clear message to parents regarding the level of risk identified by professionals at conferences.

Arrangements to identify and address child sexual exploitation continue to be developed and while individual responses to children identified at risk are effective, the strategic coordination of services across the partnership is still in its infancy. Partnership arrangements are being strengthened through the Local Safeguarding Children Board but the impact of this work to date is limited.

Children and young people missing or at risk of going missing from home or care are known and, in most cases, receive a robust and well-coordinated response. However, return home interviews are not always sufficiently robust. They are not always completed and, when they are, evidence of how information is collected and used to reduce future risk is limited. The local authority has identified this weakness and is in the process of reviewing arrangements to support children who go missing.

Caseloads are described by social workers as manageable and all staff spoken with feel well supported and describe ease of access to their managers. Social workers report that they have good access to training and are able to identify how training has developed their individual practice.

Learning from serious case reviews is limited. Social workers are not able to identify key messages from national research or how the findings inform and support their development.

Management oversight is improving. However, while case recordings reflect some scrutiny and challenge by managers, this is not sufficiently robust. Key decisions for children and young people are not consistently accompanied by a clear management rationale, and delays in the decision-making process are evident in some casework evaluated by inspectors.

In most cases a child's ethnicity is recorded in casework files. However, the child's wider needs are not sufficiently addressed in assessments or planning. Issues such as social isolation, poverty or sexual orientation are not identified by social workers.

Despite implementing the case file audit framework in January 2016, there is still some way to go to ensure that auditing is well embedded and that learning from auditing activity is improving practice.

Supervision in most cases is taking place on a monthly basis. However, the recording of supervision sessions is variable and this is compounded by the fact that Torbay children's services do not have a supervision template. Reflective supervision is reported to be taking place although this is not evident in the written supervision record.

Evaluation of progress

Based on the evidence gathered during this visit, inspectors identified areas of strength, areas where improvement is occurring, and some areas where progress has been much slower and has not met the expectations in the local authority's action plan.

The local authority recognise that key weaknesses within the service remain. While beginning to improve, the quality of assessments and plans for children, continue to be too variable and inconsistent and do not effectively inform professionals' decision making for children.

Signs of Safety is becoming embedded across the service and, whilst this is evident within some core child protection functions, this model has yet to be translated to core group meetings and the supervision of staff. Most social workers and partners have received Signs of Safety training and the aim is to deliver training to all staff by the end of 2017. Performance information and the suite of information available to all managers and staff have been further revised to deliver clear and user friendly performance information supported by an ongoing narrative. The overall culture within children's services is beginning to change. Staff are now using performance management information to focus their practice and to ensure that both quality and timeliness of work is monitored and improving. Senior leaders are working well to ensure that staff embrace a culture of increased scrutiny, challenge and oversight of their performance and practice.

A case auditing tool has been implemented. However, the impact of audit activity to date remains limited in securing more consistent practice across the social care workforce. While some audit activity has taken place in Torbay, learning from this has not been identified, collated or disseminated to staff. Audit activity has fallen

from 100% in July 2016 to 48% currently and the local authority do not have a clear understanding as to the reason for this decline. Remedial action to address this significant decrease in performance has not been implemented to date.

Social workers are not routinely involved in case audits and this limits learning from the outcome of audit activity. Action planning as a consequence of auditing is very poor. Frequently, no actions are identified by auditors, even in inadequate cases. Where actions are recorded they are not sufficiently specific or measurable and there is no mechanism for monitoring compliance with actions and no follow up review. Joint audit activity has taken place with Hampshire local authority to ensure that staff in Torbay children's services are grading and evaluating case work more effectively and this has further raised ambition in Torbay as well as supporting improved practice. However, heads of service have been slow to take a lead role in ensuring that audit activity is prioritised and informs practice appropriately, on a case by case and thematic level.

While progress has been made in a number of areas across the service, the overall pace of improvement has been too slow over the last year. The momentum of progress was lost between January and July 2016 and the overall impact of this has adversely affected the delivery of improvement to children's services in Torbay.

The pace of change has improved more recently following the appointment of the new Interim Director of Children's Services in July 2016. The very recent secondment of an interim Assistant Director has led to improved focus and the senior leadership team is now well placed to continue to deliver the ambitious and well targeted improvement plan. Senior leaders have completed a revised self-assessment that is realistic in terms of awareness of strengths and weaknesses across the service. The senior leadership team is well supported by an active and energetic scrutiny committee and Chief Executive officer.

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

Yours sincerely

Emmy Tomsett

Her Majesty's Inspector

The letter is copied to the Department for Education [at SocialCare.INSPECTION-IMPROVEMENT@education.gsi.gov.uk]