Torbay Council

Re-inspection of services for children in need of help and protection, children looked after and care leavers

Inspection date: 11 June 2018 to 5 July 2018

Report published: 24 August 2018

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	Good
	2.2 Experiences and progress of care leavers	Requires improvement
3. Leadership, management and governance		Inadequate

Executive summary

Children's services in Torbay are inadequate. Some improvements have been made, but not enough, and all judgements from the 2015 Ofsted inspection apart from the adoption judgement are unchanged. The quality of practice ranges across and within services, from areas showing serious weaknesses, such as fostering, to pockets of strong, focused work, such as early help. Overall, the pace of change has been too slow and some recommendations from the previous inspection are not met. Fundamental weaknesses remain in management oversight and supervision and in identification of and response to risk, as well as workforce development and capacity.

The quality of performance data has improved since the last inspection, but managers at all levels do not demonstrate understanding and urgency to take action when practice weaknesses are evident. Performance data is not fully developed for all service areas. Only recently, has performance data for the fostering service been collated that shows significant concerns around practice. A third of carers have not had an annual review, a large number have not had an updated medical check and half of the carers have not completed their training, support and development standards. This demonstrates failure to understand a significant service area, poor management grip to ensure regulatory compliance and lack of attention on how foster carers can best meet the needs of children.

Quality assurance arrangements are underdeveloped. The quality of audits is improving but few audits are carried out. Feedback on lessons learned is unsophisticated and does not link with staff training and re-auditing. Staff training in some important areas such as around child sexual exploitation is over reliant on online learning, which means that opportunities for discussion and sharing ideas with other professionals are missed. Similarly, learning from complaints is not well analysed or used to improve practice.

Political support and financial investment in children's services are showing some improvements. Links between the chief executive, lead member and the DCS are strong and lines of accountability are well established. The workforce is becoming more stable, and extra agency staff, over and above 'establishment', have been employed to cover staff absence and ensure that caseloads reduce. Inspectors met some very skilled and committed social workers. The workforce development strategy includes some incentives to attract staff, but leaders do not routinely conduct exit interviews to understand the reasons why social workers leave. This is a missed opportunity.

Services for children and families in need of help and protection have not improved enough from the inadequate judgement of 2015. Risks of long-term chronic neglect or domestic abuse for some children are not recognised or addressed soon enough. Staff spoken with did not have a thorough understanding of the local authority's own strategies in these important areas of work and therefore they are not fully informed about local practice and resources. In a small number of cases, child protection

medicals were not pursued, despite children's disclosures of physical abuse. This means that children are not listened to and the extent of their injuries are unknown.

The quality of social work practice is adversely affected by frequent changes of social workers, all of whom are dealing with a range of complex cases. For example, visits to some children do not adhere to recommended timescales. The quality of assessments and plans are poor, and, until very recently, legal action has not been instigated soon enough to remove some children from risk of harm. Management oversight regarding 16- and 17-year-old homeless children did not identify that 12 of these children should have been given the option to become looked after. Some managers attending multi-agency risk assessment conferences (MARAC) do not provide up-to-date information. This leads to delays in planning for children living with high-risk domestic abuse. Supervision records do not demonstrate challenge to these examples of poor practice.

Some improvements have been made in help and protection services, such as decision-making in the multi-agency safeguarding hub (MASH) and the development of effective early help services. Improvements are also evident in both the disabled children's service and emergency duty service, which provide a robust response to immediate safeguarding concerns.

Most children looked after live in stable placements. Children develop trusting relationships with their carers, but relationships with social workers are more fragmented due to frequent changes of worker. Placements are well supported by child and adolescent mental health (CAMHS) workers, who provide direct work or consultation to professionals and carers. Children's health needs are mostly well met and children make good educational progress up to key stage 2, but this declines up to key stage 4. There are insufficient numbers of foster carers, and a small minority of children live more than 20 miles from Torbay. Although these children are away from their home area, their needs, including contact, are well met.

Permanence is not secured soon enough for many children awaiting formal approval for long-term fostering or special guardianship orders (SGO). Connected persons carers are not identified early enough in some cases, because there is a lack of exploration of family options. This leads to delay.

The adoption service is good. Permanence is considered early and there are increasing numbers of children living in fostering for adoption placements. This means that children are not disrupted by changes of placement, and attachments are developed much sooner. The numbers of children adopted are on a rising trajectory, but there are few children adopted over the age of five years. Adopters are well prepared, assessed and supported. Children are well prepared for adoption, but life story work starts too late in the process for children to learn and understand about their birth family and history. Care leavers value the support from personal advisers. The local authority reports that it is in touch with all its care leavers and most live in suitable accommodation. The corporate parenting board has agreed an exemption from council tax for care leavers, and an apprenticeship scheme within the council has been developed and promoted. There is an energetic Children in Care Council

known as 'Cic' club. They regularly meet with corporate parents, and children are consulted regarding their views on services and their development. The achievements of children looked after are celebrated.

Contents

Information about this local authority area[1]

Previous Ofsted inspections

- The local authority operates no children's homes.
- The last inspection report for the local authority's children's services was published in January 2016. The judgements for the local authority were:
  - overall effectiveness: Inadequate
  - children who need help and protection: Inadequate
  - children looked after and achieving permanence: Requires improvement to be good
    - adoption performance: Requires improvement to be good
    - experiences and progress of care leavers: Requires improvement to be good
  - leadership, management and governance: Inadequate.
- Ofsted carried out four monitoring visits where letters were published between January 2017 and March 2018. These visits focused on various aspects of the inspection framework. Monitoring visits do not result in inspection judgements.

Local leadership

- The director of children's services (DCS) has been in post since July 2016.
- Agreement was reached in April 2018 that Torbay Council should enter a contractual agreement with Plymouth City Council. The DCS for both Torbay and Plymouth will take over responsibility for both councils following the Torbay re-inspection.
- The chief executive has been in post since August 2013.
- The chair of the LSCB has been in post since March 2016.
- The local authority uses the 'Signs of Safety' model of social work.

Children living in this area

- Approximately 25,400 children and young people under the age of 18 years live in Torbay. This is 19% of the total population in the area.
- Approximately 24% of the local authority's children are living in poverty.
- The proportion of children entitled to free school meals:
  - in primary schools is 18% (the national average is 14%)

[1] 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.

- in secondary schools is 12% (the national average is 13%).

- Children and young people (pupils) from minority ethnic groups account for 5% of all children living in the area, compared with 31% in the country as a whole.
- The largest minority ethnic group of children and young people in the area is mixed.
- The proportion of children and young people with English as an additional language:
  - in primary schools is 5% (the national average is 21%).
  - in secondary schools is 5% (the national average is 16%).

