

10 November 2016

Ms Suzanne Joyner
Darlington Borough Council
Town Hall
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Dear Ms Joyner

Monitoring visit of Darlington Borough Council local authority children's services

This letter summarises the findings of the monitoring visit of Darlington Borough Council children's services on 12 and 13 of October 2016. This monitoring visit was carried out by Her Majesty's Inspectors Tracey Metcalfe and Fiona Millns.

The visit was the second since the local authority was judged inadequate for services to children who need help and protection and for leadership, management and governance in September 2015. The local authority is making steady progress in relation to meeting the recommendations made at this inspection within the scope of the areas outlined below. Inspectors did find deterioration in some further practice areas. These were already identified by the local authority through their improved performance management arrangements which they are addressing.

Areas covered by the visit

During the course of this visit, inspectors reviewed the progress made in respect of the experience and progress of children looked after, with a particular focus on five important themes:

- the quality of children's experiences
- the quality of assessment and care planning
- the timeliness of decisions when children need permanence
- the effectiveness of the independent reviewing process
- management challenge and oversight.

Inspectors also considered:

- the arrangements in place to respond to children missing from care

- placement commissioning and sufficiency.

The visit considered a range of evidence, including electronic case records, supervision records, observation of social workers undertaking assessments and performance information provided by staff and managers. In addition, inspectors spoke to children from the children in care council (the Darlo Crew), foster carers and parents. Inspectors also spoke to a range of staff, including managers, social workers, Independent Reviewing Officers (IROs) and other practitioners.

Summary of findings

- The council has continued to respond purposefully to the recommendations identified following the single inspection in 2015. In particular, conducting a thorough review of all arrangements when children are accommodated under Section 20 and when children are living in family arrangements.
- Performance in relation to the stability of short and long term placements is improving for some children. Regional partnership working is used to commission good placements for children, although there continues to be a shortfall in the number of available placements for children with more complex and challenging needs.
- Children who spoke to inspectors said that they feel safe in their placements and in school. They receive good support from their social workers and carers.
- The senior leadership team has undertaken an examination of the service they provide to children looked after and has a comprehensive understanding of the key priorities for improvement. While the examination has identified where improvements have been made, it has also identified a deterioration in the services that some children receive, in particular the reassessment of children's needs, planning for permanence and leaving care. Weaknesses were also identified in frontline management oversight and in the supervision and support available to social workers.
- While there has been improvement in the timeliness of children's plans being reviewed, IROs do not demonstrate sufficient rigour when overseeing the quality and progress of children's plans.
- Decisive action has now been taken to address shortfalls when social work practice, management oversight and IRO scrutiny has not met the required standard. New practice expectations have been set, supported by an increase in staff resource, training and robust performance management and quality assurance arrangements.
- A new electronic case management system is now implemented, which is beginning to provide full-case management capabilities with better functionality and ease of use. This has resulted in increased confidence in the system by practitioners and managers.

- Performance management and quality assurance arrangements have been further strengthened. Children requiring permanent placements are identified and tracked as they progress through the Public Law Outline process. While positive, the tracking is not yet translating into activity to ensure that actions within children's plans are delivered in a timely way.

Evaluation of progress

The director of adults' and children's services (DCAS) and chief executive of the council have set very clear priorities and practice standards in order to improve the experience and progress of children looked after. Strategic plans are built on thorough and accurate evaluations of service provision and children's experiences. Improved leadership and governance arrangements have resulted in a robust analysis of the looked after and through care team (LATC) completed in August 2016. While the outcome report identified many strengths, it also identified where practice was not meeting the required standard. Consequently, social workers and managers at all levels have been required to critically reflect on their own practice and performance. Policies and procedures have been reviewed and updated where needed. Some very necessary changes have occurred in terms of the workforce, with some practitioners leaving the team and new appointments being made, including new management arrangements. Senior managers have responded swiftly to reduce caseloads, by increasing the number of employed social workers to enable the team to recover, redevelop and enable social workers to have more of an increased focus on children.

