Ofsted
Piccadilly Gate
Store Street
Manchester
M1 2WD

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

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Sharon Muldoon
Director for Children's Services
Plymouth City Council
Midland House
Notte Street
Plymouth
PL1 2EJ

Dear Ms Muldoon

Focused visit to Plymouth City Council children's services

This letter summarises the findings of the focused visit to Plymouth children's services on 13 and 14 December 2022. His Majesty's Inspectors for this visit were Anna Gravelle and Joy Howick.

Inspectors looked at the local authority's arrangements for the 'front door'.

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

Headline findings

Plymouth children's services were last inspected in 2018, when they were judged requires improvement to be good. A joint targeted area inspection was carried out in 2019, which focused on the response to children's mental health needs across the partnership, including at the front door.

Since then, the quality of social work practice for children in need of help and protection at the front door has declined. There are serious and widespread systemic failings in the front door service, which leave children at risk of significant harm. Thresholds are poorly understood by social workers, managers and professional partners. There is confusion about when to dispense with parental consent should risks to children escalate. Consequently, strategy discussions do not consistently take place, or are often delayed, when children are at risk of significant harm. This is sometimes due to the lack of availability of police colleagues out of hours. These shortfalls in practice prevent practitioners and partner agencies from sharing information effectively and agreeing a multi-agency plan. This, in turn, leads to delays in taking timely action to reduce risk for children.

Senior leaders recognise the significant practice deficits raised by inspectors during this visit and have plans in place to make the required changes. The director of children's services (DCS) has been in post for six months and has secured substantial

corporate support and financial investment to put in place the building blocks to secure the necessary improvements. This has helped secure a planned increase in workforce capacity, to progress the local authority's new vision and restructure of children's services over the coming months. The determination, enthusiasm and visibility of the newly appointed senior leadership team are much welcomed by staff.

Despite these developments, there has been a high turnover of staff in the service during the last 12 months, which has resulted in a stop-start approach to the improvement work. The recent integration of a new electronic recording system has been challenging. Much work has taken place to embed cultural change within the workforce. This is now beginning to take shape, with a move to a more open and learning culture, however, the pace of change has been too slow for children. The implementation of a proposed redesign at the front door is very new and, consequently, at the time of this visit, has not delivered the sustainable changes required.

Areas for priority action

- The consistent understanding and application of thresholds for intervention and when to obtain or dispense with parental consent to ensure children are appropriately safeguarded.
- The convening and timeliness of child protection strategy meetings and initial child protection case conferences when significant risks are evident for children.

What needs to improve in this area of social work practice?

- The quality and timeliness of assessments and initial plans.
- Response at the front door to domestic abuse.
- Timeliness of initial child protection conferences.
- Quality of supervision.
- Management oversight and decision-making.
- The specificity, prioritisation of actions and impact focus of the local authority's improvement plan.

Main findings

Children in Plymouth do not receive a comprehensive early help offer and much work is still to be done by senior leaders, with partner agencies, to develop and coordinate effective early help support. The DCS has a clear vision to implement a new locality-based operating model. As part of this new approach, the systems for receiving referrals about children are under review. The aim is to create locality teams to provide effective early help to families, to strengthen partner agencies' accountability and to reshape front door services.

While planned improvements are under way, the initial assessment of children's needs and risks and the provision of support remain weak. This means that children are not always receiving the right help at the right time, through targeted early help support, to prevent escalation into statutory children's services.

Although assessments for most children who receive early help support are thorough and lead to well-developed plans to support children, this is not the case for all children. Decisions and thresholds for children to step up to children's social care and step down to early help are mostly appropriate.

Most referrals to the multi-agency safeguarding hub (MASH) receive a timely response, but referrals are not routinely risk assessed to establish an initial understanding of the level of risk for children. There is more work to do to agree a process for this in the MASH and wider partnership, in order to prioritise work more effectively. Parental consent is not always consistently sought from parents by professionals before making a referral. When serious concerns arise for children, there is widespread confusion about the application of thresholds and assessment of risk. When parental consent should be dispensed with due to escalating safeguarding concerns, this is not always done. There is a lack of a clear rationale to explain next steps. As a result, some children are left at risk of harm.

Many children experience repeated re-referrals before receiving the help and protection they need. There is insufficient consideration and analysis of historical information, including about cumulative neglect and its impact on children. Too many children experience repeated assessments, with limited change to their outcomes. This crucial information is not informing decision-making, which means that some children are left in situations of harm for too long.

Senior leaders are aware of these practice shortfalls and are seeking to address them through their improvement plan and redesign of the front door. While the existing improvement plan identifies the significant shortfalls found during this visit, it lacks specificity, appropriate prioritisation and a sufficient focus on impact. Funding has been agreed for an additional team manager, advanced practitioner posts and an improvement manager, to address the need for an increased level of management oversight at the front door. Longer-term plans are in place to launch a professional advice line to better support professionals from other agencies. Despite this, the pace of progress has been too slow and the impact of these interventions is awaited.

A significant number of concerns for children are not escalated to a child protection strategy meeting when they should be, or there is delay in holding meetings when there are risks of significant harm for children. Much emphasis is placed on gaining parental cooperation and waiting for responses from multi-agency checks, rather than a robust initial assessment of risk and effective child protection planning. When strategy meetings do take place for children, they are mostly timely, well attended by a range of relevant professionals and include an adequate summary of the risks to children. However, some strategy meetings do not capture partner agencies' views,

to inform decision-making. Actions from strategy meetings are not always measurable, to enable a timely response to risks for children.

