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Dear Alison

Monitoring visit of Torbay children's services

This letter summarises the findings of the monitoring visit to Torbay children's services on 2 and 3 October 2019. The visit was the third monitoring visit since the local authority was judged inadequate for the second time in June 2018. The inspectors were Brenda McLaughlin and Steve Lowe, Her Majesty's Inspectors.

The local authority is taking too long to address critical weaknesses. As reported in previous monitoring visits, the quality of help and protection for vulnerable children continues to be very concerning. The local authority has made some progress to implement the necessary improvements, but the pace of change for children in need of help and protection is too slow.

Areas covered by the visit

Because there were serious and widespread child protection concerns identified during previous monitoring visits, inspectors revisited and re-evaluated the quality of help and protection provided to vulnerable children and their families in safeguarding assessment teams (SATs) and in the safeguarding and family support service (SAFS). They also evaluated the work in the 'special guardian' pilot team and in the externally commissioned interim innovation team, which began work in Torbay in May 2019.

During the visit, inspectors specifically assessed the application of thresholds and the effectiveness of practice when responding to children at risk of harm and in need of help and protection. Inspectors also evaluated the effectiveness of assessment and planning and the quality of managerial oversight and supervision.

Inspectors considered children's case records, performance management, audit activity and quality assurance information. They reviewed the minutes of the

improvement board and the recently updated improvement plans. In addition, inspectors held case discussions with social workers and their managers and met with the leader of the council, the chief executive and senior managers.

Overview

Senior leaders understand the significant weaknesses. They fully accept that progress is too slow and has stalled in some areas. Audit activity has increased, but there is some confusion about what constitutes good practice, and there is little or no consideration given to the impact on children's lived experiences. Ineffective and uncoordinated systems to analyse audit outcomes or impact on practice impede the local authority's ability to track or sustain progress. These are serious shortcomings.

On a corporate level, the chief executive, the senior leadership team and the leader of the council are strongly committed to helping and protecting Torbay's vulnerable children. The recently appointed interim deputy director has brought a sense of urgency to and focus on the needs of children. In a short period of time, she has conducted a much-needed review and analysis of the quality of practice across the service. This is encouraging because, to date, the primary focus of leaders has been on measuring compliance with processes.

Capacity in the SATs and SAFS teams has recently improved. The introduction of the 'innovation' team has helped to reduce social work caseloads, but they need to reduce further. Staff turnover in the innovation team is very high, and staff are anxious about what will happen when this team no longer exists. The proposed exit strategy appears not to have been carefully thought through as it is based on cases closing in children's social care, despite re-referral rates being high and the early help strategy not being fully implemented or operational. Leaders acknowledge that more work is needed because thresholds for access to children's social care services are not well understood by partner agencies or by local authority staff in the multi-agency safeguarding hub (MASH).

Social workers and managers report that they are no longer reacting to daily crises because they have more time to plan work. More children are being visited by the same worker. There is emerging evidence of purposeful work helping to protect some children. Staff morale is good and, while 40% of frontline staff are not permanent, there has been a reduction in the number of social workers and team managers leaving at short notice. Highly committed social workers told inspectors that they are supported by managers who now know the children who they work with well. These are positive developments. However, the quality of help and protection and management oversight remains highly variable for too many children across all teams. In several cases brought to their attention by inspectors during the visit, leaders had to act to protect children from harm or to ensure that plans were progressed quickly.

Findings and evaluation of progress

There is emerging evidence that lower caseloads are leading to more purposeful direct work being undertaken during the assessment period. Although this is positive, progress will not be sustained unless caseloads continue to reduce and rigorous performance management systems are fully implemented. The quality of children's assessments is starting to improve but, in too many cases, those carrying them out do not gather enough information and evaluate all the concerns. Assessments are overly focused on the parents rather than on the impact of adult behaviour on the children. This includes when there are concerns about parental domestic abuse, drug and alcohol misuse and mental health issues. In too many cases, analysis is over-optimistic about the ability of parents to change, and is often based on limited information. Consequently, children's cases are closed or are stepped down too soon before improvements to children's situations are sustained. For instance, inspectors referred cases to leaders where very young children and babies have been the subject of numerous child protection plans, and a small number continue to remain in situations of harm. Most children's plans are not sufficiently specific about what needs to happen, and lack clarity about the expectations of parents. Core groups often share information well, but do not effectively challenge the lack of progress. Independent child protection review officers are not effective in identifying or escalating concerns about individual children.

