Torbay

Inspection of services for children in need of help and protection, children looked after and care leavers

and

Review of the effectiveness of the Local Safeguarding Children Board[1]

Inspection date: 12 October 2015 – 5 November 2015

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Children's services in Torbay are inadequate		
1. Children who need help and protection		Inadequate
2. Children looked after and achieving permanence		Requires improvement
	2.1 Adoption performance	Requires improvement
	2.2 Experiences and progress of care leavers	Requires improvement
3. Leadership, management and governance		Inadequate

[1] Ofsted produces this report under its power to combine reports in accordance with section 152 of the Education and Inspections Act 2006. This report includes the report of the inspection of local authority functions carried out under section 136 of the Education and Inspections Act 2006 and the report of the review of the Local Safeguarding Children Board carried out under the Local Safeguarding Children Boards (Review) Regulations 2013.

Executive summary

Children's services in Torbay are inadequate. Leaders and managers in the local authority have been ineffective in prioritising, challenging and improving the quality of practice, in particular for children in need of help and protection. The local authority was judged inadequate in the inspection of safeguarding in 2010. The improvements that followed resulted in a judgement of adequate at a child protection inspection in 2013. This trajectory of improvement has not been sustained over the last year. Senior leaders have introduced initiatives and progressed a range of projects, but in doing so they have lost focus on the core task of ensuring good-quality frontline services to children and families.

High turnover within the senior leadership team over several years, combined with inconsistency in management style, sickness absence and ineffective challenge throughout the organisation, have adversely affected the speed and effectiveness of improvement. The previous Director of Children's Services (DCS) has returned on an interim basis and, together with a stabilised management team, is beginning to provide more consistent and effective strategic direction to support improvement.

The DCS and senior managers are visible to staff and are well respected. The leadership team is beginning to introduce a culture of challenge and improvement and of continuous learning. There is sustained financial investment and a clear political commitment to provide high-quality children's services. Torbay children's services benefit from a well-resourced workforce with manageable caseloads.

Performance information is not reliable and therefore cannot be used to enable effective scrutiny of activity. Quality assurance processes are not yet embedded and do not routinely lead to identifiable improvements across the service. Audit activity has been limited until recently and findings from audits have not been used effectively to inform staff training and improve practice.

Important weaknesses remain in social work practice across the service. While no children were found to be at immediate risk, children in Torbay do not receive timely responses to their needs and thresholds for access to services are not well understood or applied. Children and families experience delay in gaining access to help and protection at referral, assessment and planning stages. Practice across the service is not sufficiently proactive and a culture of incident-led social work is evident. Delays experienced by children and families in receiving services are not sufficiently challenged by managers or child protection conference chairs. Management oversight and supervision remain variable in timeliness and quality.

Assessments do not routinely include a thorough analysis of risk or clearly reflect the voice of the child. Weaknesses in practice include the poor quality and impact of child in need and child protection plans, the inconsistent application and understanding of thresholds, the high number of repeat referrals, and slowness in initiating care proceedings.

However, improvements to the quality of practice are taking place in a number of

areas. These include the introduction of the multi-agency safeguarding hub and a strengths-based model of casework. Arrangements to identify and support children at risk of sexual exploitation are improving and partnership working is becoming better integrated into services. However, the quality of individual case work is too variable in terms of improving outcomes for children. Young people are not routinely offered a return interview after they have been missing.

Arrangements to support and assess 16- and 17-year-olds who are homeless are not robust. Assessments of need and consideration of becoming a child looked after for each young person are not routinely undertaken. This means that young people may remain at risk.

Arrangements to investigate allegations of abuse or poor practice by people who work with children are not consistently timely or robust. Thresholds for referring to the designated officer are not well embedded or understood across the partnership and learning from cases is not used effectively.

The quality of early help work is significantly underdeveloped. There is no coordinated overview of early help provision across Torbay and no evaluation of its impact. Partners do not sufficiently understand the early help offer, which means that some children and families may not have access to the right help at an early stage.

Services to families experiencing domestic abuse are underdeveloped. Torbay does not provide a perpetrators' programme or direct work with children. Some children have to wait for many weeks for Child and Adolescent Mental Health Services.

Decisions to look after children in Torbay are not sufficiently timely or effective. Children experience delays in becoming looked after, particularly in cases where they have been exposed to ongoing chronic neglect. While the duration of care proceedings has reduced and the quality of court work is now much stronger, arrangements to secure permanence at the earliest opportunity for children are not prioritised or timely. Strong commissioning arrangements and increasing numbers of foster carers have contributed to good placement stability. Educational outcomes for children looked after are improving, but at Key Stage 4 they are still too low.

The local authority is in touch with the vast majority of its care leavers, who receive good support from personal advisers. However, the quality of pathway plans is poor.

Careful planning helps to ensure that most children are prepared well for adoption. However, adoption as an option for permanence is not routinely considered for all children who are unable to return home. While the average time between a child entering care and moving in with her or his adoptive family is improving, children continue to experience unnecessary delay in securing adoptive placements.

Contents

The local authority

Information about this local authority area[2]

Previous Ofsted inspections

- The previous inspection of the local authority's safeguarding arrangements/ arrangements for the protection of children was in March 2013. The local authority was judged to be adequate.
- The previous inspection of the local authority's services for children looked after was in September 2010. The local authority was judged to be adequate.

Local leadership

- The interim director of children's services (DCS) has been in post since September 2015
- The chair of the LSCB has been in post since September 2013.

Children living in this area

- Approximately 25,100 children and young people under the age of 18 years live in Torbay. This is 18.9% of the total population in the area.
- Approximately 21.6% of the local authority's children are living in poverty.
- The proportion of children entitled to free school meals:
  - in primary schools is 18.6% (the national average is 15.6%)
  - in secondary schools is 12% (the national average is 13.9%).
- Children and young people from minority ethnic groups account for 8.1% of all children living in the area, compared with 28.6% in the country as a whole.
- The largest minority ethnic group of children and young people in the area is Any Other White Background.
- The proportion of children and young people with English as an additional language:
  - in primary schools is 5.1% (the national average is19.4%)
  - in secondary schools is 4.1% (the national average is 15%).

[2] The local authority was given the opportunity to review this section of the report and has updated it with local unvalidated data where this was available.

Child protection in this area

- At 13 October 2015, 1,376 children had been identified through assessment as being formally in need of a specialist children's service. This is a reduction from 1,469 at 13 October 2014.
- At 13 October 2015, 209 children and young people were the subject of a child protection plan. This is an increase from 132 at 13 October 2014.
- At 31 March 2015, 58 children lived in a privately arranged fostering placement. This is a reduction from 74 at 31 March 2014.
- Since the previous inspection, five serious incident notifications have been submitted to Ofsted and two serious case reviews have been completed or were ongoing at the time of the inspection.

Children looked after in this area

- At 13 October 2015, 290 children were being looked after by the local authority (a rate of 116.9 per 10,000 children). This is a reduction from 297 (119.7 per 10,000 children) at 31 October 2014. Of this number:
  - 136 (47%) live outside the local authority area
  - 29 live in residential children's homes, of whom 100% live out of the authority area
  - one lives in a residential special school,[3] out of the authority area
  - 196 live with foster families, of whom 32% live out of the authority area
  - eight live with parents, of whom 50% live out of the authority area
  - there are no unaccompanied asylum-seeking children.
- In the last 12 months:
  - there have been 24 adoptions
  - 12 children became subject of special guardianship orders
  - 126 children ceased to be looked after, of whom 4% subsequently returned to be looked after
  - 18 children and young people ceased to be looked after and moved on to independent living
  - three children and young people ceased to be looked after and are now living in houses of multiple occupation.

[3] These are residential special schools that look after children for 295 days or fewer per year.

Recommendations

1. The Chief Executive should ensure that leadership in Torbay is strong, consistent and sharply focused on improving and sustaining outcomes for children throughout children's social care services (paragraphs 111–131).

2. Improve the quality of performance management and monitoring through an improved and robust suite of data, effective and challenging management oversight and rigorous action planning (paragraphs 112–119, 123–124, 129–130).

3. With partners, ensure that multi-agency thresholds are understood and consistently applied across the partnership (paragraphs 19, 20, 26, 30).

4. Ensure that timely decisions are made on contacts and referrals and that initial visits to children are prompt (paragraphs 21, 22).

5. Work effectively with partners to ensure that children receive timely and effective early help and that assessments and plans are in place for each child (paragraph 18).

