Aviation House
125 Kingsway
London WC2B 6SE

T 0300 123 1231
enquiries@ofsted.gov.uk
www.ofsted.gov.uk

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Mr Andrew Dempsey
Director of Children's Services
Torbay Children's Services
1st Floor South
c/o Town Hall
Castle Circus
Torquay
TQ1 3DR

Dear Mr Dempsey

Monitoring visit to Torbay local authority children's services

This letter summarises the findings of the monitoring visit to Torbay children's services on 31 October and 1 November 2017. The visit was the fourth monitoring visit since the local authority was judged inadequate in January 2016. The inspectors were Margaret Burke HMI and Nicola Bennett HMI. They were observed by Sarah Baker OI.

The local authority is making variable progress in improving services for children and young people. Some areas for development identified on previous monitoring visits have yet to be addressed sufficiently and, overall, the pace of change remains too slow. Senior leaders have recognised the need to accelerate positive change and, with increasing engagement and commitment from elected members, the local authority has made further financial investment in children's services. However, this investment is too recent to demonstrate improved services and outcomes for children and young people.

Areas covered by the visit

During the course of this visit, inspectors reviewed the progress made in the area of help and protection, including:

- The quality and timeliness of information gathering and decision-making within the multi-agency safeguarding hub (MASH)
- The quality of strategy discussions and section 47 decision-making, including the application of thresholds across the teams
- The effectiveness of chronologies, assessments and planning for children in need of help and protection

- The quality of management oversight challenge and staff supervision in these services
- The accuracy and quality of the performance management information that is used by senior leaders and managers to oversee practice and improve outcomes for children
- The quality assurance of social work practice through auditing of casework and the contribution that it makes to practice improvement.

The visit considered a range of evidence, including electronic case records, supervision files and notes, and the observation of social workers, managers and other workers undertaking referral and assessment duties. In addition, we spoke to parents, partner agencies in the MASH and a range of staff, including social workers, managers and other practitioners.

Overview

The local authority has been successful in achieving increased compliance with basic practice standards, despite recent staff shortages. However, the quality of practice remains too variable due, in part, to the high caseloads of social workers in some parts of the service.

The local authority has had success in recruiting permanent social work staff and has retained a number of experienced agency workers. This follows a period of staffing instability and shortages over the summer months, the repercussions of which are still evident. The period of staff turnover has resulted in a number of children and young people experiencing several changes of social worker. Some children have not had their circumstances assessed within a timescale that meets their needs, and others have not seen their social worker as quickly or as often as they should. During the summer, a very small number of children who continued to require social work support were transferred inappropriately to early help services. Positively, as a result of the findings from this visit, senior managers have undertaken to review the circumstances of all children transferred to early help services recently to ensure that these children are receiving a level of support which meets their needs.

Most workers demonstrate their commitment to improving services for children in Torbay. However, the caseloads of some practitioners remain too high, including social workers within the safeguarding and supporting families teams, some social workers in the assessment teams and independent reviewing officers (IROs) who oversee children subject to child protection plans. Consequently, while children's immediate safeguarding needs are generally met well, their other needs are not always addressed quickly enough.

While no children were identified to be at risk of immediate harm by inspectors, a small number of children, for whom risk had previously been identified, had not been

seen and spoken to within acceptable timescales to ensure that they were safe. Visits to these children did not meet the local authority's own practice standards.

Findings and evaluation of progress

When children are referred to the MASH, they receive an effective and timely response. Partners within the MASH work well together to support agencies to make referrals that are appropriate and detailed. As a result, thresholds are now better understood by referring agencies. Effective oversight and timely decision-making by both team managers and social workers within the MASH ensure that children in need of help and protection and early help services are identified swiftly.

Within the MASH, strategy meetings are held within 24 hours and are well attended by partner agencies. They lead to timely and proportionate decision-making. However, strategy meetings for children in other teams, while including appropriate agencies, are not always held as soon as an increase in risk to children is identified. This means that the local authority cannot be assured that protective action is always considered swiftly enough for these children. Once strategy meetings are held within these teams, timely protective action is taken, where appropriate. However, the records of discussions in strategy meetings are generally of poor quality, and the rationale for subsequent decision-making and the actions taken is not clear in the majority of cases seen. Plans arising from strategy discussions do not routinely contain timescales, making it difficult to hold professionals and families to account. These areas for improvement were identified in a previous monitoring visit in December 2016.