Child protection in this area

- At 31 May 2018, 1,003 children had been identified through assessment as being formally in need of a specialist children's service. This is a reduction from 1,196 at 31 March 2017.
- At 31 May 2018, 153 children and young people were the subject of a child protection plan (a rate of 60 per 10,000 children). This is a reduction from 212 children (84 per 10,000 children) at 31 March 2017.
- At 31 May 2018, 57 children lived in a privately arranged fostering placement. This is a reduction from 77 at 31 March 2017.
- In the last two years prior to inspection, four serious incident notifications have been submitted to Ofsted and two serious case reviews have been completed.
- There are three serious case reviews ongoing at the time of the inspection.

Children looked after in this area

- At 31 May 2018, 336 children were being looked after by the local authority (a rate of 132 per 10,000 children). This is an increase from 285 (112 per 10,000 children) at 31 March 2017. Of this number:
  - 144 (or 43%) live outside the local authority area
  - 30 live in residential children's homes, of whom 93% live outside the authority area
  - two live in residential special schools[2], of whom both live outside the authority area
  - 260 live with foster families, of whom 37% live outside the authority area
  - 11 live with parents, of whom 36% live outside the authority area
  - four children are unaccompanied asylum-seeking children.

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

- In the last 12 months:
  - there have been 14 adoptions
  - 11 children became subject of special guardianship orders
  - 100 children ceased to be looked after, of whom 10% 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.

Recommendations

1. Take immediate action to ensure that supervision and management oversight, including that of independent reviewing officers (IRO) and child protection (CP) chairs, are strengthened and that all work is recorded appropriately and that actions are evaluated and reviewed routinely. (This was a recommendation at the last inspection.)

2. Take immediate action to ensure that children on child protection plans, children in need and children in private fostering arrangements are visited within prescribed timescales and seen alone.

3. Take immediate action to ensure that foster care reviews, health assessments and mandatory training are completed in order that carers are equipped to meet children's needs.

4. Senior managers and leaders must take action to create an environment in which their staff have the capacity and support to carry out effective social work with children in need of help and protection.

5. Ensure that performance and quality assurance information is collated for all service areas and, where weaknesses are identified, they are addressed urgently by managers at all levels. Identified learning should be evaluated and disseminated to staff. (This was a recommendation at the last inspection.)

6. Urgently improve work with partners to ensure good quality, effective information-sharing between all agencies involved in MARAC.

7. Improve the quality of assessments and plans for children to ensure that purposeful work takes place to prevent drift. Child in need, child protection reviews and core group meetings should specifically evaluate and record children's progress, in addition to sharing and updating information. (This was a recommendation at the last inspection.)

8. The chief executive should ensure that leadership, management and governance in Torbay are strong and sharply focused on improving and sustaining outcomes for children, and all recommendations from inspection activity are addressed. (This was a recommendation at the last inspection.)

9. Ensure that when children disclose physical abuse, which leads to a s47 investigation, that a child protection medical is carried out.

10. Ensure that all 16- and 17-year-olds who present as homeless are assessed by social workers and that they are aware of the option of becoming looked after. (This was a recommendation at the last inspection.)

11. Strengthen the quality, effectiveness and management oversight of the local authority designated officer. (This was a recommendation at the last inspection.)

12. Ensure that family members who may be potential carers for children who cannot remain with their birth parents are identified as early as possible to prevent delay in children achieving permanence.

13. Ensure that all children looked after achieve permanence, as appropriate to their needs, through long-term foster care, special guardianship or reunification within their timescales, to ensure that children have certainty about their future placement stability.

14. Ensure that children looked after, with a plan for adoption, understand their life story and the reasons why they cannot live with their birth families prior to preparation for a move on to adopters.

15. Improve the effectiveness of learning from complaints and ensure that this scrutiny contributes to improved social work practice and better outcomes for children.

16. Ensure that strategic arrangements regarding workforce development are aligned with Plymouth to maximise staff recruitment and retention.

Summary for children and young people

- Services for children in Torbay are not getting better fast enough. When a child moves to live with a forever family, things are a bit better.
- Too many children have a change in their social worker. This means that it is hard for children to get to know their social worker well.
- Social workers do not always collect enough information about children and their families to make a plan to make things better. The plans are not checked often enough by managers and other people who work with children to make sure that they are making a difference.
- Sometimes when children tell social workers that they have been hurt, their social workers do not arrange for them to see a doctor. This means that some injuries may be missed.
- There are some very good social workers in Torbay who work really hard to understand children's worries and concerns. They make sure that children are safe and that other workers become involved to help and support children and make their lives better.
- When worries are so great that children cannot stay at home, social workers make sure that they live with foster carers or adopters who they can stay with until they are adults. Social workers make sure that children are healthy, can go to school or college and can see their families.
- When children cannot return home and an adoption plan is made, social workers help children understand why this is happening. Sometimes social workers do not talk to children soon enough to help them understand why they can no longer live at home.
- Young people who are leaving care are helped to find the best place to live and how to stay in education or find a job. Personal advisers give care leavers a lot of help and support about all the things they need to learn or know in order to live on their own or stay with their foster carers.
- The 'Cic' club is a group of children who are looked after. They meet together to share activities and make friends. The children also meet with managers to talk about what their lives are like and to help managers to make sure that services for children are the right ones to help children.

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

Summary

Services for children in need of help and protection in Torbay are inadequate. Risks are not always recognised, and weak managerial oversight at all levels is a common feature in too many children's cases. This is characterised by unacceptable drift and delay in progressing work, particularly for children who are exposed to long-term chronic neglect and domestic abuse. A significant number of children have remained without the help and protection that they need, sometimes for several months.

In a small number of cases where children had disclosed abuse, child protection medicals were not pursued when injuries were clearly evident and there was a history of physical abuse in the family. The frequency and quality of child protection and child in need visits have declined since the Ofsted monitoring visit in January 2017. Inspectors informed the local authority of over 30 children for whom there were considerable concerns about poor risk management, adult focused social work and the failure of managers to progress cases. Senior managers were not aware, until this inspection, of serious failings to correctly assess 12 homeless 16- and 17-year-old young people who should have been given the option of becoming looked after.

A wide range of early help services provide much-needed support for children. Many children receive the right level of targeted support quickly and by the most relevant agency. The reconfigured emergency duty service (EDS) and safeguarding services for disabled children have improved during the past year. Threshold decision-making in the multi-agency safeguarding hub (MASH) is mostly effective. Children in need of protection are identified swiftly, and strategy meetings are well attended. Information sharing in the MASH is effective and timely. Inspectors heard of some problems regarding information-sharing by children's social care to the police. On some occasions, there has been a lack of information presented by social workers to multi-agency risk assessment conferences (MARAC) and a subsequent delay in developing appropriate plans of support. Recent practice is reported to have improved.