6. Ensure that assessments are timely, proportionate and effectively identify the risks, needs and protective factors, leading to appropriate and measurable plans (paragraphs 22, 27).

7. Ensure that 16- and 17-year-olds who are homeless are given the opportunity to have a comprehensive assessment and help and support according to their needs (paragraph 32).

8. Ensure that the threshold for a referral to the designated officer is well understood across the partnership (paragraph 131).

9. Ensure that all children who go missing from home or care are offered a timely and comprehensive return interview and that information from these interviews is collated to inform effective targeting of preventative and protective services (paragraphs 37, 60).

10. Monitor the progress of children looked after more closely at Key Stage 4 and pay greater attention to ensuring that they achieve five GCSE grades A* to C, including English and mathematics (paragraph 63).

11. With partners, ensure that timely and effective services are in place, particularly in relation to domestic abuse, adult mental health, Child and Adolescent Mental Health Services (CAMHS) and the emergency duty service (paragraphs 28, 31, 43, 62).

12. Review the permanency policy and ensure that permanence planning is pursued for all children in a timely manner and that consideration is routinely given to

Fostering to Adopt arrangements and concurrent planning, where appropriate (paragraphs 78, 83).

13. Strengthen the quality assurance role of independent reviewing officers and child protection conference chairs and ensure that reviews and conferences result in effective information sharing and purposeful, timely plans for children (paragraphs 26–27, 53–55).

14. Develop ways for care leavers to receive clear and effective advice and guidance on their next steps, which include more formal communication to them of their entitlements (paragraph 95).

15. Ensure that the quality of pathway plans is consistently good and that care leavers are actively encouraged to contribute to the development and content of these plans (paragraphs 103–104).

16. Ensure that learning from audit activity and training is systematically evaluated and contributes to a learning culture within the organisation (paragraph 116).

Summary for children and young people

- Children sometimes have to wait too long to be seen by a social worker or another professional who can help them.
- Some social workers don't spend enough time talking to children and young people to understand what their life is like. This means that the plans they make for children and their families are not always good enough.
- Homeless young people who are 16- or 17-years old don't always get the help that they need from children's services; this means that they might live in accommodation that's unsafe.
- When children and young people go missing, either from their own homes or from care, they don't always meet with an adult when they come back to talk about why they went missing. This means that people who care about them don't know where they have been or how to help them to keep safe.
- Some services help children a lot, such as the Intensive Family Support Service, and the assessment resource centre, where parents are assessed as to how well they can look after their children.
- Most children who are looked after by the local authority live in the same placement for a long time and get help to ensure that they are healthy and that they go to school.
- Some children who are looked after are waiting too long to move in with a family who wants to adopt them. However, when a child does move in with a family, they and the family get a lot of help to make sure that everyone gets on well together.
- Staff are good at keeping in touch with young people when they leave care, but the quality of the written plans to help them prepare for adult life is not good enough.
- The electronic recording system doesn't help managers to find out easily about what the quality of services is like. It doesn't help social workers to find information easily either.
- Senior managers, staff and local councillors really want to help children and young people in Torbay. They have made some improvements and they are determined to make sure that services keep getting better.

The experiences and progress of children who need help and protection	Inadequate

Summary

Serious weaknesses in performance monitoring, management oversight and the quality of social work practice lead to delays in visiting children in a significant proportion of cases. This leaves children at potential risk of harm before assessments begin and before plans are put in place to protect them and meet their needs.

Thresholds are not well understood and applied by all agencies, which means that children do not always get the right service at the right time. Assessments are not sufficiently comprehensive at identifying risk for children. Planning for children in need or with a child protection plan does not effectively address all identified risks and therefore does not offer sufficient protection for some children.

The electronic recording system does not support good social work practice and performance monitoring. The quality of chronologies is poor and they do not enable historical information to be considered in assessments of children's needs. Multi-agency working is not sufficiently robust for children in need.

Young people aged 16 and 17 who present as homeless are not consistently offered an assessment by children's social care and the local authority cannot be assured that these young people have been appropriately safeguarded.

Systems and processes are improving slowly for children at risk of sexual exploitation. However, the quality of practice is still variable. Return interviews are not always undertaken when young people go missing and when they are undertaken they are not always undertaken within timescales. This leads to missed opportunities to engage with young people and to gather information to reduce risk.

Although well-coordinated work is being undertaken to develop robust systems to identify and offer early help services, children have not consistently received help at an early stage. Timely and effective support services have not been in place for children in relation to domestic abuse, adult mental health and CAMHS.

Some good quality practice was seen during the inspection, for example in the family intervention team. Some services support effective practice such as family group conferences, the assessment resource centre, which delivers good quality parenting assessments, and the Intensive Family Support Service (IFSS), which offers significant support to some families and has contributed to reduced risk to children.

Inspection findings

17. Serious weaknesses in performance monitoring, management oversight and the quality of social work practice lead to delays in visiting children. This does not enable timely and effective engagement with children and their families and leads to delays in assessing risk and need. Current systems and practice are not sufficiently robust or child-centred.

18. Determined work is now being undertaken to reinvigorate early help services, which had lost impetus and strategic direction. Assessments and plans have not been completed on the majority of early help cases. A process has been introduced from September 2015 to ensure that assessments and plans are now undertaken. Early help services and the 'team around the child' have not been systematically quality-assured or monitored, meaning that inconsistencies in the timeliness and quality of practice have not been subject to challenge or improvement. The means that some children do not receive the right help at an early stage. However, some good direct work is undertaken by the family intervention team.

19. Processes to step up cases to statutory intervention or step down to early help are not embedded, which leads to children not receiving an appropriate and timely service. Social work intervention is too reactive and cases were seen where an appropriate response did not take place until risks had escalated or a significant incident had taken place. Very recently, more robust systems have been put in place for early help, and there are early signs of improvement. For example, the early help panel, which has been in place since April 2015, effectively shares information and applies thresholds appropriately.

20. Torbay's multi-agency safeguarding hub (MASH) commenced in March 2015. Procedures and processes are not sufficiently embedded or robust and there are delays in screening and decision-making on contacts and referrals. Slowness in decision-making includes cases where the initial screening had assessed referrals as high or medium risk. This leads to delays in assessing risk of harm to children. This is affected by a lack of capacity in the MASH and the quality of referrals being too variable. In addition, a lack of understanding by partner agencies about thresholds and pathways leads to a high number of contacts that require no further action.

21. Some children's services staff in the MASH have received insufficient training, supervision and guidance, which means that they are not clear about all aspects of their role. The majority of decisions in the MASH are appropriate. However, delays occur after this initial decision and some children are exposed to ongoing unassessed risk. The MASH has led to more effective engagement of health partners, who increasingly seek advice on referrals. Repeat referrals that were seen by inspectors highlighted lack of consistently effective decision-making, including insufficient consideration of historical information.

22. In a significant proportion of cases, there are delays in initial visits to children and their families. This leaves children for too long without needs and risks being assessed and without plans being put in place to reduce risk. The majority of assessments are not sufficiently robust. Assessments are not comprehensive or proportionate to risk and need. For example, some assessments are based on one visit to the child where a more in-depth assessment would have been appropriate. Weaknesses in assessments include lack of effective identification of risk factors and being too adult-focused, with insufficient challenge to parents and little consideration of the day-to-day experience of the child. There are delays in completing some assessments and timescales for assessments are not consistently determined in accordance with risk and need. A small number of examples were seen of inadequate assessments and responses to child sexual abuse within their family, which meant that children did not receive timely help.

23. A small minority of good quality assessments were seen during the inspection. Good parenting assessments are undertaken by the assessment resource centre; some effective pre-birth assessments were seen that led to appropriate action to help and protect children.

24. Chronologies are of poor quality and historical information is not always sufficiently taken into account in assessment and decision-making. There are gaps in some children in need being visited, which do not enable good relationships with social workers to develop. Children are seen alone in the majority of cases. Most children on child protection plans are seen in accordance with their plans.

25. Strategy discussions are timely when it is recognised that child protection thresholds have been met. However, strategy discussions do not consistently include all relevant agencies and are mainly held between the police and children's social care. This means that any important information about the child or family held by partner agencies is not taken into account. However, there is some evidence of increasing involvement by health partners. In some cases, there are delays in completing child protection enquiries. The majority of decision-making following child protection enquiries is appropriate. However, it is not yet consistent and the rationale for decisions is not always sufficiently robust. There are delays in initiating some initial child protection conferences, but with evidence of recent improvement. However, plans are not routinely put in place to protect children before the initial child protection conference.