There is evidence of drift and delay, which causes too many children to be left at risk of harm. Many of these children and their families have been known to children's services for extended periods of time. The pervasive impact of long-term neglect on children's outcomes does not appear to have been recognised or sufficiently addressed. For example, the cases of two very vulnerable children raised by inspectors at a previous monitoring visit were referred to senior managers again because action had not been taken and the children remained at risk of significant harm.

When risks to children increase, the public law outline (PLO) pre-proceedings process is not yet timely enough for some children. The monthly legal gateway meeting provides improved management oversight and a cursory system to track progress. However, there are still delays because work that could have been done to support children and their families prior to attending a legal gateway PLO meeting is rarely completed in advance. This work includes, for example, updating parenting assessments or convening family group conferences to explore, support and make clear contingency plans if children cannot remain safely at home. This results in some children remaining in situations of high risk for too long.

Despite the implementation of a revised supervision policy and specific training for managers, children's experiences and their views are not consistently at the centre of supervision meetings. Most supervision records are compliance-orientated updates of circumstances, with task-based directions. The support provided to social workers to explore different ways of engaging those families who are resistant,

avoidant or hostile is limited. There is some evidence of better practice by individual managers, but it is not always clear whether previous actions have been reviewed or completed. Supervision is recorded as a one-off event, rather than a continuous, ongoing evaluation and a measure of progress of children's lived experiences. As a result, ongoing risks for some children are not understood or acted on quickly enough.

The quality of special guardianship assessments has improved, following a management decision in April 2019 to set up a dedicated team to carry out this work. However, responsibility for providing support to vulnerable children with complex needs who live with special guardians was also transferred to this team. In five cases referred by inspectors, managers had to act urgently to protect these children from ongoing significant harm. They have also agreed to review another six children due to safeguarding concerns.

Responses to exploited children remain under-developed. There is a lack of coordination with the police to understand the best way to disrupt connections between children and adults who are grooming them to sell drugs. Staff's knowledge and understanding about national concerns regarding criminally exploited children or 'county lines' is limited. This was a significant concern during the inspection in June 2018. The interim deputy director is taking immediate action to address these issues.

Most staff report that they like working in Torbay's SATs and SAFS teams. They describe the working environment as being calmer and note that they are 'able to plan' and 'reflect more about their practice', although reducing caseloads remain relatively high. Social workers who met with inspectors have over 22 children on their caseloads, and some have higher numbers. The newly appointed head of service is reviewing the support provided to newly qualified staff because some are unreasonably responsible for very complex work beyond their level of experience. Failure to address these concerns will impact negatively on the local authority 'grow your own' recruitment and retention strategy.

The work in the additionally funded interim innovations team is variable and is dependent on the skill of the individual worker. While there is evidence of strong practice by some workers, inspectors also referred cases of poor and inadequate practice. An experienced team manager has effective systems in place to track work. However, the team has experienced a 70% turnover in staff since its inception in May this year. At the time of the visit, two more workers were planning to leave the next day. This will mean more changes for children who have already experienced multiple changes in social worker. The management and support of the innovations team by Torbay senior leaders has not helped the lack of cohesion. Staff do not feel valued. The director of children's services has not visited the team, which is based in offices in the basement without natural light and situated away from the SATs and SAFS social workers. During the April 2019 visit, inspectors raised concerns about the importance of ensuring that this interim team was integrated with the existing service. This did not happen and there are tangible tensions, with an 'us and them' culture. The recently appointed interim deputy director is actively reviewing the

work across all the teams to ensure that this resource is being utilised more effectively.

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

Yours sincerely

Brenda McLaughlin
Her Majesty's Inspector