Although inspectors did see some impressive work by individual social workers, it is difficult for children to build relationships with them due to their frequent changes and the demands of highly complex caseloads in some teams. Most children have assessments and plans in place, but too many are of a poor quality. Until April 2018, insufficient management oversight had delayed decision-making about applications for legal orders to remove children from home. This had left a number of children at risk of significant harm.

The response to children who go missing or who are at risk of sexual exploitation is improving, but is not yet sufficiently consistent for all children.
Services for privately fostered children and those provided by the local authority designated officer are underdeveloped.

Inspection findings

17. Serious weaknesses to safeguard children have not been sufficiently addressed since the last inspection in 2015. Inspectors informed the local authority of over 30 children for whom there were considerable concerns about poor risk management, adult-focused social work and the failure of managers to prevent drift and progress cases. Workload pressures for staff in children's social care and the constant change of social workers, team and middle managers present the greatest challenge in Torbay. Consequently, there is a culture of 'start again' for children, families and social workers. As chronologies are not updated, workers often fail to fully understand children's previous history, leaving too many neglected children without consistent help or protection.

18. Failure of effective senior leadership has meant that until recently (March 2018), the volumes of work allocated to social workers in the single assessment (SAT) team were not manageable. Some workers had more than 40 cases and, as a consequence, were unable to provide children with the necessary, focused activity to manage and reduce risks. In addition, the SAT team social workers, whose role it is to carry out short-term initial assessments, were not able to transfer children's cases to the longer term safeguarding and family support service (SAFS). This was due to the high caseloads in the SAFS team and their lack of capacity to take on more work. Workloads are now reducing, and the appointment of additional, temporary social workers, over and above 'establishment', is assisting this. However, staff turnover and the ability of the SAFS team to absorb so many complex pieces of work mean that improvements remain fragile.

19. Prior to April 2018, the lack of active tracking, the poor management oversight and the inconsistent planning had adversely affected decision-making about applications for legal orders under public law outline arrangements. This had left too many children at risk of harm. A number of these children came into care in an unplanned way, for example under police protection or following an application for an emergency protection order. The newly established (April 2018) legal gateway process is positive because actions are now being monitored. When court proceedings are initiated, most cases progress to their conclusion within the 26-week timeframe.

20. It is difficult for a significant number of children in need, including those in need of protection, to build relationships with their social workers due to

frequent changes in social workers and high caseloads in some teams. Children and their parents have expressed concern about the number of times they have to 'retell their story'. While staff in the SAFS told inspectors that they do feel supported by their line managers, concerns were raised about the high numbers of complex cases they are expected to manage, as this is impacting on the quality of their direct social work practice with children. Inspectors agree with these concerns. (Recommendation)

21. The frequency of social work visits to children subject to a child protection plan has declined significantly since the Ofsted monitoring visit in January 2017. Insufficient numbers of children are seen alone. Many vulnerable children living in households in which they have experienced continuous neglect as a result of parental substance misuse, domestic abuse or parental mental health issues do not see their social worker within the local authority's own prescribed standards. This means that social workers are unaware when risks to children escalate. (Recommendation)

22. In a small number of cases where children had disclosed abuse, child protection medicals were not pursued when injuries were clearly evident and there was a history of physical abuse in the family. This poor practice means that children are not being listened to when they have told professionals that they have been hurt. It also means that the extent of the injuries are not known or documented and old injuries may not be picked up. (Recommendation)

23. Inspectors referred inadequate practice regarding three children from one family who had been previously referred in the November 2017 monitoring visit. Failure to intervene has left these children at continued risk of significant harm. This is one example of many where there is inconsistent management oversight that lacks purpose or focus. Supervision records do not identify or address the drift and delays that are experienced by too many children. Actions arising from both supervision and management oversight are not always accompanied by clear timescales for action and are not tracked at subsequent supervision sessions. (Recommendation)

24. The quality of social work assessments and plans are beginning to improve, albeit from a low base. Better assessments are more timely and include delivery of support for families, although some lack effective analysis of ongoing risks. Children's views are now gathered by social workers, but their views are not always captured in their plans. In stronger cases, inspectors found examples of good child-centred practice, using the local authority's model of social work, leading to more effective and robust analysis. However, some plans are ineffective. They do not demonstrate a full understanding of risks to children, and are not responsive to changes in circumstances. For example, the local authority's own audits, completed for the re-inspection, identified very serious weaknesses in half of the help and protection cases. This included over-optimistic adult-focused work and delays in progressing child in need and protection plans in some cases. Inconsistent evaluation of some children's

progress by professionals in child in need, child protection and core group meetings is resulting in superficial analysis of what needs to change. (Recommendation)

25. The caseloads of child protection conference chairs have reduced since the last inspection. The chairs have completed external, accredited training and feel more equipped to carry out their roles, including challenging the work of social workers. Only in the past four months have they been able to add cause for concern and dispute resolution notes onto the child electronic record. They recognise that more needs to be done to effectively challenge poor performance and manage the significant turnover of social workers.

26. Threshold decision-making in the multi-agency safeguarding hub (MASH) is mostly appropriate. Children in need of immediate protection are identified swiftly. The majority of child protection strategy meetings include key agencies involved with the child, and are held within 24 hours of the referral. Meetings are well recorded and management decisions are clear. Obtaining parental consent to share information, or overriding it where necessary, is carefully considered and recorded. However, despite the refreshed multi-agency threshold document, the application and understanding of thresholds by partner agencies in Torbay remain inconsistent. A newly established professional consultation phone service is intended to provide partner agencies with additional support, but it is too early to assess its impact. A number of the essential components for an effective MASH are in place, but these require further development. For example, for vulnerable children in need cases, where it is evident that an assessment is required, social workers are not completing MASH checks. This is a missed opportunity to gather relevant multi-agency information to inform risk assessments and planning.

