

Devon County Council

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 Board¹

Inspection date: 24 February – 18 March 2015

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The overall judgement is that children’s services require improvement

The authority is not yet delivering good protection and help and care for children, young people and families.

It is Ofsted’s expectation that, as a minimum, all children and young people receive good help, care and protection.²

The judgements on areas of the service that contribute to overall effectiveness are:

1. Children who need help and protection	Requires Improvement
2. Children looked after and achieving permanence	Requires Improvement
2.1 Adoption performance	Good
2.2 Experiences and progress of care leavers	Inadequate
3. Leadership, management and governance	Requires Improvement

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.

² A full description of what the inspection judgements mean can be found at the end of this report.

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The local authority

Summary of findings

Children's services in Devon require improvement because:

Quality of work with children and young people

- The local authority cannot currently assure itself that 301 of its care leavers are receiving appropriate support to prepare for adulthood.
- Not all children and their families receive a coordinated offer of early help when concerns are first identified.
- Some children experience delays in having their needs and risks appropriately identified and addressed. This is most apparent for children living within situations of chronic neglect.
- The quality of assessments and plans for children remains too variable, with some still being very poor.

Management of service quality and provision

- Frontline practice, including assessment, planning, reviewing and delivery of support to children and families, is not sufficiently quality assured to ensure a consistent and appropriate level of service.
- Performance monitoring has improved significantly. However, further work is required to ensure that it is informed by quality measures and comparator information.

Leadership, Governance and Partnerships

- Some data collected by the local authority are not yet reliable enough, particularly data about care leavers. Further work is required to make sure that data are accurately reporting activity and are sufficiently reliable to inform planning.
- Individually, children who go missing and are at risk of child sexual exploitation receive services to identify and reduce risk. However, there is limited strategic overview of the effectiveness of these services, and the themes and intelligence are not being shared for all groups of children to ensure that prevention and disruption measures are fully effective.
- The governance and planning arrangements between the local authority, the Health and Wellbeing Board, Children and Families Alliance and Local Safeguarding Children Board are not clear.
- Professionals from partner agencies are not fully engaged within early help and do not always attend relevant safeguarding meetings for children.
- Effective joint commissioning arrangements are not yet in place.

What does the local authority need to improve?

Priority and immediate action

Quality of work with children and young people

1. Review all those care leavers about whom the local authority does not have up-to-date information and ensure that they are safe.
2. Ensure that care leavers receive high quality services to meet their assessed needs, with a specific focus on pathway planning and review processes, risk assessments for all young people living in unsuitable accommodation such as bed and breakfast (B&B) and access to health histories.
3. Ensure that children's past experiences are fully considered and that professionals adequately consider factors of chronic neglect when assessing referrals to the MASH, so that all children who require a statutory social work service receive one.
4. Improve the quality, consistency and timeliness of work with children for whom there are concerns about chronic neglect, especially when these are linked to any of the 'toxic trio' of domestic abuse, drug and alcohol abuse and parental mental ill-health.

Management of service quality and provision

5. Improve the quality of care leaver data and analysis so that the local authority is able to meet its corporate parenting responsibility to this group of vulnerable young people.

Leadership, governance and partnerships

6. Clarify governance arrangements between the key children's strategic groups to improve influence and impact in setting and achieving priority improvements. The Health and Wellbeing Board (H&WB), Devon Safeguarding Children Board (DCSB), the Children and Family Alliance (C&FA) and the Corporate Parenting Board (CPB) to coordinate, share and align plans and objectives.
7. Establish ambitious plans, with clear timescales, for full implementation of an effective early help offer.
8. Enhance work with children at risk of child sexual exploitation and those who have been missing from home, care or education, by strengthening strategic arrangements with partner agencies to identify and help the most vulnerable children and to drive prevention and disruption work at a county level.
9. Establish a stable, permanent middle and senior officers' group in children's services.

Areas for improvement

Quality of work with children and young people

10. Ensure that vulnerable children, including children looked after and care leavers and those in receipt of early help, benefit from high quality assessments and plans that identify needs and risks, and that these inform coordinated support and intervention.
11. Ensure issues of diversity are both considered and addressed for children who are receiving services.
12. Improve information sharing via the Multi-Agency Risk Assessment Conference (MARAC) process by ensuring that all designated local authority attendees have access to information on the multi-agency safeguarding hub (MASH) system.
13. Ensure that children looked after have their reviews undertaken within statutory timescales.
14. Improve the education outcomes for all looked after children, but particularly those in secondary schools.

