

Devon County Council

Inspection of children’s social care services

Inspection dates: 20 January 2020 to 31 January 2020

Lead inspector: Steve Lowe
Her Majesty’s Inspector

Judgement	Grade
The impact of leaders on social work practice with children and families	Inadequate
The experiences and progress of children who need help and protection	Requires improvement to be good
The experiences and progress of children in care and care leavers	Inadequate
Overall effectiveness	Inadequate

There are serious failures in the services provided to children and young people in Devon.

Until this inspection, senior leaders did not know about the extent of the failures to protect some of the most vulnerable children and young people from harm. They were unaware that a very small minority of their care leavers were or had been living in tents on the streets. These are not isolated incidents. In general, care leavers with the greatest needs, including struggles with their mental health, are left in unsuitable accommodation for too long because their corporate parents do not step in and act. The service to care leavers was inadequate at the point of the last inspection in 2015. A focused visit in 2018 recognised some improvements, but since then there has been a further decline.

Some children who have suffered chronic neglect and emotional abuse are being left with their families for too long because social workers and their managers lack clarity about when to turn concerns into legal action. Social workers are not

gathering evidence of neglect systematically. The use of pre-proceedings under the public law outline (PLO) is inconsistent and the judiciary does not have full confidence in the evidence that is submitted to them. The oversight of permanence for children is weak and disorganised. For those same children, work to help them understand their life story starts much too late and often not at all. Some managers, at all levels, lack the drive and assertiveness required for children to make progress. This is a theme across all services and extends to children's assessments, plans, reviews and the quality of case audits.

In some areas, politicians, senior leaders and practitioners have demonstrated that they have the capacity to make the changes required. In others, they have lacked grip, and the pace of improvement has been far too slow. The development of early help for families, a mature approach to addressing exploitation, and strong partnerships with key agencies are all making a positive difference to children's lives.

Ultimately, however, a succession of inspection reports over the last seven years have emphasised that the local authority needs to have a better understanding of its strengths and weaknesses and to take robust and swift action where improvements are necessary. This report highlights the same issue.

What needs to improve

- Services to care leavers, including:
 - sufficiency of accommodation and support available for young people
 - assessment of risk and safety planning for young people
 - access for young people to full information about their health histories.
- The quality of social work practice, to assess, support and protect children who experience neglect, and the effective use of pre-proceedings.
- The effectiveness of child protection conference chairs in responding to escalating risks and identifying when progress is not being made for children.
- The consideration of child protection medicals when children disclose physical abuse or present with injuries.
- Permanence planning for children.
- The quality and timeliness of life-story work.
- The assessment of children looked after placed with parents.
- Strategic oversight and grip on areas for improvement and oversight of senior leaders, including case audits and supervision.

The experiences and progress of children who need help and protection: requires improvement to be good

1. Children experience extreme variability in the services that they receive. There are areas where progress has been made, particularly in the early help offer and when teenagers present as being homeless. However, some children who have suffered chronic neglect and emotional abuse are left with their families for too long because social workers and their managers lack clarity about how and when to escalate concerns into the legal arena. Pre-proceedings, the effective use of the PLO and preparedness for court hearings are not centred on the day-to-day experiences and needs of children. Investigations of physical abuse do not always consider the need for a medical examination. Consequently, children are too often left in situations where they are at risk of harm.
2. The early help offer in Devon has been significantly strengthened through effective partnerships with key partners. Increasingly, children and families are getting the right help at the right time from people who they know and trust. The number of families who are assessed for a statutory service has been markedly reduced through keeping services and solutions based in the community. Locality practice meetings, early help roadshows and astute use of data analytics have focused support on those partners who need it most and, accordingly, referrals to the multi-agency safeguarding hub (MASH) have reduced by almost half since this time last year.
3. The MASH in Devon is well resourced and provides an effective service to children. Partners work well together to identify key information and family histories, proportionate to the level of concern. A particular strength is that partners, including the police and health colleagues, consistently RAG-rate their own information. This promotes a shared ownership of the analysis of risk. Contacts and referrals are progressed through the MASH in a timely way, and families do not have to wait for a response. Systems support social workers and managers to gather information and reach confident decisions. Consent is routinely sought at a number of key points and overridden if necessary.
4. The understanding of thresholds is stronger in the MASH. In the majority of strategy discussions, risk is assessed, addressed and responded to in the right way. When children are injured, however, and the strategy discussions involve other areas of the service, the need for child protection medicals is not always considered. In a small number of cases, this results in missed opportunities to gather evidence and to ensure that there are no hidden injuries to children. Overall, section 47 investigations lead to the right outcome, and when children have recently become subject to a child protection plan this is the right decision.