27. The MARAC considers children living in households where there are substantial and serious risks from domestic abuse. Recent improvements are reported to have been made but there have been occasions where team managers attending MARAC have not been well prepared, and this lack of information has led to delays in cases being discussed for several months. Failures to share information has left children exposed to unassessed risks and the police expressed considerable concern to inspectors about a family of three children. As a result, inspectors referred these children to the local authority. Although these children have been known to social care for years, insufficient action has left them exposed to chronic neglect and on-going significant harm. (Recommendation)

28. Since the inspection in 2015, action to co-locate housing workers in the integrated youth support services (IYSS) has had a positive impact, with evidence of persistent, collaborative work between the homeless prevention officers, IYSS and youth offending staff. This diligent, child-centred work is making a real difference to some young people with highly complex needs who often exhibit high-risk and violent behaviours as a result of childhood trauma. Nevertheless, it is extremely concerning that senior managers were not aware of serious failings to appropriately assess the needs of 12 homeless 16- and 17-year-olds, including the option of coming into care. Senior managers took action to address the concerns and to review the services, as a result of inspection findings. Management of these children's cases is inadequate as children have been insufficiently assessed, monitored and protected. (Recommendation)

29. A wide range of early help services provide much-needed support for children. There is good support from partners at levels one and two to support children and their families. Early help interventions are well coordinated by the family intervention team (FIT). The effective weekly multi-agency targeted support panel ensures that children receive the right level of support quickly from the most relevant agency. Despite high demand and waiting lists for some services, inspectors met with some committed staff across agencies, who are resolute in their efforts to engage with, and make a positive difference for, vulnerable children and young people. This weekly panel offers effective oversight and quality assurance, both to the quality of work and application of thresholds. Inspectors saw examples of step-up and step-down processes being used appropriately.

30. The response to children who go missing or who are at risk of sexual exploitation is improving, but is not yet sufficiently strong for all children. Managers in the MASH lack knowledge and understanding about national concerns regarding criminally exploited children or 'county lines' and therefore do not exercise professional curiosity if such cases are referred. Effective tracking and cross-referencing of children at risk is over-reliant on an authoritative administrator. This is not a robust system because there is no formal mapping system which takes place with partners at a strategic level or wider analysis of return home interviews regarding trends and hotspots. Return home interviews are taking place more often and are starting to be used to inform individual plans to reduce risks to children. Arrangements to track children missing from education are satisfactory.

31. Services for privately fostered children are underdeveloped. Annual performance data shows that too many assessments are not concluded in time and too many children do not receive timely visits from social workers. Assessments are mostly detailed and clear, but do not show how 'host families' in language schools meet the individual needs of a succession of children. Torbay local authority regularly receives a large influx of language students, which puts pressure on the service. The local authority has a range of literature and an informative website to raise awareness and set out its duties and those of carers and parents. (Recommendation)

32. The reconfigured, child-focused out of hours emergency duty service (EDS) is led by a skilled and committed manager and is delivering a much improved service. The team is well resourced and its work makes a positive difference to children and families. The communication between out-of-hours and day services is effective, with the EDS 'footprint' that is visible on children's records. Strategy meetings are convened appropriately and risk assessments are comprehensive.

33. The safeguarding of disabled children has significantly improved in the past year, since the appointment of a new team manager. Disabled children on child protection plans and children looked after benefit from receiving a specialist children's social work service. Transition planning for children with complex needs is now much improved. The development of the multi-agency transition panel led by this manager has improved communication between partners. Consequently, a range of relevant agencies, together with adult services, become involved around a young person's 14th birthday, improving joint planning. This did not happen before. Supervision and management oversight is recorded regularly, with comprehensive decision-making and effective tracking of progress.

34. Arrangements to respond to allegations against professionals and people in positions of trust working with children mostly result in well-coordinated action plans to protect children. Multi-agency meetings are well attended, and information sharing is satisfactory. However, the post of the designated officer (DO) is currently shared between three different staff members as part of their roles. This does not provide consistent oversight of investigations or enable professionals across the partnership to build a relationship with a consistent single named individual. The three designated officers offer a consultation service to professionals and this is greatly valued across the partnership. The annual report is not up to date and has not been presented to the Local Safeguarding Children Board (LSCB) during the past year, as required. While some developmental work is undertaken with partners, this has been limited, and action to raise awareness of the DO role among hard-to-reach groups, such as some faith groups, as well as partners, is ineffective. Insufficient quality assurance of the work of the DO and poor analysis of performance information are concerning. For example, information on the timeliness of risk management meetings and decision-making is unknown and therefore the local authority cannot determine whether the response is swift enough when concerns arise. (Recommendation)

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

Summary

Children looked after receive services that vary from those with serious weaknesses to those that are strong. While there are pockets of very good practice, some services have not improved since the last inspection. Although foster carers provide stable homes for children where their needs are well met, there are serious weaknesses in the fostering service. There are a significant number of foster carers with no up-to-date annual review, health assessment or completion of training, support and development standards. The local authority cannot be fully assured of the quality of care being provided, although inspectors did not see any detriment to children. In contrast to these weaknesses, the direct work and support to children, carers and staff from the co-located child and adolescent mental health (CAMHS) worker is a strength and enhances placement stability.

Many children have positive relationships with their social workers. However, for some children, there are too many changes of social worker, which hampers the development of meaningful relationships. This delays the progress of plans and permanence being confirmed.

Looked after reviews are undertaken in a timely manner. There is emerging evidence of the escalation of concerns by independent reviewing officers (IROs), but it is too soon to assess the impact. The voice of the child is captured effectively and informs plans. The vast majority of children have an annual health review, which identifies and responds to changing needs. Between the ages of 16 and 18, children receive their health history document. Children looked after make good progress in education up to key stage 2, although attainment is weaker at key stage 4. Children benefit from effective personal education plans, and the virtual school closely monitors progress. Pupil premium plus funding is used effectively.

Many permanence plans to secure long-term foster care or special guardianship are not concluded as swiftly as those in adoption services. Connected carers are not assessed soon enough. Permanence planning for children recently entering care is improving. Earlier consideration of permanence, including fostering for adoption, means that children experience less disruption and develop earlier attachments. Adoption numbers are rising. Children who need adoption benefit from skilled family finding, matching and good support. Prospective adopters are well prepared. Transitions to adoptive placements are well planned, giving children a positive start in their new homes through effective post-adoption support. Children benefit from involvement in the vibrant Children in Care Council and its positive relationship with the corporate parenting board. Achievements are celebrated. Care leavers value their pathway plans. Most care leavers are in

appropriate accommodation, and the council is developing an apprenticeship scheme to provide increased employment and training opportunities for its children.

Inspection findings

35. In Torbay, some children enter care too late. Some children should be brought into care earlier, when risks escalate, in order to prevent emergency admission in traumatic circumstances.

36. Care proceedings are mostly progressed and concluded in a timely manner within the 26-week recommended timeframe. The quality of assessments, plans and information-sharing during proceedings is recognised by the Children and Family Court Advisory and Support Service (Cafcass) and the judiciary as minimising unnecessary delays for children. However, in some cases, the lack of exploratory work with members of the wider family has resulted in delays in identification of potential connected person carers. This has affected the timeliness of care proceedings and added to the delay in children achieving permanence. (Recommendation)

37. Children and families at risk of family breakdown are well supported by the Intensive Family Support Service (IFSS). Despite evidence of effective direct work and strong relationship-based practice, the numbers of children in care continue to rise. The performance information and subsequent analysis is underdeveloped.