When emergency action is taken to protect children through police powers of protection or emergency protection orders, social workers liaise effectively with the police. However, managers do not routinely consider arranging strategy discussions to ensure that wider risks are identified and comprehensive multi-agency plans to support children are agreed. This is contrary to statutory guidance.

The timeliness of assessments is improving, following a dip in performance over the summer. However, it has not yet returned to pre-summer levels and remains an area requiring further improvement. The majority of assessments include family history and are analytical. However, some do not include the views of fathers or other family members who play a significant role in children's lives. When children move from other areas to Torbay, essential information from other local authorities is not always included in assessments, preventing a fuller understanding of risk for these children.

Chronologies are not used effectively to inform planning. They neither reflect significant events for children, nor assist social workers to make sense of children's histories.

Partner agencies regularly attend meetings, contribute to children's plans and undertake appropriate tasks to improve circumstances for children and their families. Areas for development seen in planning following strategy discussions are replicated in other plans. Plans are not consistently purposeful, and often lack timescales or specific actions. Contingency plans for many children lack detail and do not always consider realistic alternative options.

Most children see their social worker regularly. However, many children do not see their social worker quickly enough when they are first in need of a social work service. This can give the wrong message to children and families about the urgency of their needs.

Senior managers' continued emphasis on ensuring that children's views are heard and that their experiences are understood is increasingly evident in social work practice. Social workers demonstrate that they know children well. Some workers advocate tenaciously on behalf of children, conducting sensitive direct work leading to child-centred planning. While this is still an emerging area of good practice, it provides firm foundations on which to build and has been identified in previous monitoring visits. However, the work undertaken with children is often better articulated by workers than is shown in written records.

The local authority has had success in recruiting both experienced social workers from overseas and newly qualified staff. This has substantially reduced the local authority's reliance on agency staff. Effective arrangements support these new workers. However, caseloads in some parts of the service remain too high and continue to challenge the overall stability of the social work workforce. Some workers' ability to competently perform their duties and respond to changes in children's needs is noticeably hindered by excessive workloads. A small number of workers reported that they felt under considerable pressure and that their workload at times prevented them from attending relevant training.

Management oversight of practice, while improving, is still too variable. Managers do not routinely sign off work. This deficit was identified in the monitoring visit of December 2016 and has yet to be addressed. Managers comply with supervision practice standards and are increasingly providing social workers with regular monthly supervision. However, these meetings are largely focused on performance compliance rather than children's needs. Managers' oversight often lacks challenge and does not improve the quality of social work practice or outcomes for children sufficiently. Supervision does not routinely provide social workers with the opportunity for reflection to inform their work and learning. However, most social workers state that they feel supported by their managers and that their managers are accessible.

IROs' oversight of practice supports effective multi-agency planning at case conferences and reviews. Their support and challenge to social workers, team managers and senior managers increasingly ensure that children are safe and that

their outcomes improve. IROs are unable to contribute more widely to improving social work practice with children and families through quality assurance of casework between conferences, due to their workloads.

The quality and range of performance management information used by the senior leadership team to understand and monitor children's experiences have improved from a low baseline. Senior managers now routinely have access to and make use of a suite of performance reports. Their oversight has led to improved compliance with good practice standards, such as in the frequency of visits to children. However, senior managers recognise that more is required to improve the quality of practice and that visits are purposeful, not just whether they have taken place.

The quality and use of performance management information at a team level show a more mixed picture. Team managers are starting to use performance information more confidently across and within teams, but they are not yet using this information to ensure improvements in practice.

Senior managers recognise that, although the quality assurance of practice through auditing is improving, auditors do not yet include sufficiently in audit findings an analysis of the difference that social work intervention is making for children. Auditing of casework focuses heavily on compliance with practice standards. While some of the more recent audits have accurately identified deficits in practice, including delay for children, others are too descriptive or overly optimistic. Consequently, there is little evidence that the actions identified have resulted in improvements in children's circumstances.

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

Yours sincerely

Margaret Burke
Her Majesty's Inspector