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Dear Stuart

Monitoring visit to Devon children's services

This letter summarises the findings of the monitoring visit to Devon children's services on 5 and 6 March 2024. This was the seventh monitoring visit since the local authority was judged inadequate in January 2020. His Majesty's Inspectors for this visit were Steve Lowe and Tom Anthony.

Areas covered by the visit

Inspectors reviewed the progress made in the effectiveness of the local authority's 'front door' services that consider and agree the initial response to concerns raised about children who may be in need or at risk of harm. Inspectors looked at the following areas of concern identified at the last inspection:

- Making sure that decisions taken by the multi-agency safeguarding hub (MASH) are acted on.
- Professional curiosity and the quality of assessments.
- The quality of recorded management oversight and critical challenge.

These areas of practice were also assessed during a monitoring visit in March 2022, when inspectors found that children at risk of significant harm were not seen quickly enough, and many remained in unsafe circumstances for too long.

This visit was carried out in line with the inspection of local authority children's services (ILACS) framework.

Headline findings

It is four years since Devon children's services were rated as inadequate and serious concerns were raised about whether children were being kept safe. Since that time, multiple changes to the corporate and departmental leadership team have resulted in slow and inconsistent progress. A decision was made to revisit the front door to assess whether Devon County Council now has the capacity to make positive,

significant and enduring change for children. In the summer of 2023, the new senior leadership team identified a significant number of children referred to the front door who had not had the risks they faced assessed for several weeks, leaving many vulnerable to further harm. At the point of the last monitoring visit, the senior leadership team had already prioritised making this service safer. The team's response has been effective, eradicating the waiting list and establishing a permanent workforce in the MASH that is making better use of simpler processes. During this visit, inspectors did not find any decisions in the MASH that had left children at unassessed risk of significant harm. Substantial improvements still need to be made to build on these foundations, but senior leaders have a credible plan in place, with additional capacity to deliver those changes.

When risks to children require further social work assessment, too many children are not seen on their own because parents' refusals to allow social work visits to their children are too readily accepted in situations where children may be at risk. Too often, this focus on adults rather than children leaves children without a voice. For this and other key elements of practice, management oversight still lacks clarity and purpose. Quality assurance, including audits, has increased in quantity but does not currently have an impact for children, and collaboration with statutory safeguarding partners at both a practice and strategic level requires further development.

Findings and evaluation of progress

Following a period when the oversight of contacts and referrals regarding concerns about children had become unmanageable, the response to demand is now under control, with minimal delay in decision-making by team managers who oversee the three main routes into the front door. Significant and effective efforts have been made to simplify the processes that staff have to follow. This affords referrers quicker access to advice, guidance and decisions regarding their concerns about children. A consultation line staffed by social workers has been received positively by partner agencies and has reduced the time families wait for appropriate support.

Managers in the MASH understand thresholds of need and apply them appropriately, directing enquiries to either early help connectors or social workers for further background checks in line with children's identified or emerging needs and risks. Some information is kept about families that is not added to children's records, reducing the ability to analyse cumulative risks, but the local authority is taking steps to remedy this.

Children who could benefit from non-statutory support rather than a formal social work intervention are considered by early help connectors who hold a directory of local resources, contact families quickly and signpost them to what is available. For some families, this includes targeted support from skilled practitioners within the local authority, which is having a positive impact for children. Early help beyond this specialist support lacks coordination and strategic oversight. Children needing support with their mental health or waiting for assessments of neurodivergence are signposted to services that are a 'best fit' rather than those that fully meet their

needs. Records of whether these lower-level supports have been effective are not linked to children's records, increasing the likelihood that the same solution will be offered in the future despite not having been effective the first time.

For children with more significant needs or risks, social workers gather additional background information and have a clear understanding of when consent from parents should be sought or overridden. This background information is often slow to be returned and analysed, with some key decisions being made without a full understanding of family background. In addition, most decisions are made based on presenting concerns within the family, with little consideration of wider risks outside of the home. In recent months, clearer pathways for linking together intelligence relating to child exploitation have been developed, but beyond advice from the specialist exploitation team these are not routine.

Linked to a lack of confidence by both local authority staff and those from partner agencies, the number of strategy discussions and consequent child protection inquiries was far too high. The subjection of families to unnecessary investigation has now decreased significantly, almost halving over the last six months. There is now more emphasis on helping families identify underlying reasons for family conflict through assessment or the support of family practitioners.

When there are clear and significant risks to children, these are largely responded to quickly and effectively. Child protection strategy discussions are timely and include relevant professionals, including those who raised the concerns whenever possible. This extends to evenings and weekends, when the emergency duty service provides an assured and sensitive response to crises. However, safety planning and actions to be taken following strategy discussions are often generic and lack clarity on how and when children are going to be seen.

Assessment teams are now more closely aligned with the MASH, with recently instigated meetings about the most appropriate intervention for families easing transitions from one team to the next. Improved decision-making as to whether children need further social work assessment, or could be supported through early help, has reduced the number of families that need to be allocated to assessment teams. Social workers' caseloads are now manageable.

However, the quality and impact of assessments of children's needs vary. At their best, assessments identify the areas of concern that, longer term, teams should focus on, and some support for children and families is put in place alongside the work to complete the assessment. In weaker examples, social workers too often complete assessments without speaking directly to children. Predominantly, this happens when parents do not give consent for social workers to speak to children, which is often accepted too readily, leaving children without a voice and more vulnerable to harm.

The regularity of supervision and management oversight is improving. Social workers' morale has improved and they feel increasingly confident in their managers'

guidance and direction. Children's records do not mirror the level of thoughtful reflection about practice and what support is likely to work best for individual children and their families that workers report. Oversight at the conclusion of assessments is, for example, too often simple endorsements of social workers' recommendations.

A key failing at the time of the last inspection was that senior leaders did not have a clear 'line of sight' into what was happening for children. Positively, the current leadership team, including heads of service and service managers, has improved its line of sight by introducing manageable spans of responsibility, and staff report a more open culture that encourages them to raise concerns. Conversely, quality assurance, including but not restricted to audits, has increased in volume but is yet to become the valuable, independent insight into practice that is required as an additional safeguard for children. Rapid improvement in the impact of quality assurance, primarily within children's social care but also alongside statutory partners, is a key next step.

Since the last inspection, the quality of response that children receive at the front door has improved and declined in waves over time. The response to the most recent and concerning dip in practice is encouraging, with a suitable plan for sustainable improvement based on consistent adherence to basic standards of practice.

I am copying this letter to the Department for Education.

Yours sincerely

Steve Lowe
His Majesty's Inspector