38. Purposeful reunification and support plans assist children in care to return home to their birth families. Direct work undertaken by social workers and IFSS workers ensures that children return to an improved environment in which children and families can live together safely.

39. Assessments are generally comprehensive and effective in informing decision-making and subsequent plans for children. The voice of the child is regularly captured, and research is used well in some cases. The use of chronologies is limited and therefore significant events are not always captured in order to inform future work and plans. Assessments of parents and family members are of a suitable quality.

40. Too many children in Torbay do not enjoy meaningful and consistent relationships with social workers due to the considerable turnover of staff. Some children looked after in Torbay have enduring and trusting relationships with social workers who know them well. For these children, social work visiting is regular and purposeful. These children understand the reasons why they are in care, as well as their future plans.

41. The response to children who go missing from care is not effective in arranging well-coordinated plans and actions to reduce risks. Return home interviews are not always completed or held within the required timescale. More recent examples completed by a commissioned service show emerging improvements, although reports continue to be of variable quality.

42. Children in care who are at risk of sexual exploitation are appropriately assessed and supported. Children at higher risk are referred to the Missing and Children Sexual Exploitation (MACSE) meeting to ensure a coordinated multi-agency action plan is in place. However, this information-sharing forum remains underdeveloped. It does not use the skills and expertise of the wide range of attendees to effectively reduce risk to children, or develop strategic responses, such as coordinated disruption activity.

43. Most children's initial health assessments are not completed within timescales, meaning that their immediate health needs are not understood quickly enough when they enter care. The large majority of children do have an annual health review that identifies and responds to their changing health needs. Between the ages of 16 and 18, children receive their health history document. Children are currently being surveyed about the format and value of this document to inform a revised electronic version due to be implemented later in the year.

44. Children in care and care leavers have timely access to specifically commissioned CAMHS services, which, in turn, impacts positively on stability of placements, children's emotional well-being and educational achievement. CAMHS workers, located in children's services, support social workers in their work with children who have complex emotional needs. CAMHS workers also provide consultation, direct therapeutic interventions with children, and run a group offering support to foster carers.

45. Effective services are in place across agencies to ensure that professionals are aware of and are able to support children who are experiencing bullying or discrimination. The virtual school takes a lead role in supporting children in these circumstances, and works closely with schools to ensure an effective resolution.

46. Children have access to a wide range of leisure activities and are actively supported by their carers to pursue their hobbies and interests. The Children in Care group facilitates numerous social and recreational outings and provides opportunities for children to develop their confidence and to learn new skills. The virtual school has comprehensive information on the attainment and progress of children looked after. The effective use of pupil premium plus funding enables the purchase of a wide range of equipment, activities or specific support. This helps to develop children's skills, talents and confidence.

47. The educational outcomes for children looked after in 2016/17 show that progress was strong from their starting points to the end of key stage 2. At key stage 4, the 2016/17 progress and attainment measures were weaker. Progress 8 and Attainment 8 measures for children looked after were broadly in line with similar authorities.

48. In 2016/17, the average school attendance for children looked after was 96% and this was in line with comparators. Last year, there were no permanent exclusions. The proportion of children with at least one fixed-term exclusion was lower than similar authorities and nationally.

49. Most children looked after attend schools judged to be good or outstanding by Ofsted. The virtual headteacher ensures that each child attends the school that meets their various needs most effectively.

50. Children looked after have clear and up-to-date personal education plans (PEPs). All are signed off by virtual school staff and monitored for appropriate targets and funding to ensure positive impact for individual children. The virtual school has full details of the destinations of Year 11 pupils. This includes clear links with the local further education college to develop smooth transitions for pupils who move on to attend the college. Staff also maintain appropriate information about the pupils who attend alternative provision. This shows effective oversight and scrutiny by the virtual school.

51. Most children who are looked after in Torbay enjoy supportive and stable placements with foster families. Where appropriate, children live with their brothers and sisters and do not move placement unless it is in their interests to do so.

52. There are insufficient local foster carers to meet rising demand, and more children looked after are having to live too far away from their families. In May 2018, 27% of children looked after were placed more than 20 miles from home. The local authority is not meeting its target to recruit 10 additional fostering households each year. However, most children looked after at a distance from home are in appropriate placements where their identified needs are being met. All children are visited and have regular reviews, PEPs and health assessments.

53. Children's views, wishes and feelings are routinely and clearly captured to inform plans. There is inconsistent use of the 'My Care Plan' document, and some are not written in child-friendly language, nor do they adequately consider risks and contingency plans. Most care plans are not informed by an annual reassessment or updated following a significant event. They therefore do not adhere to the local authority's practice standards. This means that plans do not always reflect a child's current needs and circumstances.

54. Children regularly attend or are represented at their reviews, ensuring that their voices inform planning. Looked after reviews are undertaken in a timely manner and there is emerging evidence of the escalation of concerns where there are delays in implementing plans. Progress against care plans is increasingly being monitored, although review recommendation timescales are not specific in all cases. This does not enable timely tracking of actions or prevent drift and delay in pursuing permanence. IROs are not yet consistently overseeing progress between reviews, and some children continue to experience drift and delay in permanence decisions being made and acted upon.

55. Children have the right level of contact with those people who are important to them. Contact arrangements are carefully considered and reviewed following any increased risk or change in circumstances. Family members or community support workers supervise contact in appropriate venues. Observations of contact are well recorded and inform assessments, plans and life story work.

56. Matching is generally carefully considered and effective in ensuring that children benefit from good-quality placements that meet their needs. At the time of this inspection, 87 of the 145 children placed with foster carers have remained in the same placement for more than two years. This demonstrates effective matching, leading to placement stability.

57. The fostering service in Torbay is failing to meet its regulatory requirements. Until very recently, there has been no performance information available to the team manager to assist her tracking of the team's work. An action plan is now in place to address the relevant shortcomings, and a new permanent manager has been appointed to oversee its implementation. However, at present there are a significant number of carers for whom there in no up-to-date annual review or health assessment, and half have not completed all their training, support and development standards. The local authority cannot be fully assured of the quality of care being provided to its children. However, inspectors did not see any evidence of detriment to children placed. (Recommendation)

58. Some parts of the fostering service are working well. Foster carers appreciate the support, communication and advice offered by their fostering social workers. Carers benefit from a wide range of support groups and training activities, in particular the CAMHS support group offering valuable help in supporting the care of children who have complex emotional and behavioural needs. Groups are arranged at various times to facilitate carers' involvement and peer support. Recent training in therapeutic fostering and 'Fostering Changes' behavioural management have been highly valued by carers.

