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Dear Ms Ioannides

Monitoring visit to Croydon children's services

This letter summarises the findings of the monitoring visit to Croydon children's services on 10 and 11 July 2018. The visit was the third monitoring visit since the local authority was judged inadequate in September 2017. The inspectors were Anne Waterman and Andy Whippey, Her Majesty's Inspectors.

The pace of change since the inspection in September 2017 has been too slow. The newly appointed director of children's services and senior managers are in the process of refreshing the improvement plan so that priority areas are tackled with increased vigour.

Areas covered by the visit

During the course of this visit, inspectors reviewed the progress made in areas of help and protection. The inspectors looked at plans and planning, with a focus on experiences for children when risks increase or are not reducing, including:

- child in need cases moving to child protection
- child protection cases reaching the threshold for consideration under the Public Law Outline (PLO)
- PLO cases where proceedings were issued during the three months prior to the visit.

Overview

Thresholds are not applied consistently, which means that some children remain in neglectful circumstances for too long.

The PLO is being used more effectively, with more cases moving appropriately into this process. However, the tracking of this work is not robust, leading to drift and delay in some cases.

Management oversight of practice is too variable. While there has been an increase in the frequency of supervision, the quality is inconsistent. Additionally, case transfer processes have been ineffective. This means that children's plans are not progressed in a timely way and that escalating risks are not always identified.

Overall, progress in these areas has been too slow and too many children do not receive a service that meets their needs. Senior managers have correctly identified the priority actions that are necessary, but implementation has not been at the pace required to ensure that children's circumstances improve in a timely way.

Findings and evaluation of progress

There is inconsistency in the application and understanding of thresholds and this is impacting on the quality of care planning for children. Decisions to 'step up' are not taken quickly enough when children's needs change or risks escalate. Many children are left in neglectful circumstances for too long. However, in a small number of cases seen by inspectors, increases in risks to children had been swiftly identified and responded to appropriately.

The effective use of the pre-proceedings phase of the PLO is improving. An increasing number of children have become subject to these arrangements since the last inspection. Inspectors saw some examples of timely escalation and implementation of actions to improve children's outcomes. However, there are delays for too many children. The lack of recognition of the lived experience of children in neglectful circumstances or where risks are increasing means that the decision to escalate into pre-proceedings is often not taken soon enough. A lack of effective assessment at an early stage, including the use of family group conferences, means that some cases are not thoroughly considered until a decision is made to instigate the PLO process.

When decisions have been taken, there are often delays in implementing them. For example, inspectors saw letters that had been issued to parents some weeks after decisions had been taken as well as delays in convening meetings with parents and solicitors. As a result of preparatory work for this visit, senior managers recognised the need to improve their oversight of cases within the PLO process, and an improved tracking system has been implemented to better monitor the progress of children. It is too soon to see the impact of this.

Many children who are subject to a child in need plan are not seen often enough, and their reviews are not held frequently enough to consider whether their needs have changed. Senior managers recognised that better oversight of these plans was needed, and since April of this year they have put processes in place to review long-term and complex cases and have appointed a child in need reviewing officer. Over 300 cases have now been reviewed and, as a consequence, 44 cases have been

stepped down and three have been stepped up. Senior managers also regularly review cases of children who have been subject to a child protection plan for more than a year. It is too early to see the full impact of this increased oversight, although inspectors saw a small number of cases that had been appropriately escalated from child in need to child protection and from child protection to the PLO process.

Senior managers have taken active steps to reduce caseloads by increasing the number of teams within the care planning service. However, an increase in demand and a high vacancy rate mean that caseloads remain high. Frontline staff and managers expressed concern about increasing workloads and not always being able to undertake their statutory visits on time. A lack of capacity within the workforce means that when workers are on leave, off sick or leave the organisation, managers struggle to ensure that children receive a satisfactory service. Performance data on social worker caseload volume is inaccurate, as it fails to take into account the cases that are currently allocated to team managers. This reporting error is being amended. These urgent workforce issues have been recognised by senior leaders, and further action is being taken to increase capacity to alleviate workload pressures. Some agency social workers and team managers have now become permanent employees, and several social workers told inspectors that they enjoyed working for the local authority.

There is evidence of more consistent management oversight since the last monitoring visit, but this is still too variable. In some cases, there have been significant gaps, contributing to delays in the progress of children's plans, and children have remained in neglectful circumstances for too long when escalating risks have not been recognised. In too many cases, records of management oversight, although more frequent, were descriptive, and showed a lack of analysis, support or challenge. The supervision policy has been updated to provide greater clarity. However, it relies on team managers to identify the cases that require more than the minimum level of supervision, and this is not being applied effectively.

The application of the local authority's practice model is becoming increasingly evident in more recent case supervision records. Practitioners are positive about the training that they have received, and when the supervision template is fully completed, there is more evidence of improved analysis and clarity regarding the next steps to take. The introduction of group supervision within teams is also valued by social workers, and inspectors saw good examples of the impact of this.

At the time of the monitoring visit, there were 23 cases allocated to a manager, with no named social worker. There is no clear process to manage these cases, which are temporarily allocated either when a social worker leaves or at the point of transfer from assessment teams to care planning teams. Inspectors sampled two cases that had been allocated to a manager for more than 20 days, and in both cases there were delays in the progress of children's plans.

Senior managers had identified that there were significant delays in the progress of cases when they transferred from the assessment teams to the care planning teams, and they have recently introduced a case transfer policy to clarify timing and

expectations, although it is too soon to assess impact. In many of the cases sampled by inspectors, there had been significant delays, including gaps in visits to children, gaps in management oversight and delays in actions on children's plans. In most cases, social workers from receiving teams had not attended the initial child protection conference or the child in need review due to capacity issues, despite this being the point of transfer. This means that they were not able to have a full understanding of children's circumstances and histories.

The quality assurance process for auditing cases is sound, although the impact of practice on outcomes for children is not always clear. Although there were appropriate action plans in place following case audits, inspectors found that not all of these actions had been undertaken, meaning that there was delay in improvements being made.

The recording of direct work with children on case records is variable and it is not clear how this is used to influence their plans. Children are not always seen frequently enough, because visits are undertaken late or are missed. This was particularly evident when cases transferred from the assessment teams to the care planning teams, and impacted on the ability of children to develop relationships with their social workers. However, inspectors did see some examples where social workers had developed a good relationship with children and were using tools to support this in order to understand their lived experiences. Inspectors also saw some good recording of observations of pre-verbal children.

Senior managers have recognised that the identification of neglect is an area for development, and social workers in the care planning teams are currently being trained on the use of the graded care profile. This has not yet been implemented, but social workers were positive about the training that they had received and were looking forward to putting it into practice.

Managers have audited 46 cases, focusing on those that had been stepped up, and have reviewed performance data relevant to this area of work. As a result, they have begun to take action to address areas of practice identified as weak. This includes making improvements to the case transfer process, updating the supervision protocol and the implementing an improved tracker for cases in pre-proceedings. Senior managers are aware that there is more work to be done to improve the timeliness and availability of family group conferences and they are planning to address this.

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

Yours sincerely

Anne Waterman
Her Majesty's Inspector