26. Thresholds are not consistently applied. A high number of families are subject to assessments and child protection enquiries without any further action. The rationale for decision-making at child protection conferences is not sufficiently robust and risks are not always effectively identified. In some cases, there are delays in recognising thresholds for initiating child protection processes. There has been a recent rise in relation to children subject to child protection plans, but the reasons for this have not yet been identified by the local authority. A significant number of children are on plans for a second time. Evidence of

challenge was seen from child protection conference chairs, but this is not yet consistent. Few children attend child protection conferences, although they are offered advocacy. The advocates effectively represent the voice of children who are aged eight and over. Parents' and children's views are not routinely captured so there is no effective evaluation of their experience of child protection conferences.

27. A significant number of children in need and child protection plans are not specific and measurable with clear timescales and outcomes. Many plans are too adult-focused and do not effectively address identified risks; therefore they do not offer sufficient protection for some children. Progress on plans is not monitored well, and drift was seen by inspectors in some cases, including where children were experiencing neglect. Core groups do not consistently develop child protection plans. Examples were seen of well-attended core groups. However, this is not always the case and a recent audit identified that some key agencies working with families do not routinely attend core groups, which undermines their effectiveness. In some children in need cases, there is a lack of multi-agency planning due to the absence of regular children in need reviews.

28. Insufficient services for domestic abuse and adult mental health, combined with a lack of effective planning, lead to delays in effective intervention. One of the findings from a recent multi-agency audit of children who live in households where a parent misuses substances, suffers from mental ill-health, or where there is domestic violence, was that there was insufficient information sharing and joint working between agencies. This continues to be an area for development in Torbay. Multi-agency risk assessment conferences (MARACs) are well attended, enabling information to be effectively shared. The local authority has recognised that few referrals to MARACs are made by children's social care services and has introduced a risk assessment tool for social workers. However, this is not consistently used. Representatives from children's social care do not attend all multi-agency public protection arrangements (MAPPA) meetings, which means that important information may not be shared.

29. While a minority of case files reflect the equality and diversity needs of children, for example ethnicity or religion, little consideration of this is demonstrated in assessments and plans.

30. The children with disabilities team does not effectively manage children in need cases. Some cases, identifying low levels of need, could be closed. In some other cases, up-to-date assessments and plans are not in place. This does not enable effective identification of risks. In addition, examples were seen of delays in recognising child protection thresholds and in addressing neglect and permanence for children.

31. There is insufficient timely access to CAMHS. The local authority has identified this as an area for development and is in the process of commissioning

additional mental health services to support the demand for therapeutic provision.

32. Arrangements to identify, support and assess 16- and 17-year-olds presenting as homeless are not compliant with statutory guidance. Assessments of need are not routinely completed and are only undertaken when the young person requests an assessment. Therefore, some homeless 16- and 17-year-olds do not receive help from children's social care services. Some young people are provided with multi-occupancy accommodation, including bed and breakfast, without having their needs and risks assessed. The local authority cannot be assured that these young people are being safeguarded effectively. Assessments undertaken by children's social care for 16- and 17-year-olds who present as homeless are of variable quality and do not result in effective planning, including whether the young person should become looked after.

33. Management oversight of casework is not sufficiently rigorous or challenging. Timescales for actions are not routinely in place and there is not consistent evidence that agreed actions are monitored. There is insufficient rigour in decisions to close or step down cases, which leads to some cases inappropriately being closed to children's social care before the risks to children have reduced. However, social workers report good access to their managers and social workers consult regularly with their managers on casework. Caseloads are manageable and have reduced considerably over recent years.

34. The local authority's new model of casework, Signs of Safety, has not been effectively implemented and is used inconsistently by practitioners. Direct work tools are not routinely used with children. In a minority of cases, good examples were seen of the use of specific assessment tools to gain the views of children. These helped to maintain a clearer focus on the child. Social workers have received training in the new model and are very committed to this approach. They are beginning to integrate this learning into their practice.

35. In examples of better work seen by inspectors, the voice of child is clear, assessments are child-focused and the day-to-day experience of the child is effectively assessed, risk is identified and the social worker is focused on progressing the plan, with effective joint working between agencies. Social workers have access to an established and effective family group conference service. In addition, the intensive family support service provides good quality support to families.

36. Arrangements to identify and monitor children at risk of sexual exploitation are beginning to provide effective support to young people and to reduce the risks to which they are exposed. Tackling child sexual exploitation is a high priority for the local authority and its partners. Improved systems for tracking and sharing information are in place. 'Missing Monday' meetings take place, which are attended by police, children's social care, education, health and the voluntary sector and provide a good forum for information sharing and action planning to safeguard children. Missing and child sexual exploitation meetings

take place and there is some evidence of mapping of intelligence and disruption activity. There is an increasing understanding of the local profile, which informs planning and helps services to be targeted more effectively.

37. The partnership has found that very few boys are identified as at risk of child sexual exploitation and, as a result, plans are in place to raise awareness. While social workers are aware of the risks of child sexual exploitation, the quality of practice is still variable and risk assessments and robust plans are not consistently in place. Some interventions are not sufficiently effective in reducing risks to children. The quality of return interviews is variable and return interviews do not always take place when children go missing from home and care. Children do not therefore have a consistent opportunity to speak with an independent person to share their wishes and feelings. Additionally some key information concerning individual young people and their patterns of absconding is not routinely gathered or collated and cannot therefore be used to inform risk-reduction strategies. A significant proportion of interviews do not take place within 72 hours and further discourage young people to share information or experiences.

38. Arrangements to monitor children missing from education are robust and ensure that children at risk of harm are identified in a timely manner. The educational needs of young people in Torbay are well prioritised. An attendance improvement officer actively tracks and follows up children missing education. The virtual head effectively monitors children being educated in alternative provision. Currently, there are 51 children on reduced timetables; none of the children are looked after by the local authority. There are no children looked after out of area in alternative provision. Three pupils have special educational needs and their progress and attainment are tracked and carefully monitored.

39. A high number of children (137) receive elective home education. This is an increase from the 99 recorded in 2013–14. The progress of children receiving elective home education is monitored by the elective home education officer to ensure that children receive a suitable education. The virtual school head teacher also maintains an overview of these arrangements, including home visits.

40. The electronic recording system does not effectively support social work practice and nor does it provide sufficient performance management information. The local authority has recognised this and improvements to the system are being implemented.

41. Social workers spoken to by inspectors had not received training or sufficient information on female genital mutilation. Female genital mutilation has been incorporated into current training and is included in the South West child protection procedures. However, it has not been incorporated into key local guidance. Currently, there have been no incidents of female genital mutilation identified in Torbay.

42. Arrangements to identify and monitor children in private fostering placements are not sufficiently robust. Despite an increase in capacity to respond to private fostering arrangements, the local authority is still not ensuring that the high number of children who travel from abroad to attend language courses receive initial visits within timescales or that their welfare is sufficiently protected. During 2014–15, only a quarter of children received initial visits within timescales.

43. A service level agreement and indicators to measure performance are currently not in place for the emergency duty team. The emergency duty team does not consistently provide an effective response. Children are subject to high usage of police powers of protection. Discussions between the police and children's social care do not consistently take place before the use of police powers of protection; this means that alternative options are not fully considered.

The experiences and progress of children looked after and achieving permanence	Requires improvement

Summary

Outcomes for children looked after in Torbay are not yet good. Permanency planning is not considered for all children at their second review and this has led to delays in securing long-term arrangements. Independent Reviewing Officers have not always been effective in raising concerns.

No cases were found of children entering care unnecessarily. Once risks are identified, thresholds for commencing care proceedings are well understood and applied consistently. Most social workers know the children on their caseloads well and visit them regularly. Good advocacy arrangements are in place.

The quality of assessments and plans for children in care proceedings is mostly good and improving. The quality is more variable for other children looked after, meaning that their needs and exposure to risk are not fully considered.

Children who go missing from care or who are considered to be at risk from sexual exploitation are not responded to consistently and not all missing episodes trigger a return home interview. The quality of some return interviews is poor.

Educational outcomes for children looked after, although improving at Key Stages 1, 2 and 4, are not yet good enough. Their attendance at school is high and through well-considered personal education plans they receive good help and support.

There has been an increase in the number of foster carers recruited and the local authority has a robust and well-targeted placement sufficiency plan, which includes strong commissioning arrangements. There is sufficient choice of placement for children with foster carers and consideration is given to achieving the best match. This has led to good placement stability. Children have good access to education and health services, both within and outside the borough. However, children looked after wait too long to be seen by specialist mental health services.