5. In contrast, there are too many examples of children being the subject of child protection or children in need plans for extended lengths of time without families being able to evidence progress or change. The threshold for escalating concerns when children have been subjected to chronic neglect is too high. This is compounded by social workers not having the tools or the management oversight necessary for gathering evidence of neglect over time. Thresholds for initiating legal planning meetings, pre-proceedings and legal intervention are muddled, leaving children at risk of significant harm.
6. The local judiciary has little confidence in the quality and thoroughness of social work assessments. In too many cases, the court orders additional assessments because social workers do not present compelling evidence. This results in drift and delay for children, and some remain in neglectful situations for longer than necessary.
7. The quality and timeliness of single assessments were beginning to improve at the time of the focused visit in May 2019, but not at a rapid pace. Both quality and timeliness are showing further improvement. All children have an up-to-date assessment, and the vast majority of assessments consider family and environmental factors, parenting capacity and the views of other adults, including absent fathers. There is variability in how well social workers capture the voice of the child, particularly when children are young or communication is more challenging. However, in the majority of cases, children's views contribute to planning. There is also evidence of services being deployed during the assessment so that families do not have to wait longer than necessary.
8. The quality of both children in need and child protection plans remains variable, both within and across the different localities in Devon. An increasing number of plans are clear and achievable and contain analysis of risk. However, not all actions are timebound or realistic for families, making it difficult to measure progress. When social workers investigate child protection concerns, timescales for families to demonstrate change are often unclear. This compounds over time, and some children on a child protection plan continue to live in circumstances of harm for too long.
9. Teams around the child, around the school, and in one case around a whole village are having a positive impact on children. They are well attended by the people who can best offer support to families. Similarly, core groups are timely and focus on the strengths in families as well as strategies for change. Social workers and their managers are not always assertive or realistic about capacity to change when parents display entrenched behaviours such as substance misuse and neglect.
10. Although there is some variability, case supervision and oversight are largely timely but lack impact. Significantly, managers at all levels, including the chairs of child protection conferences, are not responding effectively to accumulating

concerns or challenging drift and delay for children. Supervision records consistently lack reflection on how to make quicker progress with families. Managers do not consistently agree timebound actions with social workers that are revisited at the next supervision.

11. The service provided to disabled children is inconsistent across Devon. Social workers know the children they work for very well. They use creative and sensitive ways of communicating that place children's views at the centre of their work. Children are involved in meetings about them whenever possible. However, the service operates in isolation from the rest of children's services. Changes in personnel and a lack of analysis in case supervision result in plans for children that are narrow and focus on health issues rather than wider safeguarding concerns.
12. The local authority has responded well to the increasing risk of exploitation of children. Social workers and other professionals in the community identify potential risks early. Senior leaders in the safeguarding partnership have committed additional resources to mapping and disrupting exploitation. The adolescent safety framework is having a positive impact. Specialist assessments are increasingly being used to identify key risk factors and inform strategic planning. There is still more to do in terms of joining up intelligence from the out-of-hours service, but this work is underway.
13. When children go missing from home or care, they are offered return home interviews (RHI) in the vast majority of cases. When completed, there is a thorough exploration of risks and wider issues. Children's views are ascertained, as well as those of relevant family and professionals. There is wider exploration of push and pull factors. Risks are analysed and evaluated and actions arising from RHIs are clear and appropriate. The local authority has reduced the number of times children go missing from residential care significantly through strong partnerships with local providers.
14. Young people who present as homeless are seen promptly and receive a full assessment of their needs. They are made aware of their rights and are accommodated safely and quickly. Temporary accommodation is rarely used. Specialist workers develop trusting relationships quickly. However, the local authority does not sufficiently prioritise engaging families in making it safe for young people to return home or maintain contact once in their own accommodation.
15. The system for managing allegations or concerns about adults who work with children is effective. The team targets partners and providers appropriately and has successfully raised the profile of safeguarding in the community. The resultant rise in referrals has been responded to quickly and efficiently.
16. Children who are privately fostered have their circumstances assessed and monitored in a timely way by a committed specialist team. Extensive promotion