Management of service quality and provision

15. Ensure that the local authority designated officer (LADO) service has sufficient capacity to manage and monitor in a timely manner investigation of allegations against professionals who work with children.
16. Ensure that there are clear transition arrangements in place for disabled children and young people when they are moving over to adult services.
17. Ensure that the health needs of looked after children are met, particularly those identified as needing a child and adolescent mental health service (CAMHS).
18. Improve the preparation, introduction and support for children who move from foster care to their adoptive placement to ensure that it is a positive experience for them.
19. Revise Public Law Outline (PLO) processes to reduce delay for the most vulnerable children, including timely completion of assessments and family group conferences (FGC).
20. Improve placement stability for children looked after.
21. Improve the proportion of care leavers in education, employment or training (EET), including higher and further education.
22. Ensure that work with homeless 16 and 17 year olds delivers improved outcomes.

Leadership, governance and partnership

23. Develop commissioning arrangements to ensure that they are aligned with agreed plans and engage all relevant statutory, voluntary and community sector agencies. Where possible these should be joint, shared or aligned across the statutory agencies.
24. Improve performance monitoring, reporting and evaluation of trends. This should include qualitative measures and comparator information.
25. Ensure that routine, quality feedback from children and families contributes to service direction and development at all levels.

The local authority's strengths

26. The local authority's positive recruitment strategy has resulted in a more stable workforce, thereby reducing the previous reliance on agency staff.
27. The local authority has recently established a model for undertaking strategy discussions within their MASH. Strategy discussions, following relevant consents, now fully engage key partners in important decision making and planning prior to child protection enquiries.
28. The local authority provides services to individual children at risk of sexual exploitation via its now expanding REACH team and has recently established weekly 'Missing Monday' meetings which effectively review and monitor the progress of children missing education (CME).
29. Privately fostered children receive a high quality and effective service which promotes their welfare. The service has built constructive links with local language schools and guardianship agencies. Assessments and intervention with children fully meet their needs, including those arising from religion and trans-national placements.
30. The quality of personal education plans (PEPs) for children looked after has significantly improved as a result of robust quality assurance by education managers within the local authority. This is yet to have a positive impact on educational outcomes for children in secondary schools.
31. The local authority has developed an innovative mobile telephone application (app) to engage more directly with children and young people.
32. The adoption team provides a good service to children with a plan for adoption. The team successfully achieves placements for children with complex needs, provides comprehensive training both for adopters and social workers and also delivers highly valued adoption support.

33. Adoption performance is a strength within the local authority, as is the promotion and support for special guardianship orders, which means that children are able to move quickly into their permanent family home.

Progress since the last inspection

34. The last Ofsted inspection of Devon County Council's arrangements for the protection of children was in April 2013. The local authority was judged to be inadequate. The last Ofsted inspection of Devon County Council's services for looked after children was in August 2009. The local authority was judged to be good. The quality of services for children looked after has deteriorated since this inspection.
35. The pace of change and progress since the last inspection has been sufficient to move the local authority to a position where its safeguarding services now require improvement. However, the pace of change was initially slow and this now needs to be increased significantly, particularly through active engagement of partners to ensure that early help and safeguarding services to children and their families continue to develop and become fully effective.
36. The last six months have seen notable progress made against recommendations from the previous inspection, including the improvement of risk assessment, management oversight and the extent to which the individual experiences of children are identified and considered. However, these improvements are recent and not yet found in all work with children and young people.
37. Progress against recommendations to improve the early help offer made at the time of the last inspection has been insufficient. Although plans to improve the co-ordination, quality and impact of early help services are now being put in place, these are too recent to have yet had an impact.
38. The local authority's workforce strategy has been effective in addressing the serious staffing challenges from the past. A far more stable base of permanent staff is being secured, thereby reducing the previous over-reliance on agency and interim staff and managers. This has meant that compliance and managerial oversight has increased, which is leading to some emerging improvements in the quality of work with children and families.
39. Senior managers within children's social care services have significantly increased their contact with frontline staff to ensure that they understand issues affecting them. This has led to a more responsive approach from managers to tackling problems as they arise.

40. By necessity, the local authority and its partners, through the Children's Improvement Board (CIB), have rightly focused their priority work on improving safeguarding services for children. This means that less attention has been given to developing services for children looked after. However, recent developments such as the launch of the refreshed Children's Access to Resources Panel (CARP) are beginning to bring greater focus to planning for children becoming looked after.