The newly formed care leavers' team keeps in touch with almost all care leavers and provides helpful information and support. Care leavers are helped to become independent but their pathway plans are not sufficiently comprehensive or ambitious.

Adoption is considered for children in care. However, there are low numbers of adoptions for children older than five years and some children wait too long to be placed with their adoptive families following an agency decision.

Inspection findings

44. Torbay currently has 290 children looked after; this figure is high compared to both statutory neighbours and nationally. Torbay has developed a five-year plan to reduce the number of children looked after through strengthening services for children on the edge of care. However, this strategy has only recently been implemented and has not yet impacted on the overall number of children looked after.

45. Children and young people only become looked after when necessary. However, decisions to look after children and young people are not sufficiently timely. In the vast majority of cases seen by inspectors, opportunities were missed by social workers to intervene earlier for children. Children are left too long in situations of neglect and witnessing domestic abuse, without meaningful work being offered to improve their circumstances. Children often enter care in an unplanned way during a crisis, following a critical event or because the police use their powers to protect children.

46. Arrangements to support children on the edge of care are mostly effective. Children on the edge of care are offered intensive family support, brief intervention therapy and parenting programmes. The service is currently supporting 70 children in 30 families and typically offers a package of intensive support work to families over 16 weeks. However, there is no performance information gathered on a regular basis and managers are therefore not able to evaluate the impact of this work effectively.

47. Most social workers spoken to by inspectors know the children on their caseloads and have clear aspirations for their future. Visits to children, young people and their families take place regularly and children are seen alone by their social workers. Inspectors saw good examples of direct work with children using recognised tools to help them to understand what was happening and to gain their views.

48. At the time of the inspection, 21% of children looked after were the subject of section 20 voluntary placements. While this figure is below the national average of 28%, a significant number of these cases seen by inspectors demonstrate that children's permanency is not sufficiently considered for this cohort of children and young people. Managers are reviewing all of these cases to ensure that the legal status is appropriate.

49. Cases subject to the pre-proceedings phase of the Public Law Outline are effective and monitored robustly. This work is comprehensively recorded on files. Letters to parents setting out concerns are present on most files. However, not all letters include the impact of these concerns on children or set out expectations of what needs to change, so parents may not be clear about what they need to do and by when. Family group conferences are timely and effective and are used frequently to explore if more support is available for

children. Decisions to enter proceedings are appropriately made through legal threshold meetings chaired by senior managers.

50. The quality of social work and evidence put before the court is generally good and improving as a result of increased challenge and scrutiny. Feedback from the judiciary is that there has been a dramatic improvement in quality in the last year. Assessments and plans are comprehensive, well evidenced and completed in a timely way. The views of children and young people are better reflected and considered where appropriate. The employment of an in-house barrister has had a further positive impact on the standard and consistency of reports and plans for children involved in care proceedings.

51. The quality of assessments for children looked after overall is variable; some are thorough, address developmental needs well and capture the views of children. Others are not completed in sufficient detail and do not reflect an accurate picture of need; most lack analysis. Assessments are not routinely updated and much of the information on file is out of date and not reflective of the current situation. Even when circumstances have significantly changed, for example a change of placement, assessments are not updated. While social workers can articulate a clear analysis of risk for individual children, this is not sufficiently reflected in all written assessments. Social workers do not routinely take account of children's histories or consider relevant documents when they are allocated a case. This makes it difficult to get a sense of children's stories or understand their needs and how they can be helped.

52. Chronologies are included on children's files but some have significant information missing and others are too long and descriptive; this makes it difficult to quickly establish the most important events in children's lives.

53. The quality of plans for children is variable. While most children have a plan on their file and some clearly explain expectations and goals and involve children in the process, others lack key information, have no timescales or clear goals or desired outcomes for the child.

54. Reviews of children looked after are timely and ensure that plans are reviewed regularly and the views of children and young people are routinely sought. However, the impact of the independent reviewing officers (IROs) is weak and lacks consistent, purposeful scrutiny of casework and outcomes for children. The quality assurance role of the IROs is not currently effective and lacks focus on constructive challenge and direction when practice is not good. Management arrangements for the safeguarding unit, where the IROs are based, have been inconsistent and this has further hampered improvement in the service.

55. Permanency planning is not routinely considered for all children at their second review and this has led to delays in making plans for a minority of children. IROs do not consistently challenge this lack of timely planning. While an escalation process is in place for IROs to raise concerns about poor practice, drift in casework and subsequent delays experienced by children, this is not

always effective. Inspectors saw case examples where IROs had given specific recommendations to workers in circumstances where children were experiencing delay and these actions were outstanding several months later.

56. While children contribute to their individual arrangements, feedback from children and families on the service they have received is not routinely gathered and does not contribute to service development or to priorities set within the service. Similarly, feedback from families is not gathered by the IROs regarding their experiences throughout the looked after process; this is another important omission.

57. Inspectors saw examples of good advocacy arrangements helping children and parents to share their wishes and feelings in reviews and other complex meetings.

58. The effectiveness of re-unification plans is too variable. Some seen were well planned and considered and children and families were prepared for the return, but other children returned home without thorough preparation and support or contingency planning. When children are not living at home, contact for children with their families is prioritised and generally well organised, with a flexible approach.

59. Children placed outside of Torbay are well monitored and social workers are proactive in ensuring that these children have immediate access to education and health services to help meet their needs. Social workers visit these children regularly and all placements are monitored for quality and value for money by commissioning staff.

60. Arrangements to identify and support children looked after who go missing from home or care or are identified as being at risk of sexual exploitation are not always effective. Some return interviews are completed by a commissioned service and while this provides a good level of independence, information from individual return interviews is not systematically shared with the social worker of the child. This lack of communication does not enable effective assessment and planning for the young person.

61. The health needs of children looked after are prioritised and are well promoted in Torbay. The local authority reports that 100% of initial and review health assessments are completed on time. Similarly, 98% of children looked after are reported to receive timely dental checks. Specialist nurses attached to the looked after children team ensure that referrals to specialist services are made where appropriate. These nurses also ensure that medical information provided to the fostering panel regarding children is of good quality and supports effective decision-making by panel members.

62. Children looked after are experiencing significant delays in accessing a service from Child and Adolescent Mental Health Services (CAMHS). The local authority has recognised the delays and has invested £240,000 on a commissioned

CAMHS service, which currently works with 60 children looked after. Additionally, the local authority has appointed primary mental health workers to provide consultation to any social workers and foster carers who may require advice. In addition, these staff provide dedicated therapeutic input to children looked after. However, demand is increasing and waiting lists are getting longer; children wait up to four months to be seen.

63. The virtual school head teacher closely tracks the attainment and progress of children looked after. The specialist teachers in the virtual school team provide good support to the schools to help children improve their English and mathematics through additional and after school lessons. They also improve the self-confidence of the pupils and the capabilities of the teachers by running 'Thrive' courses that are highly regarded and well received. Educational outcomes for children looked after at primary school are improving at Key Stages 1 and 2; outcomes for children in secondary schools are still too low at Key Stage 4. The proportion of children looked after who gain a minimum of five GCSEs at grades A* to C, including English and mathematics, is low. The gap in attainment between children looked after and other children in Torbay is still too wide.

64. The average attendance of children looked after up to the end of Key Stage 4 was 95.7% in 2014-15. This is in line with the national average and better than the average for other children in Torbay. It is evidence of the effective working and strong partnership between the schools, the virtual school and the attendance officer.

65. In 2014–15 there were no permanent exclusions of children looked after. This reflects the close working relationship between the virtual school team and schools.

66. Approximately 76% of children looked after attend schools judged as good or outstanding by Ofsted. The head of the virtual school and her team monitor the individual placements closely and provide additional support if necessary.

67. All children looked after in schools have a good quality and up-to-date personal education plan (PEP). The PEP has recently been revised and schools find it helpful in providing a clear focus for planning and reviewing the progress of pupils. The voice and views of the pupil are clearly captured, showing how they view their own performance and achievements. The Pupil Premium is appropriately used to provide very specific help.

68. The virtual school head teacher monitors the destinations of Year 11 pupils but currently does not analyse these to inform planning. Transition arrangements for children looked after with the local further education college are good.