of what constitutes private fostering has resulted in more children being identified. The workers know these children and their circumstances well.

17. The local authority has a good understanding of the needs of children who are electively home educated (EHE). Schools complete exit interviews that identify wider safeguarding concerns before children leave their school. These are analysed and risk-assessed regularly. Families receive support from their communities through the early help offer, and the number of children being withdrawn from mainstream education is reducing at key points. For example, there was a drop of almost a half in children in Year 11 moving to EHE in autumn 2019 compared with the previous year. Children missing education are also tracked and monitored effectively.

The experiences and progress of children in care and care leavers are: inadequate

18. At the time of this inspection, a small minority of the most vulnerable care leavers were living in situations where they were at significant risk of harm. In the most extreme cases, care leavers were, or had recently been, living in tents on the streets.
19. For those children who are living in unregulated provision and care leavers who are living in unsuitable accommodation, the risks are not routinely assessed or analysed. Accordingly, safety planning for these young people is not well organised and fails to identify simple issues such as how often the young person will be contacted or visited. There is too much emphasis on care leavers in particular taking responsibility for finding their own accommodation or access to healthcare without the support that should be expected from their corporate parents.
20. Importantly, PAs and social workers do work hard to maintain relationships with young people and are often seen as a positive influence by young people themselves. However, a primary focus on building trusting relationships at the expense of supporting and preparing young people for independence has led to a dereliction of corporate parenting responsibilities when children are at the point of most need and unable to make informed decisions for themselves. PAs are creative in finding ways to continue their relationship with young people, but this is not routinely captured in case recordings, which are poor and not updated in a timely way. This means that PAs know young people well but are not translating this into meaningful plans, assessments of risk or interventions.
21. When children come into care, they are moved to where their needs can be best met. For too many children, including some babies, this decision is made too late because of an incoherent approach to legal planning, poor oversight of children's plans by team managers and over-optimism about families' capacity to change.

22. In too many cases, children's permanence is not considered early enough or ratified when they are in long-term, stable homes. Permanence is not consistently embedded in social workers' and managers' thinking, and independent reviewing officers (IROs) do not fulfil their role of challenging this shortfall. There is a real confusion among staff about how to secure permanence for children. Some children remain in long-term arrangements without formal matching. This impacts on children's opportunities to experience emotional permanence and a full sense of belonging.
23. In response to these deficiencies, senior managers have recently formalised the tracking of permanence decision-making. This is inconsistent across the local authority, but has begun to support small improvements in decision-making.
24. When children on care orders are placed with their parents, the potential risks to these children are not routinely assessed in line with relevant regulation. Consequently, plans for those children are not fully formulated in line with presenting risk.
25. Assessments are updated and used to inform the child's review. Mostly, these are analytical and have detailed information on children's needs and risks, but do not always give sufficient focus to children's longer-term needs for permanence. Updated pathway plans do not assess increased risks in a way that explains to young people why adults are concerned, or assess decreased risks so that young people can see what they have achieved.
26. Not all children have an up-to-date care plan. This is more acute when children first come into care. As children move through care, their plans are of a better quality and are reviewed regularly. Advocates are used well to ensure that children's wishes and feelings are integral to the plan for their future. Significant adults are involved in reviews, including education and health professionals and family members.
27. Children are seen regularly in a variety of settings, and are seen alone. Their views are recorded and captured effectively. Social workers visit children often and more frequently when the child's circumstances change. This remains the case when children are not living in Devon. Children are supported to see their families safely, with social workers facilitating this, sometimes over great distances. There are examples of reducing risks for children who have mental ill health and who go missing, such as moving them closer to support networks or using protocols to secure adult mental health input.
28. IROs do not fulfil their statutory responsibility to unearth inadequacies in safeguarding young people. Plans for children often lack timescales; escalation by IROs to managers is slow, poorly tracked and not used to inform strategic thinking; mid-point reviews have been more apparent recently, but it is hard to see how they are used to drive practice.

