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16 March 2018

Mr Andrew Dempsey
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Dear Mr Dempsey

Monitoring visit of Torbay local authority children's services

This letter summarises the findings of the monitoring visit to Torbay children's services on 21 and 22 February 2018. The visit was the fifth monitoring visit since the local authority was judged inadequate in January 2016. The inspectors were Emmy Tomsett, HMI and Tara Geere, HMI.

The local authority's progress in improving services for its children and young people remains too slow. The quality of service that some children looked after receive has declined since the local authority was inspected in October 2015.

Children who are subject to the public law outline (PLO) in Torbay experience delays in arrangements to secure permanent settled homes for them. Risk to children, while generally identified, is not consistently addressed by social workers and their managers. Although senior managers were aware of all of the deficits seen by inspectors on this visit, actions taken to address deficits have not yet been effective in achieving the required improvements to practice.

Areas covered by the visit

During the course of this visit, inspectors reviewed the progress of children looked after in the following areas:

- the quality and timeliness of decisions for children to become looked after
- the effectiveness of pre-proceedings work with children and their families under the PLO
- the effectiveness of arrangements to ensure that permanency is achieved at the earliest opportunity for children in the context of the PLO
- the quality and effectiveness of care plans and reviewing processes for children looked after
- the quality and effectiveness of the oversight of children looked after by independent reviewing officers (IROs) and social work team managers
- the frequency and quality of visits by social workers to see children looked after
- the quality and effectiveness of the edge of care service provided by intensive family support services in reducing the number of children who need to be looked after away from their families.

A range of evidence was considered during the visit, including electronic case records, supervision files and notes, observation of social workers and team managers and scrutiny of performance information. In addition, we spoke to a range of staff, including managers, social workers, IROs and administrative staff.

Overview

The quality of services for some children looked after in Torbay has declined since the last inspection. Despite a long-standing commitment in the senior leadership team to address this deterioration and improve services, positive changes that improve outcomes for children are not yet having sufficient impact. In some areas of children's services seen on this visit, the lack of challenge to poor practice is entrenched in the culture. Progress in implementing the necessary infrastructure and framework to improving social work practice for children on the edge of care and children looked after has been far too slow. Recent changes include: reduced caseloads for staff, improved training for social workers and managers, and increasing use of quality assurance of casework and performance management information to inform practice improvement. Workforce stability and social work and IRO capacity have recently significantly improved due to additional funding for

children's services secured by the current director of children's services, and have been readily supported by the local authority. These are positive developments. However, some children remain in situations of known risk of significant harm for too long without effective action being taken to protect them and monitor their welfare.

While senior leaders have begun to move from a compliance-based improvement model to one in which quality is a key feature and focus, many frontline workers are struggling to make the transition. While staff supervision and quality assurance of casework through auditing and by IROs are regular, they are not yet addressing the aforementioned deficits.

Social workers' professional accountability is improving from a low base, but widespread poor practice remains. Social workers and team managers in the teams inspected demonstrate insufficient professional curiosity and some social workers lack aspiration to develop their practice. Poor quality frontline management oversight, poor decision-making to protect children and ineffective quality assurance of casework by IROs are widespread.

Findings and evaluation of progress

Decision-making by social workers is not always timely or responsive to the identified risk to the child. Social workers miss opportunities to intervene to protect children. Delays in issuing care proceedings when intervention has been ineffective were a common theme in those cases seen by inspectors. While social workers identify risk to children appropriately, they do not act in a timely way to safeguard children. In some cases, children have been left exposed to known risk of significant harm.

While the workforce has stabilised in recent months, frequent changes of social workers have resulted in children having to repeat their stories and, in some cases, experience repeated ineffective interventions. This 'start again' approach has sometimes resulted in extensive delay, particularly for children on the edge of care.

Over-optimistic social work practice and unrealistic expectations of parents' capacity to change, particularly in relation to cases in which domestic abuse or mental health are features, continue to be significant weaknesses. There is an overreliance by social workers on an adherence to written agreements to protect children. Case records demonstrate that social workers rely heavily on unreliable parental self-reporting to inform assessments of risk.

Edge of care services, provided by the intensive family support services (IFSS) are widely used, but interventions have resulted in outcomes for children that are too variable. Some children have enjoyed improved parenting as a result of well-targeted and sustained individual work with their parents. In other cases, the work by IFSS has been lengthy and, despite multiple services being provided to parents, there has been no positive change to the quality of parenting that children receive. Social

workers are sometimes too slow in considering the timescales for children and in initiating care proceedings to protect the needs of the children.

Arrangements to support children on the edge of care are not effective or purposeful. Letters before proceedings under the PLO are not issued in a timely manner and do not, at times, clearly detail for parents what has to change. Family group conferencing is not well embedded or routinely considered by social workers and managers, and the use of parallel planning for children is poor. As a result, children experience delays in both protecting them from harm and securing permanency for their futures. The local authority has recently revised the tracker tool it uses to monitor work under the PLO, but it is too early to see improved timescales for children in pre-proceedings work. The local authority acknowledges that some children have experienced significant delay.