69. The majority of children looked after live in good-quality, stable foster placements within 20 miles of home. The focused recruitment drive for in-house carers ensures that there is usually sufficient choice of placement for

children. When children's social workers request a foster placement, they are given a choice of carers with an analysis of what they can offer, which helps them to make good choices of placement for children. Brothers and sisters are placed together unless there is good reason for them not to be, and this is well evidenced through effective assessment.

70. Social workers report that their managers are visible and supportive; they feel valued and listened to and have positive relationships with them. While supervision is regular, the content of supervision sessions is not recorded thoroughly. The majority of files seen by inspectors lacked management oversight, direction and challenge. There is no evidence that managers are giving direction to social workers and holding them to account for poor practice. Caseloads are reported by social workers to be manageable.

71. There is inconsistent practice of how managers use the electronic recording system to record management notes and to store case records. Some key documents could not be found by staff on files. The current electronic recording system does not easily provide managers with key data and management information and managers are therefore not able to maintain a consistent overview of either staff performance or service development. For example, the local authority could not provide information on the number or reasons for foster placement breakdown.

72. Commissioning arrangements for children looked after are robust and well considered. Managers have given consideration to the current and future needs of the service and this is reflected in commissioning plans. This year, the local authority has specifically recruited 47 new foster carers who are able to offer homes for children with challenging behaviour as well as for older children. Additionally, three specialist parent and child placements have been approved; these placements enable vulnerable and high risk families to be assessed within a family setting rather than an assessment unit.

73. The quality of fostering assessments is good. Assessments clearly record carers' strengths and vulnerabilities and include timely decisions and appropriate checks. The quality of assessments and reports presented at panel meetings is improving and is beginning to contribute to more effective matching arrangements for children and young people.

74. The quality of information given to carers about children being placed with them is good and children are well supported at all stages. Foster carers report that bridging placements and moving children on to adoption are handled particularly sensitively by social workers. Delegated decision-making processes are being used appropriately and foster carers spoken to understand the processes and implications of these arrangements.

75. Foster carers were less positive about the support they receive from the local authority for themselves and some felt pressurised into taking children that they felt were unsuitable for their family. Other carers did not feel well

supported when they were going through difficult situations such as complaints. Foster carers spoken to reported that support groups are often cancelled and that social workers cancel visits. Carers reported significant variability in the quality of social workers and felt that managers did not ensure consistently high standards. One foster carer commented that, 'Social workers do what they want and there are no consequences; some are absolutely brilliant and others do not do a good job.'

76. The 'Thrive' programme, which helps to develop skills in promoting attachment behaviours in children, provides foster carers with a consistently high quality level of support and guidance and this is reported by foster carers to have contributed to preventing some placement breakdowns and improving outcomes for children looked after.

77. The corporate parenting board is a committed and passionate group of elected members who involve young people from the children in care council in recruitment of senior staff, in commissioning of services and in celebration events. While the corporate parenting board has good relationships with senior managers, arrangements to scrutinise and challenge performance across the service are under-developed and do not lead to ongoing improvements.

The graded judgement for adoption performance is that it requires improvement

78. Delays in initiating care proceedings and variability in timeliness of work have led to some children not being placed in adoptive families in a timely manner. Practice around early permanence is substantially under-developed. While there are policies in place with regard to fostering to adopt and concurrency arrangements, these are not routinely considered by social workers and as a result, some children are potentially being denied the benefits of such placements. Adoptive families do not have the information on which to base decisions as to whether such arrangements are suitable for children placed with them. The local authority has recognised areas where improvements are necessary but has yet to consolidate these findings in an improvement plan.

79. While some areas of adoption timeliness are improving, children have waited too long before going to live with adoptive families. Recent performance against the adoption scorecard for 2014–15 shows an improvement in timeliness; data for the last year indicate the average time between children entering care and moving in with their adoptive family was 432 days. Data also indicate the average time between a placement order and matching for the local authority is improving and for 2014–15 was 201 days. While this timeliness has improved from 245 days in the previous year, this still exceeds the threshold target of 121 days.

80. Arrangements to consider adoption for children who are aged over five years are not well embedded in Torbay. Of the 47 children who were either adopted or placed for adoption in 2014–15, only four were aged over five years. All of these children had an agency decision for adoption made before they were five.

81. Comparatively few children looked after in Torbay are placed for adoption. Between April 2014 and March 2015, 15% of children looked after were adopted. This performance is below the England average of 17% and the statistical neighbour average of 24.2%. In the past year, 24 adoption orders have been granted and at the time of the inspection, three children were awaiting placement orders following an agency decision for adoption.

82. The annual report of the adoption panel identifies that the authority matched 29 children between September 2014 and September 2015, with 17 single placements and six placements of brothers and sisters. At the time of the inspection, the local authority had four children who were the subject of placement orders who had not yet been matched. The local authority has identified potential adopters for all these children.

83. The Chair of the adoption panel is very experienced and highly knowledgeable. The panel provides adequate scrutiny and challenge. The Agency Decision Maker provides prompt scrutiny of panel recommendations and ensures that children are appropriately matched in a timely manner with a family which meets their needs. However, in the past year, there have been seven children who have had a change of plan from adoption. All these children were aged five or over. The rationale for such a change of plan was not clear in a significant number of cases seen by inspectors, particularly where decisions were being made from a change of plan to adoption to long-term fostering. The local authority has recognised the need to review its permanency policy to provide clarity around permanency decision-making for children, and ensure that adoption is considered at a much earlier stage where appropriate for older children.

84. While in the majority of cases seen by inspectors there was evidence of active family-finding once a decision for adoption had been made, this was not consistent.

85. The quality of child permanence reports varies from requiring improvement to good. The local authority had identified this as an area for development and as a result held a training day in order to improve consistency and quality. Arrangements to quality assure permanence reports have been recently strengthened and very recent examples are of more consistent and higher quality.

86. Children are effectively prepared for adoption with careful planning of the introduction process. Examples were seen by inspectors of good direct work being undertaken with children to assist them to understand the process and to develop a secure attachment with their adoptive parents. This work ensured

that children's wishes and feelings were comprehensively understood and considered. However, in a small minority of cases, this process had been hampered by a change of social worker at a critical point in a child's journey, when a placement order was made.

87. Adopter recruitment is at a low level for potential adopters for older children. In the past year, there were only six new approvals of adopter families at panel. Currently, the service has only five assessments ongoing. Assessments have mostly been completed in a timely manner with minor delays outside the service's control. The reasons for any delay are clearly recorded. The authority has effective recruitment arrangements with Adopt South West and the South West Adoption consortium, with a rolling programme of information evenings.

88. The local authority has no clear recruitment strategy to ensure that it is in a position to meet the future projected demand for adopter families, particularly in ensuring that they are in a position to offer placements for brothers and sisters and older children. While current levels of family finding are low, the high number of care proceedings the authority has initiated indicates that future activity levels may be higher; this may leave the authority vulnerable to an increase in future placement demand. The authority currently has six adoptive families who have been approved and are awaiting a match. Two of these families were approved in 2014 and four in 2015.

89. The local authority offers a comprehensive range of adoption support both pre- and post-adoption order. There is an impressive commitment to adoption support which is reflected in the low level of disruption activity. There has been only one placement breakdown in the past year, prior to an adoption order being made. Families spoke positively to inspectors about the range and quality of support offered. Families particularly highlighted the therapeutic parenting course, reporting that it gave them a greater insight into their child's behaviour. In addition to training provision, there are a number of support groups for adopted young people, adoptive parents and birth parents, all of which have received positive feedback.

90. Efforts are made to ensure that contact is maintained with brothers and sisters where this is in the child's best interests. 'Letterbox' contact is effectively promoted by the local authority and ongoing advice to carers is offered in relation to contact with birth and adoptive families.

91. Life story books seen by inspectors were of a good quality. They were engaging for children with a good 'narrative' that details their journey into care and to adoption. Later-life letters were also of a good quality and comprehensive, enabling children to fully understand the circumstances leading to their adoption, as they get older.

The graded judgement about the experience and progress of care leavers is that it requires improvement

92. The staff in the care leavers service are in touch with 162 (96%) of their 169 current care leavers. Of these, they have updated information on five and there are only two care leavers about whom they do not have any current information. This is an improvement from 2013–14, when the local authority reported that they had no information on about 27% of their care leavers.

93. Cases were seen of workers who provided children looked after with sustained support and care. This included calling young people daily to check on their progress and making sure they had attended appointments, helping them to secure jobs, apprenticeships and housing. Good examples were seen of social workers giving practical support such as helping young people move house and emotional support such as offering mediation work to a young person and her foster carer when they were experiencing difficulties in their relationship.