29. Children in care have regular annual health reviews, and these include using strengths and difficulties questionnaires to inform the child's assessment and plan. Specialist health professionals are actively involved in supporting children's health. There is a delay in specialist child and adolescent mental health therapeutic support for some children. The local authority deploys interim psychiatric support in these cases. Despite a reliable system overseen by health partners, there is no clear record of care leavers having received their health information on case records. Young people are often unclear about their rights and entitlements to health information.
30. The leaders of the virtual school are systematic and evidence-based in their approach. They are using insights from attachment theory to work with schools and reduce the risk of exclusion. The number of fixed-term exclusions is reducing. On a less positive note, absence has increased recently, especially authorised absence. In terms of pupils' academic outcomes, the impact of the virtual school is less clear. Their work on getting pupils into school has yet to translate into better outcomes. The introduction of 'E peeps' is a positive one, with online access increasing the tracking of children's progress for all key partners.
31. Foster carer recruitment, assessment training and support are effective. The local authority is keenly aware of the need to maintain and grow its own foster carer cohort and support the local market to expand in line with need. A specialist team successfully supports carers and children when there is a potential for breakdown and helps to increase stability for children.
32. Children in long-term fostering arrangements, including those who are staying put, are supported well and have access to a wide range of activities, such as overseas trips, leisure pursuits and social events, which prepares them well for later independence. This is also the case for unaccompanied asylum-seeking children, whose cultural, religious and linguistic needs are fully considered and addressed.
33. The local authority ensures that children from Devon receive a timely and supportive service from the Regional Adoption Agency. Adopters are recruited, trained and supported well.
34. Social workers and personal advisers are not equipped or driven to help children understand their life stories. This is a significant weakness at all points during a child's journey through care. Rather than being an integral part of direct work with children, life-story work is seen as a discrete and time-consuming piece of work by social workers. Children's memories are not routinely gathered in a way that helps them to make sense of their identity and history. This continues for care leavers, where PAs are not supported or equipped to address the significance of early life events for young people.

35. For children in care and care leavers who are not in education employment or training, and who are not living in stable accommodation, the support they receive is less effective than for those who have stable living conditions. As a corporate parent, the local authority has not fully exploited its contacts in the local community to offer young people opportunities to learn, succeed and contribute.
36. The local authority celebrates success at annual events. Individual success is also celebrated throughout the year.
37. The Children in Care Council in Devon and consultation with young people have had a recent resurgence following investment in the participation team. The infrastructure for meaningful involvement is now in place and is starting to yield positive results, with more children starting to get involved.
38. The transition point for children moving from a child in care social worker to a PA is too high. In fact, the reality of increased caseloads for PAs means that many care leavers do not get a PA or pathway plan until they are well beyond 17. This results in some delays in securing adult services, despite some well-developed joint protocols for these changes. There is a lot of inconsistency across the local authority in how the protocol is applied, with some young people receiving a better service than others, depending on where they live.