59. Improving practice in planning and earlier consideration of permanence options are having a positive impact on children recently entering care. However, a formal matching process for long-term fostering or special guardianship has not been carried out for many children looked after. There is an increased focus on the need to address this, and a clear plan is now in place to review and ensure that permanence is achieved. The dedicated SGO social worker is completing good-quality assessments and is beginning to progress applications, but there is insufficient capacity to consider the high number of these cases. (Recommendation)

60. Children who are permanently placed are helped to understand their birth history by effective life story and direct work provided by social workers and family support workers. The majority of life story books are age appropriate and are written sensitively and clearly, containing photographs, key documents and later-life letters, and helping children to understand their journey into and through care.

61. Children benefit from involvement in the Children in Care Council, known as 'CiC' club. It is positive that corporate parenting board representatives come to 'CiC' to hear about children's experiences, seek their views, and join in with their many organised activities. Children are involved in interviews for social workers, the review of the corporate parenting pledge, the development of an information pack given to children who become looked after, and the organisation of the annual children looked after awards event.

The graded judgement for adoption performance is that it is good

62. There is evident commitment, particularly from the adoption team and its manager, to achieving permanence through adoption for children who need an enduring home outside of their birth family. Twenty children were adopted between April 2017 and March 2018, including three groups of brothers and sisters. This is an improved position on the previous year, when 14 children were adopted. Eleven children are currently placed for adoption and 19 children are subject to a placement order, awaiting a match.

63. The local authority has sought to embed fostering for adoption arrangements through training and guidance to ensure that social workers consider such placements at the earliest opportunity. Ten children have been placed in fostering-for-adoption placements since the last inspection, with six currently placed. This has minimised disruption for these very young children who need adoptive parents.

64. Most children benefiting from adoption are aged five or younger, but only three children over five currently have an adoption plan. The local authority is aware of this issue and work has been undertaken with social work teams to help ensure that adoption is also considered for older children.

65. The local authority performance against the DfE scorecard is improving, with the average time between a child entering care and placement in 2014–17 at 418 days against the threshold of 426. Local authority data for 2015–18 shows improvement for all adoption measures.

66. The adoption team provides a responsive service to prospective adopters. During 2016–18, 10 enquiries have led to assessment and most of these have been completed within timescales. Currently, there are only three adopters awaiting a placement. Prospective adopter reports reviewed are adequate and most are good. Preparation training assists adopters to gain an understanding of adoption from the perspectives of children, families and adopters, and, once approved, they are offered places on twice-yearly therapeutic parenting courses.

67. Torbay collaborates with its regional partners in Adopt South West (ASW) in family finding, recruitment and training activities. Children's profiles and DVDs are shared and discussed at regular ASW profile meetings. In order to secure potential links between children and adopters, referrals are made to a variety of services such as Adoption Match, and adoption activity days are held. This range of family-finding activity is ensuring that the lack of in-house provision is not causing delay for children.

68. When the placement order is granted, the family finder becomes the child's social worker. This means that the child and prospective adopters benefit from the adoption social worker's experience and expertise, but it also means that the child has a new social worker at the time of a significant transition. Life story work does not start until this worker is in place, which is late for children to hear and understand why they will be moving away from their birth family permanently. This social worker is not the one who has worked with the child and family over time or the one who has a detailed knowledge and understanding of the child's history. (Recommendation)

69. Child permanence reports and adoption placement reports are mostly of a good standard. Careful consideration is given to evaluating the best permanence option for the child, matching the child to adopters, ensuring appropriate contact arrangements to birth family members and to the introductory process. Meetings between birth parents and adopters are facilitated, and ongoing contact between the child and their foster carers is also promoted. This represents good practice.

70. The adoption panel chair is experienced and knowledgeable and the panel provides scrutiny and challenge. Reports received by panel are generally of a good standard. Minutes of panel and the record of the ADM's decision clearly evidence the issues considered and the rationale for decision-making.

71. Adoption support needs are carefully considered in the adoption placement report. There are a range of adoption services available to adoptive families. This includes direct work such as theraplay, support groups, therapeutic parenting courses and play therapy. Adopters have access to the adoption support fund. Thirty-six applications were made during 2017–18, and significant funding was secured. The adoption team currently supports a large number of active letter box arrangements. There have been no adoption disruptions since the last inspection, which indicates that children are well matched and that adoptive families are getting appropriate support when needed.

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

72. Following the monitoring visit by Ofsted in August 2017, there were significant changes in the management structure and staffing of the leaving care service. A clear action plan was developed to 'get the basics right' and caseloads of personal advisers (PAs) were reduced. These improvements are still relatively recent and managers acknowledge that there is much more to do in order to embed consistency and develop the work of the leaving care team.

73. Records show that staff are in contact with all 156 care leavers in the local authority. Care leavers are well supported. There are examples of PAs working with the same young people for a number of years and care leavers spoken to appreciate this continuity. All said that they would not hesitate to seek advice and guidance from their PA. There is clear support offered to care leavers relating to accommodation, health issues and education and training. PAs provide appropriate challenge to care leavers when required. This contributes to their developing independence and the very real challenge of emotional resilience.

74. Since the last inspection, the leaving care team has worked hard to ensure that information regarding care leavers' entitlements is widely shared. Leaflets are sent to all care leavers, foster carers and supported lodgings providers. A general guide for care leavers in Torbay is available, and this covers how to access social care records, the complaints procedure and the Torbay care leavers' pledge. Some developments are appropriately practical. For example, the council has agreed to 'round up' personal allowances so that all of these funds are accessible from cash machines.

75. Just over half of care leavers aged 19, 20 and 21 are in education, employment or training. This is an improvement on the 2017 figure and in line with the average for similar authorities and the national average for that year. There are clear links between the leaving care team, the local further education college and staff from Careers South West. This enables individualised programmes to be developed that match the needs and aspirations of care leavers. Ten care leavers are studying at higher education institutions, which is a slightly reduced number since the last inspection.

76. The council has developed and promoted its apprenticeship programme and 12 care leavers have recently applied for the 11 apprenticeships on offer. Care leavers were provided with support in the application process by the council's human resources professionals and their PAs. The outcomes of the application process were not known at the time of the inspection.

77. In March 2018, managers undertook a survey to gain feedback from a randomly selected sample of 50 care leavers. Although 30 replies were received, these have not been analysed. This is a missed opportunity and a poor response to assuring care leavers that their views are valued in developing the service.