The timeliness of visits to see children looked after has declined and is now at 73%, having been at 79% in December 2016. The visiting frequency set is not always sufficient to adequately monitor the safety and welfare of the child. Social work visits to children lack focus and purpose.

The quality of social work case recording continues to be poor. Chronologies are not routinely updated and are not used as an effective working tool to inform risk assessments or decision-making processes. These weaknesses are not identified or addressed by supervision and management oversight. The vast majority of children's case records do not reflect the child's day-to-day experiences or wishes. Inspectors found that social workers know their children well, but are focused on compliance rather than the difference that interventions are making for children.

Assessments of children already looked after are not sufficiently comprehensive or analytical and do not adequately inform planning arrangements for children. While most assessments identify risk well, they do not result in a robust plan to protect the child; an analysis of the effect of the risk is often absent in case recording. Individual children's needs in relation to equality and diversity are poorly considered and recorded at assessment and planning stages by social workers. The voice of the child in assessments is improving in most cases and children's views are starting to inform planning arrangements. Records of the views of parents, particularly fathers, are often brief or missing. Social workers do not routinely consider or identify disguised compliance by parents.

The quality of plans for children looked after is poor. Plans are not consistently outcome focused, and recording of information detailing what needs to be done, by whom and by when, is not clear or specific. Contingency planning is often absent.

Although scrutiny and oversight of case work by IROs are regular, they are of poor quality. IROs are not routinely identifying delays experienced by children. They do not routinely challenge social workers and team managers about key decision-making or delays. Senior leaders have identified that the IRO service requires strengthening and have recently appointed a new manager as well as reducing

caseloads and increasing IRO capacity. Training has been provided very recently to support the improvement of IROs' quality assurance of practice. While some very recent appropriate challenge to practice by IROs is evident on some case files, some social workers and team managers are resistant to this scrutiny and do not routinely respond well to this challenge. The dispute resolution process has recently been revised and strengthened to support escalation of concerns that are not resolved, but it is not yet sufficiently used and children's care records do not sufficiently reflect divergence of views between professionals.

The timeliness of reviews for children looked after is currently at 90% and has been for some time. As a result, senior managers have issued clear expectations of practice to social workers and IROs to avoid unnecessary delays in reviewing processes.

Placement stability is improving: 5% of children looked after had three or more placement moves in the last 12 months.

The local authority appointed a dedicated special guardianship coordinator in November 2017 to ensure that children subject to these arrangements are well monitored and supported. Oversight from this worker has yet to demonstrate sustained improvements at this early stage.

Attention to the basic healthcare needs of children looked after is poor. The timeliness of completion of health assessments for children looked after is good and children looked after now have a dedicated child and adolescent mental health service resource funded by the local authority. However, other health needs have not been well addressed. The percentage of children looked after who have seen a dentist in the last 12 months is now at 62%, which is a further decline from an already low base. The completion of the strengths and difficulties questionnaire for children looked after is very low. As a result, the local authority cannot be assured that all children looked after who require additional support to meet their emotional needs are identified and provided with the services that they require.

While supervision of social workers is now timely, management oversight does not yet result in effective action plans for social workers to follow, and the actions that are set are not given clear timescales. Team managers are not identifying the delays experienced by children. Some children remain exposed to risk for prolonged periods of time before effective action is taken to protect them. Recording of supervision sessions by team managers is mostly of poor quality and predominantly takes the form of a case summary. Team managers do not track completion of actions from one supervision session to the next and this adds to the delays experienced by children. Social workers consistently report good management support. However, there is a significant gap between the expectations of supervision set out by the senior leadership team and the content and impact of supervision being delivered by frontline managers.

Social work caseloads have reduced and training opportunities have been strengthened and revised, although the quality of social work practice continues to be poor for the majority of children in cases seen on this visit.

While the quality of case audit activity is beginning to improve from a very low base, the overall learning from audits is not collated or disseminated effectively to social workers and frontline managers in a timely manner. Audits focus on compliance rather than quality of practice, and the audit findings and outcomes for children are not routinely considered by practitioners. Audits completed by team managers do not always identify delay, poor recording or decision-making. However, audits completed by quality assurance moderators are of better quality and in most cases do identify key weaknesses.

The use of performance information to identify key strengths and weaknesses continues to be embedded as a working tool for managers and social workers to measure their performance. Data collection has been refined further since the last monitoring visit; managers now have access to a comprehensive suite of performance information. While this is used throughout the senior management structure, it has not led to sufficient practice improvement and frontline managers' use of performance management information is inconsistent.

The senior leadership team has now stabilised and consistency of leadership has been achieved. However, the overall pace of change has been too slow. While the framework is now in place to deliver and support sustained improvements for children in Torbay, some of this work has very recently been implemented. A key contributory factor to the lack of progress in recent months is senior and middle managers' failure to effectively address the poor performance of frontline staff, or to ensure that the clear expectations and timescales set by senior managers are adhered to.

A culture of resistance to challenge within many areas of the workforce remains. This ultimately acts as a barrier to achieving permanent improvement for children across children's services in Torbay. Actions introduced by senior managers to challenge this poor performance have not been effective in the two years since the full inspection. 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