The impact of leaders on social work practice with children and families is: inadequate

39. Since the last inspection in 2015, key priority areas where children are most at risk have not improved. These areas include: responding to chronic neglect; the use of pre-proceedings, legal planning meetings and instigation of care proceedings; life story work; permanency; and, most significantly, the risks to care leavers in unsuitable accommodation. All of these issues were highlighted at the previous inspection and there has been little progress.
40. In the interim, senior leaders have lost their line of sight to some of the most vulnerable children. Care leavers in unsuitable accommodation and children living in unregulated settings are not receiving a service that assesses and reduces the risks that they face. The quality assurance of the care leavers service through case auditing has been negligible over the last 18 months, despite it being an area that has inherent weaknesses. Crucially, senior leaders failed as corporate parents and were not aware that a very small minority of young people were, or had been, living in tents and on the streets.
41. Senior leaders, and the Devon children and families partnership, demonstrate the capacity to improve services in some areas, and there have been some notable advances. The early help offer has been significantly improved, and more children get the help they need at the right time. The response to the threat of child exploitation has been mature and proactive.

42. The corporate parenting committee meets regularly, and the associated strategy is generous in terms of the local offer to children in care and care leavers. However, acting as a good parent when children are struggling with their mental health, their accommodation, work, money and relationships is less evident in practice.
43. Potentially, the local authority has the infrastructure and political support that are necessary for children to receive the right service at the right time. The scrutiny committee has the right professional support. The lead member and senior leaders are well established, and they have responded openly to the weaknesses highlighted during the inspection. Politicians across all parties are willing to invest in areas of the service that are under pressure, yet scrutiny and accountability mechanisms have not prevented serious failures in respect of Devon's corporate parenting responsibilities for a small minority of their care leavers.
44. Corporate senior leaders have invested heavily in creating an environment where workers feel valued and supported. Social care staff have good access to training. Devon is very proud of 'growing its own', and the workforce development strategy is centred on providing opportunities for staff to progress, which in turn promotes consistency for children.
45. These successes are undermined by gaps in key practice standards or responses that are too slow. Assessment of risk, clear planning and professional supervision have shown some signs of improvement since the focused visit in May 2019, but this is not enough. Senior leaders have created an environment where, on the whole, caseloads are manageable and social workers and their colleagues have the time and resources to do impactful work with children. Crucially, this is not the case for PAs. Even where caseloads are manageable, the drive, commitment and challenge necessary to take children out of unsafe living conditions have not increased. The pace of change has been too slow and lacks sustainable impact in some key areas.
46. Relationships with the local judiciary and the Children and Family Court Advisory and Support Service are strained and there is a lack of trust that social workers will have gathered compelling, comprehensive evidence when they go to family court. Senior leaders have not been proactive in rebuilding this trust or brokering solutions that reduce delay for children.
47. Performance reporting and the use of data are not fully accurate and not fully systematic. They are inconsistent within and across localities. Several areas of the service are relying on manual spreadsheets while the full suite of performance tools is introduced. As an interim measure, this is having mixed success, with key indicators, such as transition points for children in care, not being tracked. The use of different tools to track pre-proceedings work and

permanence in each locality leads to inconsistent and incomplete performance data.

48. Similarly, the approach to quality assurance is inconsistent. In some areas, such as spot checks in the MASH, supporting the completion of early help assessments and commissioning preferred providers, quality assurance is effective and maintains good standards of practice. In too many other elements, especially case auditing, observations of practice and annual appraisals, there is a lack of clarity about what good practice looks like, and weak practice is insufficiently challenged.
49. Senior leaders seek peer challenge and they actively listen to the findings of reviews and inspections. Although action plans are generated and monitored through the challenge board, progress has been slow. Learning from complaints, audits, advocacy and directly from young people is under-developed. For example, the complaints annual report does not contain learning themes, and although children benefit from over 1,000 pieces of advocacy each year, there are limited examples of learning and change.
50. Children, carers and parents spoken to during the inspection were mainly positive about the service they receive when things are stable and going well. When there are stressors or changes in social worker, then things do not go as smoothly. The involvement of children and young people in the strategic direction of the local authority is starting to gain momentum following recent investment in the participation team. There has been limited activity until very recently, but there is now increased potential for children to be part of the way forward.



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Piccadilly Gate
Store Street
Manchester
M1 2WD

T: 0300 123 1231
Textphone: 0161 618 8524
E: enquiries@ofsted.gov.uk
W: www.gov.uk/ofsted

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