Summary for children and young people

- Inspectors found that some services for children have improved since the last inspection. For example, children in need of protection now receive services that reduce risks more quickly and efficiently.
- The adoption service is good; it is successful in placing children with complex needs and provides very good post adoption support for children and families.
- Managers have led improvements to services, but these have not been quick enough. The Director is very aware of this and plans to use the outcome of this inspection to help drive improvement faster.
- The quality of work with children and families has improved, particularly over the last six months. However, significant areas remain where practice is not yet good enough.
- There is a range of early help support for families, with professionals from schools, health and family services involved. However, not all agencies are making sure children and their families receive the right help at the right time.
- The quality of assessments and plans for vulnerable children is too variable, with some plans still being very poor and not fully addressing children's needs.
- Arrangements to support children missing education are good, but for children who go missing from home and care, they could be better.
- Children who are looked after achieve quite well at primary school, but too many older children do not do well enough at their secondary schools. The quality of personal education plans is improving.
- Children spoken to by inspectors knew their social workers and felt that they were listened to. However, a number had experienced frequent changes in social worker. Some children have to move homes too often, which means they may not feel settled.
- Support for care leavers is inadequate. There was some effective work seen which supported individual care leavers well. However, the local authority has lost touch with too many care leavers, and too few are in suitable accommodation or in education, employment or training.
- Care leavers are not clear about what they should be able to expect from the local authority in terms of support and financial assistance.

Information about this local authority area³

Children living in this area

- Approximately 141,554 children and young people under the age of 18 years live in Devon. This is 19% of the total population in the area.
- Approximately 13% of the local authority's children are living in poverty.
- The proportion of children entitled to free school meals:
 - in primary schools is 12% (the national average is 17%)
 - in secondary schools is 10% (the national average is 15%).
- Children and young people from minority ethnic groups account for 4% of all children living in the area, compared with 22% in the country as a whole.
- The largest minority ethnic groups of children and young people in the area are Mixed and Asian or Asian British.
- The proportion of children and young people with English as an additional language:
 - in primary schools is 3% (the national average is 19%)
 - in secondary schools is 3% (the national average is 14%).
- Additional contextual statement: The local authority's coastal areas have a transient population due to seasonal work and this is echoed in the agricultural areas of the county. There are a significant number of children from other authorities who are looked after in Devon.

Child protection in this area

- At 16 March 2015, 4,578 children had been identified through assessment as being formally in need of a specialist children's service. This is a reduction from 5,738 at 31 March 2014.
- At 16 March 2015, 476 children and young people were the subject of a child protection plan. This is a reduction from 600 at 31 March 2014.
- At 16 March 2015, 56 children lived in a privately arranged fostering placement. This is an increase from 48 at 31 March 2014.

³ 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.

Children looked after in this area

- At 16 March 2015, 684 children are being looked after by the LA (a rate of 48.3 per 10,000 children). This is a reduction from 685 (48 per 10,000 children) at 31 March 2014. Of this number:
 - 149 (or 21.8%) live outside the local authority area
 - 63 live in residential children’s homes, of whom 28.6% live out of the authority area
 - 18 live in residential special schools, of whom 16.7% live out of the authority area
 - 472 live with foster families, of whom 15.0% live out of the authority area
 - 15 live with parents, of whom 13.3% live out of the authority area
 - 2 children are unaccompanied asylum-seeking children.

- In the last 12 months, there have been:
 - 59 adoptions
 - 20 children became subjects of special guardianship orders
 - 344 children have ceased to be looked after, of whom 6.4% subsequently returned to be looked after
 - 15 children and young people have ceased to be looked after and moved on to independent living
 - the local authority did not record data regarding children and young people who ceased to be looked after and are now living in houses of multiple occupation during the year 2014–15.

Other Ofsted inspections

- The local authority operates one (secure) children’s home. This was judged to be adequate in the most recent Ofsted full inspection on 23 September 2014. An interim inspection was held on 24 February 2015 and the judgement was that the home has sustained effectiveness.

Other information about this area

- The Director of Children’s Services, who is also the Director of Adults Social Services, has been in post since 27 May 2011.
- The chair of the LSCB has been in post since August 2013.