94. The practical help and emotional support from personal advisers enables many care leavers to develop independence and acquire emotional resilience in coping with personal difficulties. Personal advisers are supportive and proactive in ensuring that care leavers receive appropriate medical and health attention for their needs.

95. Care leavers know about the help to which they are entitled but this information is too frequently communicated to them informally, without suitable checks on whether they have received the full range of information and their entitlements.

96. The recent move of the care leavers' service to a more central and accessible location has been a positive step and has enabled improved access arrangements for care leavers to visit the team. Care leavers are already making more use of professional services such as a care leavers' nurse, and mental health professionals. The new location for the team also provides increased opportunities for meeting together, socialising and expressing their views in a safe forum.

97. There are good arrangements and highly productive links with the local further education college to provide suitable courses for care leavers. These courses are often tailored to helping them gain or improve their English or mathematics skills and qualifications. Other programmes help care leavers to improve their qualifications and develop the skills needed to gain employment and progress in education or training.

98. A survey in January 2015 of young people that included all care leavers showed that they are aware of the risks and dangers of child sexual exploitation and how this might affect them. Care leavers who go missing are identified and receive a timely response to their needs of help and protection. Risks are

mostly identified in a timely way and while risk assessments seen by inspectors varied in quality, all were at least adequate.

99. No care leaver is currently in accommodation deemed as unsuitable. Only two care leavers were placed in temporary emergency accommodation and this was on a very short term basis. Care leavers receive appropriate help in finding suitable accommodation. Checks are made to ensure the accommodation is safe and that young people feel secure. However, once the details have been recorded on the information system, follow-up checks for any possible issues are not systematically made.

100. Quality assurance mechanisms to ensure that care leavers receive consistently high quality support and guidance are under-developed and there is no formal process in place to evaluate performance across the service. The quality in the services being provided to care leavers varies too greatly and it is too dependent on the help and advice provided by individuals such as personal advisers.

101. The organisation and management of care leavers' services to date has not contributed effectively enough to raising the aspirations of care leavers and broadening their horizons. There is little evidence of how well or actively care leavers are encouraged to participate in Torbay's user surveys or other forums for user groups.

102. Preparation for their next steps is not structured or planned well enough around young people's circumstances; arrangements to help care leavers make a smooth transition to becoming responsible and active citizens do not contribute sufficiently well or significantly to helping care leavers improve and develop themselves.

103. Pathway plans record essential information such as checks on health and safety, accommodation and physical health. However, they do not use the views of care leavers to make improvements or to record the effectiveness of the process of decision-making and planning. The targets and timescales in records and plans are not clear or well-defined. For example, behaviours and issues such as drugs and alcohol are recorded clearly but the plans do not indicate what actions might be taken that could lead to curbing or addressing these behaviours.

104. Nearly all the 25 pathway plans reviewed fail to take proper account of next steps and longer-term aspirations; they do not record whether the young person has received advice and guidance and there is no monitoring of actions agreed. They do not record adequately educational achievements, in order to enable reflection and improvement.

105. Currently, care leavers do not receive well-considered, timely advice and guidance in a formal way for both academic and personal development at different stages and phases of their education or chosen employment routes.

They have to rely too much on information from informal and casual sources rather than more expert or informed professionals.

106. The development and provision of health passports has not been undertaken with sufficient rigour and urgency to make a positive difference. Although care leavers have been involved in the design and production of the forthcoming health passport, the use of their views to improve the service to care leavers is under-utilised, such as in the commissioning of suitable and high quality accommodation.

107. Positive attainment outcomes for care leavers are too variable. The local authority currently does not collect detailed information on destinations of former care leavers in training or employment. At present, only one care leaver is on an apprenticeship programme. This is in spite of the fact that the local authority has made available 14 places for care leavers to take up apprenticeships, but attempts to recruit have been unsuccessful.

108. The service recognises and celebrates the achievements of care leavers positively at an end-of-year awards ceremony. The care leavers' service is working with current young people to involve them further in organising similar celebratory events.

109. About 22% of care leavers are not in education, employment or training; this figure is lower than the national average for care leavers (39%). However, about 66% of care leavers, numbering 111 young people, are in full- or part-time education or training.

110. The number of care leavers progressing to higher education is low; currently 11 former care leavers are studying in higher education. However, one former care leaver supported by the local authority gained his Law degree this year.

Leadership, management and governance	Inadequate

Summary

Leadership, management and governance are inadequate. The local authority has been ineffective in prioritising and challenging the quality of practice, in particular with children in need of help and protection. Senior leaders have introduced new initiatives and progressed a range of projects, but in doing so they have lost focus on ensuring good quality frontline services to children and families.

Performance information is unreliable and therefore senior managers and elected members are unable to use data and information effectively to improve the quality of services. Local authority audits have been based on findings from an audit tool which has not been fit for purpose. This has led to an over-optimistic impression of the quality of social work and weaknesses in practice have not been sufficiently identified and acted upon. The local authority has been slow in developing effective performance monitoring to analyse performance and to drive improvement.

Management oversight of cases has not been rigorous enough to ensure that risks are identified and managed and that services are of a good quality. Social workers spoke highly of the support and availability of their line managers but there is little evidence of challenge within supervision records. The lack of challenge and lack of urgency to address poor practice are themes across children's services, although slightly less so for children looked after.

Senior leaders have not exercised sufficient management oversight and scrutiny over new services such as the MASH and the single assessment team. Insufficient levels of staffing in the MASH, lack of training and supervision have led to an inadequate service with delays in children being seen and risks not properly assessed. Improvements in early help services are now being driven forward but only recently have assessments and plans been introduced.

Not all actions from previous inspections have been addressed, such as the provision of services for perpetrators of domestic abuse. This is significant in Torbay where domestic abuse features highly in cases held by children's services.

The local authority has developed relationships with partners and strategic boards with priorities for children and families aligned. However, this has not had an impact on practice at the frontline.

Improvements across children's services have been made in relation to the reduced and manageable caseloads, the introduction of the MASH, the implementation of the new social work model and increased social work capacity, as well as improving the early help offer in Torbay.

Inspection findings

111. Senior leaders and managers have not sustained quality services for children and families due to failures in oversight of practice, the use of unreliable data and the lack of urgency in challenging and driving forward improvements. High turnover within the senior leadership team over several years, combined with inconsistency in management style, sickness absence and ineffective challenge throughout the organisation, have adversely affected the speed and effectiveness of improvement.

112. The local authority does not understand its effectiveness, due to the unreliability of performance information. The local authority has been slow in developing monthly performance monitoring to help managers and leaders understand and use data. Until September 2015, managers had not systematically analysed performance data or effectively identified areas for improvement across the service.

113. The local authority self-assessment and audits demonstrate that the local authority is aware of areas for improvement but it has not shown sufficient urgency to address these deficits. Not all actions from previous inspections have been addressed. For example, the 2013 inspection recommended that all plans should have measurable outcomes, the health and wellbeing strategy should contain actions and timescales, and services for domestic abuse perpetrators should be developed; all have yet to be achieved.

114. The local authority recognises the deficiencies of the electronic recording system in producing reliable data, and during the inspection struggled to provide some basic information. While a management dashboard is being created to provide managers and leaders with more accurate data regarding individual team performance, this is not yet in place.

115. Quality assurance processes are significantly under-developed in Torbay. The local authority identified during the inspection that its own auditing tool was not fit for purpose. This tool has led to the local authority gaining an over-optimistic impression regarding the quality of social work, as many local authority audits rated as good were judged by inspectors as requiring improvement and some were inadequate. This means that weaknesses in practice have not been sufficiently identified and acted on. Despite having a quality assurance framework in place, managers and supervisors are not clear about what is expected of them in how to complete audits.

116. The local authority has completed a number of thematic audits where findings are reported to staff via a quality assurance newsletter. Learning from audits is communicated to staff but there is no indication of action plans being formulated by managers to drive forward improvements. For example, a thematic audit of children on child protection plans looked at 12 cases and found that 10 had been subject to previous referrals. This key finding had not led to a further investigation of repeat referrals in the service.

117. Management oversight of the service has not been sufficiently rigorous and has not ensured that risks are identified and managed and that services are of a good quality. Case supervision notes on the electronic recording system are regular but most are brief, do not set timescales and do not challenge workers about practice. Inspectors have seen child in need cases closed, for example, where meetings have not occurred regularly and risks have not been adequately addressed, but they contain no comments or actions from managers.