Although partner agencies report a positive development in terms of co-location in the MASH, they also recognise that the understanding and application of thresholds remain a work in progress. They also report a lack of clear process to escalate concerns when they consider child protection strategy meetings should take place for children. There are too many times when professionals from partner agencies do not understand thresholds or how to appropriately refer and escalate concerns for children.

Most domestic abuse referrals are not triaged well. There is a lack of recorded use of domestic abuse tools to assess risks, or escalation to a multi-agency risk assessment conference. The impact of repeated incidents of domestic abuse and past history on children is not analysed well. Thresholds are not appropriately applied in terms of understanding and identifying when children are at risk of harm from domestic abuse, and when to escalate concerns. Although the local authority commissions a specialist domestic abuse service, it is not used sufficiently to strengthen practice at the front door.

Since the last inspection, the local authority has strengthened its process in response to children at risk of criminal or sexual exploitation. A review of the multi-agency child exploitation (MACE) meeting process and daily risk meetings within the MASH have helped to increase the focus on children at risk of exploitation, and for those who go missing. While some children do now benefit from detailed assessments that capture the risks to them accurately, and increased involvement when risks escalate, this is still not the case for all children. Work to tackle the risks to children from criminal or sexual exploitation is not aligned well with wider work to improve their welfare and safeguarding.

Most children receive a timely and effective response when emergency situations arise out of office hours. Decisions to accommodate children are appropriate. However, when children are placed with neighbours or family members in an emergency, recording of incidents is weak and senior manager oversight and rationale for decisions is not recorded. This makes it more difficult for senior managers to assure themselves that children are placed with families that are safe and well matched to children's needs. The local authority out-of-hours team experiences significant challenges and delays in contacting the police, due to police availability. This means that when joint working with the police is necessary, for example holding child protection strategy discussions or visits to some children and families, this is less effective. This means that there is a delay in providing a protective response and safety planning to some children.

Overall, the quality of assessments carried out by the initial response teams is inconsistent. Almost half of assessments lack a comprehensive analysis, and fail to identify cumulative neglect, patterns of parental behaviour and the impact on

children. Approximately a third of assessments are not completed in a sufficiently timely way to meet the individual needs of children. The quality of plans is variable. Stronger plans identify detailed actions and are written to the child. Weaker plans lack specific and measurable actions to support children and rarely include appropriate contingency planning.

Most children are seen at a frequency that matches their needs, are spoken to alone when appropriate, and their views are captured sufficiently. In some cases, some meaningful and sensitive direct work takes place with children to help capture their voices, although this is not consistently evident on the child's record. Some children's records are, however, missing from the electronic recording system. This includes records of child protection enquiries, assessments and visits to children. It is, therefore, unclear how risks have been managed and outcomes achieved for those children. There is a lack of management oversight in addressing these significant shortfalls.

When child protection enquiries identify that children's needs have escalated, appropriate decisions are made to proceed to an initial child protection conference. However, a substantial number of initial child protection conferences are significantly delayed, due to a combination of capacity issues and insufficient management oversight. During this visit, some children were still awaiting a child protection conference several weeks after the outcome of a child protection enquiry. Senior leaders acknowledge that this area of performance has declined. They have recently developed an action plan, which they shared with inspectors, to address this deficit. This includes a review of safety planning for children awaiting a child protection conference and increased levels of visiting by social workers. Despite this, children are still waiting far too long to receive the support they need through a multi-agency child protection plan.

Management oversight of practice at the front door is weak. Decisions are not consistently well recorded, do not demonstrate professional curiosity and lack an effective rationale for next steps to protect children. Social workers receive regular supervision, but the quality of supervision is not consistently reflective. Supervision does not address practice deficits through measurable and timely actions, in order to drive practice improvement.

The local authority has made some progress in improving the effectiveness of its quality assurance framework since the last inspection, although the pace of change has been too slow. The turnover of staff in the quality assurance and audit service has exacerbated this situation. However, there has been an increase in the frequency of audits in the last six months. This includes thematic and multi-agency audits, which now have a more consistent focus on the voices of children, and their experiences and outcomes. An additonal strength of audit work is that practitioners and families are now part of this process, to help effect organisational change. At this early stage of implementation, the impact of audit findings on practice is inevitably very limited. There is more to do to embed learning from audit work. The senior leadership team also has plans to strengthen data quality and performance

management arrangements, which are currently underdeveloped and lacking effectiveness, which limits the local authority's ability to track and improve the timeliness of practice.

Senior leaders recognise that practice improvement has been delayed by additonal workload pressures, high caseloads and staff retention challenges. There are now plans under way and funding in place to implement a service redesign at the front door. This will include an expansion of staffing and management oversight.

Staff report that senior leaders are exceptionally visible and that there is a much improved work culture. Most staff describe feeling much more confident in raising potential issues and describe an open and learning culture. While there is an extensive training offer, this is ineffective, as some staff struggle to attend training due to their high caseloads. The DCS has secured funding to strengthen practice through a team manager development programme, and the roll-out of a delayed neglect training programme to strengthen staff practice and their understanding of the impact of neglect.

Ofsted will take the findings from this focused visit into account when planning the next inspection or visit.

We have notified the Department for Education of the areas for priority action. You should submit an action plan that responds to these areas within 70 working days of receiving this letter. It would be very helpful if you can share an early draft of the action plan with us within 20 working days of receiving this letter.

Yours sincerely

Anna Gravelle
His Majesty's Inspector