78. Ninety per cent of care leavers are reported to live in suitable accommodation. This is lower than the published figure for 2017. No care leavers are homeless or in bed and breakfast accommodation and 15 live in houses of multiple occupation. There is a six-monthly assessment, signed off by managers, of the suitability of accommodation for each care leaver. Management supervision has a focus on ensuring that the full range of accommodation options are available. There are increasing numbers of care leavers in 'staying put' arrangements, with 13 currently placed.

79. The preparation and transition planning for young people to move from the children looked after service to the leaving care team begins when the young person is 17 years and one month. This is in line with the local authority established protocol. This is very late for children to get to know their new workers and make plans for their lives after care. Managers note that capacity issues mean that this cannot be started earlier.

80. Pathway plans are detailed documents that cover the varying needs of care leavers and their views and aspirations. Young people say their pathway plans are helpful. The pathway planning process is a significant part of the supervision process and all plans are appropriately signed off by a team manager. More needs to be done to ensure consistency in the completion and quality of the plans. While the views of the young people are clear, some plans do not show sufficient analysis and appropriate consideration of next steps. Managers acknowledged that this is an area for further improvement.

81. Health needs are monitored within pathway plans with appropriate support usually provided. A 'health passport' is provided to care leavers between the ages of 16 and 18.

82. There was no event to celebrate the achievements of care leavers last year. This is a missed opportunity to share care leavers' successes as well as underlining the commitment and support from council members as corporate parents.

Leadership, management and governance	Inadequate

Summary

Leadership, management and governance are inadequate in Torbay. The pace of progress has been slow in many areas, and serious weaknesses in the quality of practice and responses to children remain. A number of recommendations from the previous inspection have not been fully met and are repeated in this report.

While senior leaders have had a consistent focus on improvement, and improvements have been made in some areas, they have been ineffective in delivering sustained improvement in the quality of practice. Improvements are not assisted by the constant turnover of staff, and leaders often rely on the commitment and skills of individual workers. Senior leaders have not sufficiently evaluated the impact of their strengthened practice standards, expectations and directives to staff, or ensured that these have been uniformly implemented by all managers.

Performance management, quality assurance processes and scrutiny arrangements, while improving, are not sufficiently strong and do not enable senior leaders to monitor staff performance effectively. Despite strengthened performance information, this is not used by all managers to identify and address key weaknesses in practice. There is no performance data to measure the work of the designated officer or private fostering arrangements. Only recently has performance data been produced to show managers the non-compliance with fostering regulations. Audit activity has been limited. Learning from audit activity and complaints is underdeveloped.

Supervision and management oversight of casework is not yet consistent, timely or effective. Supervision does not always result in comprehensive written records that include clear instructions and time-bound action plans for social workers.

The workforce is becoming more stable, and senior leaders have successfully reduced social work caseloads. However, in some teams, the complexity and demands of their caseloads adversely affect the timeliness of their visits to assess and monitor the welfare of children.

Governance arrangements are clear. Links between the chief executive, lead member and the DCS are strong and lines of accountability are well established. Corporate parenting is developing and senior leaders are committed to the needs of children looked after in Torbay. Although improvements have been made, more work needs to be done to ensure that services get to 'good'. The views and experiences of children and young people contribute effectively to service planning and delivery in most cases. Of notable exception is the survey of care leavers.

Improvements in some children's services have been made, such as decision-making in the MASH, the quality of the adoption service and care leavers service. Initiatives such as the co-location of CAMHS workers enable a better understanding and response to the emotional needs of children looked after.

Inspection findings

83. During this inspection, inspectors identified critical weaknesses that were evident during the previous inspection. A number of recommendations from the previous inspection of 2015 (published in 2016) remain incomplete. The overall pace of improvement has been slow, despite significant external scrutiny and support. Senior leaders have been ineffective in prioritising, challenging and making improvements in all areas of children's services.

84. Performance has been disparate across children's services in Torbay and improvements in the quality of practice are either not yet evident, are inconsistent or are not yet sustained. The local authority recognises the deficiencies in practice, but has not shown sufficient urgency to address this. While action has been taken to address individual poor performance, senior leaders have not comprehensively addressed underperformance in all areas, either at individual or team level. As a result, inspectors saw too many cases where there were failings to protect or look after children.

85. While the recent, more stable senior leadership team has implemented a number of practice standards and strategies to support the overall improvement plan, these actions have not been uniformly implemented. Senior leaders have not sufficiently assured themselves that these directives and service improvements are being delivered or have been evaluated. For example, frontline staff had little knowledge or understanding of the domestic abuse strategy, despite this being a feature in many cases in Torbay. Managers are not adhering to supervision guidelines regarding how meetings are recorded or considering the required elements of personal development and support.

86. The local authority has appropriately identified areas for further improvement, for example consistency of social work staff, the professional development of team managers, strengthening the quality assurance framework, improving the timeliness of visits to children, assessments and improving the timeliness and impact of supervision. While these areas are the subject of much scrutiny by senior leaders, the impact of this focus is not yet demonstrated through better outcomes for children. For example, the fostering service has serious weaknesses and while an action plan to remedy this is in place, senior leaders cannot be assured of the quality of care being provided to its children.

87. There is emerging evidence of better quality work in Torbay in a number of areas. Progress has been made, for example, in the quality and timeliness of decision-making by the MASH, strengthened partnership working and edge-of-care services, as well as improved support to care leavers. CAMHS workers are providing valued work and support for children, staff and carers in dealing with complex emotional health concerns. The performance of the adoption service has improved from the last inspection and is now good. While pockets of good practice are evident, they are not seen across all services or analysed regarding their impact. For example, the edge of care service provides some good direct work for families, but has not been evaluated or analysed to understand why, despite the work completed, numbers of children looked after continue to rise.

88. While the local authority has introduced a neglect strategy, a domestic abuse strategy, and revised its permanence policy, staff spoken to by inspectors had a mixed understanding of these key documents and how they affect their day-to-day practice. The revised early help strategy has also been delayed. Changes in managers and staff, and lack of focus on new initiatives during team meetings, supervision and training mean that new developments are not embedded in practice.

89. The quality of supervision and management oversight in Torbay continues to be a key weakness in improving the quality and timeliness of response to children. This was a recommendation from the previous inspection. Senior managers have strengthened expectations of management oversight and supervision and delivered training to staff, yet the timeliness of supervision continues to be poor in many teams. While some good examples of supervision records were seen by inspectors, the vast majority are not comprehensive, specific, and actions set are not time-bound. Tracking of actions from one supervision to another is not taking place and supervision records do not routinely reflect challenge to poor performance, such as missed visits to children or overdue assessments. Most staff do not have an up-to-date appraisal of their practice and performance. This means that staff lack an understanding of what they do well and what they need to do in order to improve outcomes for children. (Recommendation)

90. The Principal Social Worker (PSW) has been in post since April 2018 and has developed a well-targeted action plan to address key weaknesses in practice. However, it is too early to identify the impact of this work.