118. Leaders have shown ambition to improve services with the introduction of the MASH, the single assessment team and a new casework model. However, the focus on initiatives has resulted in the local authority not assuring itself that frontline services are safe and effective. For example, the MASH is not yet operating effectively and there are not yet sufficient numbers of staff who are trained and supervised regularly to ensure that this team performs well.

119. Inspectors have seen cases, particularly in help and protection, where risk has not been adequately identified and assessed. There have been delays in seeing children and the quality of assessments and plans has been variable. When actions have been taken to improve practice, such as introducing the new casework model, the local authority has not provided sufficient training, supervision and oversight of practice to assure itself of an improved service for children and families. The coordination and delivery of early help services have also lacked effective oversight, scrutiny and drive to deliver improved and coordinated preventative services in Torbay.

120. Across the service, there are strategies, policies and procedures that are in draft or have been revised in line with the improvement plan timescale and during the course of the inspection. As a result, consistency in practice and focus in some areas has not yet been achieved. For example, the MASH operational procedures have not been signed off despite the MASH going live in March 2015. The 'youth homelessness multi-agency pevention protocol' and practice guidance on children and young people missing from home, care and education remain in draft. Services such as adoption do not have an adoption carer recruitment strategy in place. While the current leadership team is ensuring that staff are provided with a clear framework of expectations to work within, this has not yet been embedded and as a result, the outcomes are not evident.

121. There are appropriate arrangements for local authority senior managers, leaders and elected members to discharge their individual and collective responsibilities. There is now evidence of challenge between the Chief Executive, DCS, LSCB chair and the lead member and this is beginning to have an impact in some areas of the service. The Chief Executive is clearly focused on establishing a consistent, robust and challenging leadership team to deliver the improvement agenda in a timely manner. Individuals participate in strategic boards such as the Health and Wellbeing Board and LSCB and there is evidence

of partnership working with priorities aligned, but this has not yet had an impact on practice at the frontline.

122. Senior leaders and managers have been working with partners to develop the Social Work Innovation Fund Torbay developments. A public services trust has been established with police, probation, health, education and the voluntary sector to pool budgets and develop services. This will develop an integrated care organisation between hospitals, community-based health and adult social care and with a proposal for children's social care to be integrated in 2017. These are recent developments and the impact of this work has yet to be seen.

123. The lead member is new in post and is assisted by an experienced and enthusiastic group of elected members. The corporate parenting board is clear about what it wants to achieve for children looked after and care leavers and has established links with the children in care council. Board members know the local authority's strategic plans well and the priorities of the corporate parenting strategy but could not explain to inspectors how they hold senior managers to account for lack of progress. Their scrutiny and challenge of senior managers therefore lacks rigour.

124. The joint strategic needs assessment (JSNA) and a range of other data inform the commissioning of services. The JSNA gives a good overview of the local community and its needs but has out-of-date information on children looked after, on which to base service planning. A joint commissioning team has been in operation since June 2015 and during the inspection updated the 'Children's commissioning plan and sufficiency strategy 2014–2019' to ensure that all service areas are covered. The updated document continues to lack specificity and actions on some key areas. For example, the document sets out what domestic abuse services offer but does not address the lack of services for domestic abuse perpetrators, which is a known service gap and one highlighted at the 2013 inspection.

125. The local authority has an effective workforce development strategy which contains a workforce profile, recruitment and retention, success measures and information for specific groups, such as entitlements for newly qualified social workers. The local authority's employment of agency staff has reduced from 45% in 2012 to a current figure of 23%. This falls short of the target figure of 5% but the local authority ensures that vacant posts are filled by agency workers while permanent staff are recruited. Due to an increase of 10 new posts, the current vacancy rate is 23%. About 40% of the workforce are in their first or second year of practice and managers have taken steps to protect caseloads and mix new and experienced workers in teams.

126. The local authority's focus on staff development and retention has led to staff remaining with Torbay for an average of seven years. The local authority uses a talent management programme to develop and to mentor new managers, which has led to 10 individuals being placed in secondment opportunities this year. The local authority has had success with a 'grow your own' programme to

support staff in gaining a social work qualification and take student placements, which have led to these students taking up permanent appointments. However, the turbulence within the senior management team over several years has meant that staff have not had consistent messages about what is expected of them.

127. The local authority collaborates with other local authorities in the South West on staff recruitment, retention and delivery and support of post qualification training. A range of face-to-face and e-learning courses is available to staff members and learning from audits and complaints is disseminated to staff via bulletins and practice discussion. Training courses are evaluated at the time of the course and one month later, but learning from training courses is not followed up in supervision sessions to examine how staff practice has developed.

128. Leaders gain knowledge of frontline services by regular meetings with social workers. The DCS has led social work forums to hear directly about practice issues. Feedback from social workers has been listened to and acted on, for example, regarding the need for more direct time to be spent with families. This has resulted in a pilot project giving additional administrative support to social workers. This direct contact with frontline staff gives leaders a snapshot of frontline services, but the lack of accurate data means that they do not have a clear picture of performance.

129. Case sampling shows that improvement is still required in key areas such as producing clear written plans. The effectiveness of initiatives is not followed up with children and families to assess the impact of changes of practice. The local authority has gained some feedback from the children in care council and can demonstrate learning from complaints, but gaining regular service user feedback is under-developed.

130. A supervision policy is in place that sets out the purpose, frequency and areas of discussion between staff and managers. Most supervision files seen contained brief recordings, did not demonstrate reflective practice or challenge and there was a variation in frequency. Some new staff had not had supervision for several months, despite being new to the role and to the local authority.

131. Arrangements to investigate allegations of abuse or poor practice by professionals are not sufficiently robust. Thresholds for referring to the designated officer are not well embedded or understood across the partnership and learning identified from cases is not used to inform training or raise awareness across partner agencies. Where awareness raising has taken place, an increase in referrals has followed.

The Local Safeguarding Children Board (LSCB)

The Local Safeguarding Children Board is inadequate

Executive summary

The Torbay Safeguarding Children Board (TSCB) is judged inadequate because it does not currently discharge its statutory functions. The TSCB does not effectively fulfil its core functions to assess the effectiveness of the help being provided to children and families, including early help. The TSCB does not have robust multi-agency performance information, an up-to-date and overarching business plan which has been signed off by the Board, or an annual report for the period April 2014 – March 2015, to outline and evaluate the range of safeguarding work that needs to be progressed. The TSCB has very limited mechanisms in place to understand the voice or experience of the child.

Improvements to safeguarding practice have been slow to develop and there are considerable delays to address key deficiencies, particularly in services for neglect and domestic abuse. Apart from child sexual exploitation, the focus on local priorities has been limited. The key function of monitoring of thresholds across Torbay has not been undertaken in sufficient depth to understand or effectively evaluate current practice. Evaluation and oversight of early help services have not been sufficiently effective. The impact of this for children and families and the extent of the problems have not been fully recognised.

The TSCB and executive board are appropriately constituted and meet regularly. Recent improvements to the sub-groups since May 2015 have had very limited impact. Quarterly themed multi-agency audits have been improved to ensure more breadth and regularity. The section 11 audit process has been improved in 2015 to provide more rigour and impact. Apart from child sexual exploitation, there has been little evidence of changes to frontline safeguarding practice as a result of these processes.

Safeguarding training, appropriate policies and procedures and the dissemination of safeguarding practice across the partnership is in place. Best practice forums are positively regarded by practitioners. Improvements are required to evaluate the impact of training and to update key documents.

The Child Death Overview Panel processes are appropriate. Two serious case reviews have been published in relation to Torbay in the last year and relevant issues and learning from these have been identified by the TSCB and appropriately disseminated to the children's workforce.

Recommendations

132. Produce an effective multi-agency performance data set and report, and an up-to-date annual report that provides a rigorous and transparent assessment of the performance and effectiveness of local services that provide help for children and young people (paragraphs 140, 143, 158).

133. Monitor and evaluate the effectiveness of early help services (paragraph 144).

134. Ensure that partners monitor the application of thresholds for intervention consistently and robustly across Torbay (paragraph 152).

135. Ensure that mechanisms to gather the experiences and views of young people and families in Torbay regarding safeguarding practice are introduced and that learning from this contributes effectively to the development of the work of the TSCB (paragraph 155).

136. Strengthen the monitoring and evaluation of services in relation to domestic abuse and neglect so that it is clear where improvements are needed (paragraph 156).