A rigorous framework of performance management and quality standards has been introduced. This includes regular reviews of progress against challenging targets. A robust auditing programme has been developed and a review of the vast majority of children's cases in the LACT has taken place. This has identified that too many children experience delay in their plans being progressed. Inspectors found that in all cases scrutinised during the two-day monitoring visit, no child has had an updated assessment of need. Consequently, plans have not been updated and do not reflect children's current needs. Particular delays were identified in progressing children's plans for permanence; and where young people were preparing to leave care, pathway plans were incomplete and lacked aspiration and focus on the outcomes to be achieved. More positively, case records evidenced children being seen regularly by a social worker and there was some evidence of children's views being recorded.

Within the LACT, inspectors found limited evidence that managers were overseeing and driving children's plans prior to August 2016, with significant gaps in supervision and poor quality management oversight and challenge for most social workers. Inspectors also found that, while IROs had improved the timeliness of reviews, they were not scrutinising children's plans with sufficient rigour or challenging social workers or their managers with any discernible impact in improving children's outcomes.

However, inspectors have been reassured by the decisive action being taken, arising from the review of the LACT service. Frontline management arrangements have been strengthened and supervision is now a regular occurrence, when previously there had been significant gaps. A risk assessment was undertaken prioritising the review of children's circumstances and the vast majority of children's cases held in the LACT have now been reviewed. There are clear timescales for the review of those cases remaining. Multi-agency planning meetings have been held and some are scheduled to take place in the near future to review children's assessments and plans. This has resulted in strategy meetings being held in a small number of cases and action being taken when potential risks have been identified.

A whole service review of children accommodated under Section 20 and those children living in family arrangements has been undertaken. This has resulted in care proceedings being issued in 22 children's cases when there had been drift and delay in progressing their plans for permanence. This review has now become a requirement of a new quarterly performance cycle. A tracking system has been developed to monitor all children's cases when letters before proceedings have been issued and when care proceedings have commenced. A robust focus on permanence planning has been developed, with new guidance being communicated to all staff. Clear requirements have been made of IROs to monitor permanence plans by a child's second review and at subsequent reviews with clear management monitoring standards and expectations of IRO practice. A new suite of performance measures have been introduced to the IRO service which is monitoring and reporting on activity, challenges and outcomes. Quarterly IRO reporting to senior managers has been introduced in order to identify themes, emerging challenges and to inform training needs across the service.

A new electronic case management system has been introduced, with an enhanced performance reporting function. This system incorporates a performance score card aligned to the strategic improvement plan. A revised performance reporting cycle, together with clear leadership direction to hold performance and quality clinics, has seen the development of a hierarchy of meetings and performance discussions at every management level. A robust auditing programme is in operation. Inspectors agreed with the outcome of audits in five of six children's case files tracked during the monitoring visit, demonstrating that managers are focusing on the right things and scrutinising case work effectively.

While inspectors found decisions for children to become looked after are appropriate, scrutiny of the files of children who have more recently become looked after identified insufficient support available to children on the edge of care and evidence of drift and delay in intervening to safeguard children experiencing neglect.

Improvements have been seen in the number of children receiving initial and annual health assessments and a new template for personal education plans has been developed. However, it is too soon to see how these improvements are leading to

better health outcomes or educational attainment for children. Long-term and short-term placement stability has improved. However, the council has not yet undertaken an analysis of the patterns of children becoming looked after or the current cohort of children they care for in terms of placement requirements. This is impacting on the council's ability to predict future placement need. Currently, there is insufficient placement choice available to match children to appropriate carers. When children in long-term placements are experiencing difficulty, not enough support is available to identify problems and prevent placement breakdown. Not enough analysis is done to understand the reasons for placement disruption to inform learning and practice improvement.

A well-supported children in care council (the Darlo Crew) routinely influences and shapes service development and is regularly involved in the recruitment and training of staff and foster carers. Children who spoke to inspectors say they feel safe in their placements and at school and have trusted relationships with their carers. Some children have experienced too many changes of social worker, which is impacting on their ability to develop a rapport and meaningful relationship with them.

There has been a very recent improvement in responding to children who go missing. In the two months leading up to the monitoring visit of the 19 children who went missing, 17 children received a return home interview within 72 hours of their return. This is an improvement on previous performance. However, when risks are identified, not all are effectively managed, with some delay in strategy meetings being held to agree the nature and management of risk. Return home interviews are not informing children's individual care plans or an understanding of potential links to child sexual exploitation, push and pull factors or the implications of any broader risks to children.

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

Yours sincerely,

Tracey Metcalfe

Her Majesty's Inspector