91. The use of performance information to drive improvements in practice and outcomes for children is inconsistent. The quality and accuracy of performance information has been strengthened since the last inspection, and managers and social workers now have access to a suite of information at any given time. However, there is significant variation in the use of this information by managers at all levels. While managers now have a better understanding of individual and team performance, inspectors did not see urgent action taken, when, for example, children's visits were clearly out of timescales. The collation and interrogation of performance data has been slow in development for some services. Performance information is not currently collected on the work of the designated officer. The collation of private fostering data is developing, and fostering service data has only recently been compiled. (Recommendation)

92. Performance activity continues to largely focus on compliance with practice standards. The local authority's emerging focus on quality and outcomes for children as the next stage of improvement is becoming more evident, although senior leaders recognise that moving to a performance management culture has been slow and challenging. A critical analysis of the local authority's performance across children's services is not yet fully reflected in its documents. The self-evaluation, for example, is over-optimistic in relation to performance regarding supervision, management oversight and timeliness of visits to children.

93. Quality assurance activity in Torbay is underdeveloped, and this is a key omission in senior leaders' ability to assess the quality of practice. While the quality and grading of individual audits undertaken has begun to show early signs of improvement, the overall breadth and depth of audit activity is limited. Dissemination of key lessons learned are not routinely fed back to staff in a systematic and coherent manner. While a regular newsletter to staff from the DCS does refer to some learning identified, much more needs to be done to use and show how findings inform personal development and training, and how re-auditing evidences improvements in practice. (Recommendation)

94. Social work stability over recent years has been a significant challenge in Torbay. Senior leaders have revised the workforce development strategy, and there are a number of incentives to attract more experienced, permanent staff. This is starting to make a difference, as recently the workforce has been more stable. All vacancies across children's services have been filled by agency staff and the current number of agency staff in Torbay has been increased above establishment figures to cover staff sickness and reduce caseloads. Exit interviews for staff are not completed, and this is a missed opportunity to gather crucial information in circumstances in which recruitment remains an ongoing challenge. (Recommendation)

95. The professional development framework has recently been revised and now reflects closer alignment with both organisational and staff requirements. The current training plan is not comprehensive enough to deliver a range of essential training to a staff group with varying needs and experience. There is an over-reliance on e-learning as a mechanism for delivering essential training in complex topics such as child sexual exploitation. This means that opportunities to discuss and share learning from colleagues and partners is missed. While evaluation of training does occur following some training events, consistent evaluation of training and its impact on learning for practitioners is underdeveloped.

96. Senior leaders have ensured that social work caseloads have significantly decreased since the last inspection. However, many social workers report caseload pressures as primary factors leading to drift and delay in progressing plans. Complex caseloads, particularly for social workers with children in court proceedings, have adversely affected timely case recording, frequency of visits to children and timeliness of assessments. Caseload numbers are reducing, but further work is needed by leaders and managers to actively manage workflow. In addition, leaders and managers need to better understand the risks and complexities of caseloads in order to ensure that caseloads become more consistently manageable for staff.

97. Learning from complaints in Torbay is underdeveloped. Progress has been made in ensuring that complaints are now dealt with in a systematic and timely manner. The learning from complaints and the dissemination of this learning is not well coordinated, analysed or used to improve performance. Quality assurance arrangements regarding the response to complaints and compliments are not well embedded. While the local authority acknowledges that this requires strengthening, this has been slow to be remedied. (Recommendation)

98. Torbay has a range of both commissioned and in-house services for young people and families, and monitoring arrangements of these is developing. Strategic commissioning is informed by a joint strategic needs assessment (JSNA), but this is not comprehensive. It includes information on safeguarding issues, children looked after and risk in relation to missing children. However, child sexual exploitation is not sufficiently prioritised. Strategic planning has identified, for example, the need to improve services for young people between 16 and 18 years as well as those with mental health needs and complex needs, including support services for children who have witnessed domestic abuse in the community. This has resulted in a well-coordinated multi-agency review of all commissioned services. The aim is to prevent duplication of services and target resources to areas of need. However, it is too early to see the impact of this focus and currently preventative services are not sufficiently streamlined.

99. The views of children, young people and their families are sought by senior leaders in Torbay through a range of mechanisms, including the 'Checkpoint Well-Being Survey', independent advocacy service feedback and the 'Imagine Torbay' engagement project. Parents and young people are very well engaged in service developments and children's views are routinely considered by senior leaders through well-established links with the active Children in Care Council. However, the findings from a recent survey of care leavers have not been analysed and this does not demonstrate that their views are valued.

100. Corporate parenting in Torbay has been strengthened through revised commitments and improved communication with children looked after and care leavers. The corporate parenting board is energetic and advocates strongly for children and young people. Ambition for children looked after is developing. There is meaningful engagement with children and young people through the Children in Care Council, questionnaires and other groups locally. The board has developed strong links with the housing department, and this is beginning to assist in the challenge of finding suitable accommodation for care leavers.

101. Governance arrangements in Torbay are clear. Links between the chief executive, lead member and the DCS are strong and lines of accountability are well established. The lead member is a particularly proactive leader in Torbay, and has demonstrated a sustained and passionate commitment to the improvement of children's services across Torbay. There is a clear and sustained financial commitment to children's services. While savings are being made in the local authority, the budget for children's services has been re-based, with a further £3 million included, and a commitment not to reduce the budget next year. New child-friendly premises with dedicated conference facilities have been built and are now being used. Financial commitment to replace the existing electronic recording system has been agreed.

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 inspection team consisted of four of Her Majesty's Inspectors (HMI) and two Ofsted Inspectors (OI).

The inspection team

Lead inspector: Karen Wareing

Deputy lead inspector: Emmy Tomsett

Team inspectors: Brenda McLaughlin, John Roughton, Carolyn Spray (OI), Rob Pyner (OI)

Senior data analyst: Judith Swindell

Quality assurance manager: Paul Armitage

Any complaints about the inspection or the report should be made following the procedures set out in the guidance 'Raising concerns and making complaints about Ofsted', which is available from Ofsted's website: www.gov.uk/government/publications/complaints-about-ofsted. If you would like Ofsted to send you a copy of the guidance, please telephone 0300123 4234, or email enquiries@ofsted.gov.uk.

Piccadilly Gate
Store St
Manchester
M1 2WD
T: 0300 123 4234
Textphone: 0161 618 8524
E: enquiries@ofsted.gov.uk
W: www.ofsted.gov.uk