Inspection findings – the Local Safeguarding Children Board

137. The TSCB is judged inadequate because it does not discharge its statutory functions.

138. The core functions of the TSCB, to assess the effectiveness of the help being provided to children and families including early help, and the mechanisms to assess and evaluate whether partners are fulfilling statutory obligations, are not robust. While arrangements to quality assure practice and to monitor the effectiveness of training to safeguard and promote the welfare of children are in place, these are under-developed. There is insufficient impact or progress to the improvement of safeguarding practice across Torbay.

139. The main board and the executive board are appropriately constituted, and both are regularly attended by partners. Since May 2015, with the appointment of a business manager, there has been recent improvement made to the sub-groups to embed, monitor and increase the scope of safeguarding work undertaken. The serious case review sub-group, which had been joint with another local authority, reverted to a Torbay specific sub-group in July 2015. Other sub-groups such as the training sub-group and the Peninsula Child Death Overview Panel (CDOP) are working appropriately.

140. The TSCB does not have an overarching, clear, up-to-date and agreed business plan to outline the range of safeguarding work across all the relevant sub-groups that needs to be improved or progressed. There is no annual report for 2014–2015 and outstanding priorities from the annual report of 2013–14 such as further developing and fully embedding the voice of the child into the work

of the TSCB, and improving the multi-agency data set, are not in place. This means that there is no current comprehensive overview of the quality and impact of services delivered to children and families in Torbay.

141. There are established links between the TSCB and strategic partners. The chair of the TSCB attends key board meetings and has used his influence to align safeguarding priorities with the appropriate strategic board. However, the TSCB acknowledges that this work has still to show an impact on practice at the frontline.

142. The TSCB has set local priorities with partners and these are linked to issues arising from serious case reviews, previous multi-agency case audits and an understanding of local need. These include neglect, children looked after, domestic abuse, child sexual exploitation and 'Think Family'. Apart from child sexual exploitation, the implementation of these priorities has been slow, with limited impact or progress in these areas to date. For example, the neglect strategy has not yet been completed, although work is underway in partnership with the Health and Wellbeing Board. The graded care profile assessment tool is not fully embedded, and services to address domestic abuse have not been put in place.

143. The TSCB has limited ability to monitor and evaluate frontline practice effectively, or hold partners to account, as there is not a sufficiently detailed and relevant multi-agency performance information data set in place. Systems to routinely engage with young people and their families are not embedded.

144. The TSCB has not monitored the effectiveness of early help appropriately, or understood the issues affecting operational practice. Despite it being identified as a priority area in 2013–14 and audited in June 2014, practice or performance have not been consistently audited or scrutinised by the TSCB since then. Delay in prioritising early help is evident. For example, multi-agency auditing was postponed from July 2015 to January 2016 and feedback to the TSCB has been postponed from September 2015 to November 2015. The focus of work has been on launching the early help strategy (April 2015), implementing systems and processes, such as launching a referral form and producing step down guidance, and for partners to identify representatives to sit on the early help panel.

145. The impact of challenge between by partner agencies is limited. Challenge by the independent chair in June 2015 has led to recent improvements, for example the improved attendance of health professionals at initial child protection conferences, adult mental health workers attending strategy discussions and agencies better fulfilling their safeguarding duties via section 11 audits. However, a challenge log is not in place to underpin the positive relationships and engagement between partner agencies that are developing.

146. Partners report a commitment to ensure that children are safeguarded. The section 11 audit process is completed by partners on a south-west peninsula-

wide basis. During 2015, the TSCB started to focus on improving the process to ensure that more rigour and impact are in place. For example, partner agencies were invited to attend events to present their findings. Challenge from the independent chair regarding agencies that were found not to be compliant was evident. A task and finish group has been initiated to ensure that the audit process will have a sharper future focus and is sufficiently localised to be relevant to practice in Torbay.

147. Partner agencies contribute towards an appropriate TSCB budget.

148. The learning and improvement framework, written in 2013, is currently being reviewed on a peninsula-wide basis, to ensure compliance with statutory guidance. Effective communication of safeguarding practice via the TSCB website and newsletters is in place. Staff spoken to during the inspection were appropriately aware of the TSCB. Best practice forums are held regularly and are well attended by partner agencies and used to disseminate key information about safeguarding practice including issues arising from serious case reviews, case audits and section 11 audits.

149. Serious case reviews (SCRs) are appropriately initiated and acted upon. Two SCRs have been published in relation to Torbay in the last year and the issues from these have informed multi-agency audits and have led to identified areas for improvement and progression across partner agencies. Learning has been appropriately disseminated to the children's workforce.

150. Child Death Overview Panel processes are appropriate and have improved scrutiny and categorisation of modifiable deaths across the south-west peninsula area from 14% to 26%. The mortality rate in Torbay is lower than the national average. There has been recent clarity sought with public health officials in order to ensure that tight processes for disseminating relevant information back to TSCB are in place.

151. The TSCB has accessible safeguarding policies and procedures in place via the regional south west peninsula group. These are currently being recommissioned for further improvement.

152. The monitoring of thresholds by the TSCB has not been sufficiently rigorous or purposeful. The impact on children and their families of poorly understood and applied thresholds for intervention has not been identified. Partners report that the updated threshold document is improved, but understanding by professionals is still variable. The development of the MASH is in its early stages, and for children and families there is no consistency in the response provided to them.

153. The TSCB has prioritised child sexual exploitation during 2015. Findings from the child sexual exploitation audit in April 2015 have been influential in progressing safeguarding practice in this area, and this has had a positive effect on frontline practice. Following this, a specific TSCB event was held to

disseminate learning and to highlight areas for improvement. The child sexual exploitation sub-group is working effectively and links to the wider peninsula group to ensure that all learning and systems are in place. A child sexual exploitation coordinator has been a valuable asset to the progression and implementation of the child sexual exploitation strategy across partner agencies and partners reported positive progression and that responses on the ground are more effective as a result.

154. Appropriately themed multi-agency case audits (MACAs) are linked to local priorities and happen quarterly, having improved from a low base two years ago. Appropriate involvement of partner agencies is in place. Despite regular feedback to the TSCB, there is little evidence that the MACAs have had any significant impact in changing safeguarding practice across Torbay, with the exception of child sexual exploitation and the initiation of a focus on early help across partner agencies.

155. The TSCB has not properly engaged with young people or families to ensure that their understanding and experience of safeguarding services informs the work that it does. This is still in development despite this being a priority for the TSCB in 2014–2015. No established links are in place between the TSCB and existing children's groups or youth groups. The multi-agency audit process includes questions for children and young people and families, but this is not fully effective. The TSCB quality assurance sub-group has recently set up a task and finish group to look into this.

156. The TSCB has influenced the planning and commissioning of services but the impact of this on safeguarding practice is limited. Think Family, children looked after, neglect and domestic abuse are areas of previous TSCB focus, that have now become priorities for the relevant strategic boards. There has been no evidence yet that this influence has led to any improvements in the effectiveness of safeguarding practice.

157. Relevant safeguarding training is commissioned appropriately and is well supported by all partners. Staff attendance at training is good, particularly by health partners. The evaluation of the quality and impact of training is not well developed. This is being addressed to ensure that appropriate staff capacity is in place.

158. The annual report has not been updated for 2014–15. Therefore, there is no recent evidence of a rigorous and transparent assessment of the performance and effectiveness of local services since March 2014. A draft business plan 2015–16 is available, with five new well-targeted priorities now set following a discussion at the TSCB in June 2015.

Information about this inspection

Inspectors have looked closely at the experiences of children and young people who have needed or still need help and/or protection. This also includes children and young people who are looked after and young people who are leaving care and starting their lives as young adults.

Inspectors considered the quality of work and the difference adults make to the lives of children, young people and families. They read case files, watched how professional staff work with families and each other and discussed the effectiveness of help and care given to children and young people. Wherever possible, they talked to children, young people and their families. In addition the inspectors have tried to understand what the local authority knows about how well it is performing, how well it is doing and what difference it is making for the people who it is trying to help, protect and look after.

The inspection of the local authority was carried out under section 136 of the Education and Inspections Act 2006.

The review of the Local Safeguarding Children Board was carried out under section 15A of the Children Act 2004.

Ofsted produces this report of the inspection of local authority functions and the review of the local safeguarding children board under its power to combine reports in accordance with section 152 of the Education and Inspections Act 2006.

The inspection team consisted of seven of Her Majesty's Inspectors (HMI) from Ofsted.

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