Inspection judgements about the local authority

Key judgement	Judgement grade
The experiences and progress of children who need help and protection	Requires improvement
<p>Summary</p> <p>The quality of work with children and families, and the structures and procedures through which it is delivered, have improved since the last inspection. Consequently, outcomes for children and young people have also improved. This improvement is particularly evident over the last six months. Significant areas remain where practice is not yet good and strong services are not in place. However, where failings have been identified, these are not widespread or serious and children have not been left at risk of harm.</p> <p>The local authority is not yet working effectively with partners to improve the co-ordination and impact of early help services. This was a recommendation arising from the last inspection, and insufficient progress has been made. Partner agencies do not fully understand or apply thresholds for making referrals for a statutory social work service. A small number of threshold decisions result in no further action or a referral to early help services when the level of children’s or young people’s needs requires a statutory response.</p> <p>Information sharing between the local authority and partner agencies in the MASH is timely and thorough. Child protection strategy discussions happen quickly when a child who has been referred is thought to be at immediate risk of significant harm. Consistent management oversight and monitoring of cases within the MASH ensure that decisions are followed through and children are transferred to other teams or agencies to receive assessment and services.</p> <p>The quality of assessments and plans is not consistently good enough, and work with children who have suffered from neglect is not effectively addressing their needs. Social workers do not always consider the impact of children’s past history, particularly when domestic abuse, drug and alcohol abuse or parental mental ill-health have been a concern. Partner agencies are not attending important meetings for children, and so cannot be fully involved in information sharing and planning for children to ensure that the best decisions are made. Services for children with emotional difficulties or emerging mental health problems are limited, difficult to access and not joined up with other services for children.</p> <p>Individual work with children and young people who are at risk of child sexual exploitation or have been missing from home or education is often effective in reducing risk. The local authority and its partners have been less good at sharing information and planning strategically to identify the most vulnerable children and young people and to improve prevention and disruption work at a county level.</p>	

41. The local authority has not improved the quality, co-ordination and impact of early help services sufficiently for children and families in Devon since the recommendation arising from Ofsted's last inspection in April 2013. Although the current early help offer has been in place since April 2014, agencies are not as involved as they need to be to improve outcomes for children with additional needs. Schools take on the lead professional role in 59% of Devon Assessment Framework (DAF) interventions and children's centres in a further 15%. Other agencies are less involved, with health agencies being particularly low at 4% (as reported by the local authority's recording system at the time of the inspection). The quality of DAFs is variable, with most seen by inspectors being of poor quality with limited information included. This does not support effective planning with families to improve outcomes for children and young people.
42. Step-down arrangements have been in place since September 2014. However, the lack of engagement of some partner agencies means that when risk for children has been reduced and their needs could best be met through the provision of early help services, this cannot always be achieved in a timely or well-co-ordinated manner due to the difficulty in identifying a lead professional for the DAF and team around the child (TAC) process.
43. The early help offer is now being restructured to improve co-ordination and impact. This includes bringing together the youth service, youth offending service, young person's substance misuse service and targeted family support more firmly within early help. Additionally, eight early help co-ordinators, four early help advisors and a new county-level senior manager have recently been appointed. These are positive steps, but are too recent to have had an impact on practice.
44. Targeted Families, which is the name in Devon for the government's Troubled Families programme, has operated in isolation rather than as an integrated part of the early help offer and had 'turned around' 53% of the 1,370 identified families by the end of December 2014. This is below the national average of 59%. Plans are in place to move this service into the broader early help offer from April 2015 onwards.
45. Referral thresholds for statutory social work services are not fully understood or applied consistently by referring agencies. This means that some children are referred when their needs may be met by early help services, while other children may miss out on the service needed to adequately address their needs.
46. Contacts about children for whom there are safeguarding concerns are quickly passed by the contact centre to the MASH, which brings together staff from the local authority with professionals from a broad range of relevant agencies. Parental consent to share information is routinely sought when contacts are received. The MASH also offers helpful consultation and advice to members of the public and professionals who are considering making a referral.

47. Managers within the MASH have oversight of all incoming work and, once children's cases are progressed as referrals to children's social care, they provide timely direction about assessments or services required. Information sharing between agencies within the MASH is thorough, particularly within child protection strategy discussions, which routinely involve health and education in addition to the statutory presence of police and local authority staff. This provides a solid foundation for assessing risk and making decisions, and is a strength.
48. When children are assessed as at immediate risk of significant harm, child protection investigations are almost always undertaken in a timely and focused manner, both within and outside office hours. The local authority has made significant improvements in the timeliness with which they hold initial child protection case conferences, 92% of which were held within the statutory timescale of 15 days at December 2014; this is better than similar local authorities.
49. Whilst there is regular managerial oversight of work within the MASH, the rationale for decisions is not always clear when there is not an immediate presenting risk of significant harm for a child. In a minority of cases, contacts about children result in no further action or a referral to early help services when the information received should have led to a statutory social work service. This means that children do not always receive assessments and services that are proportionate to their needs or robust enough to improve their outcomes. For some children, repeated contacts or referrals take place before services are provided and improvements achieved. Decision making in these cases frequently lacks an adequate consideration of children's histories or recognition of the cumulative impact of neglect.
50. Many children have experienced multiple changes of social worker and team manager and, for some children, this has led to poor decision making and delay. This is particularly evident in situations of chronic neglect, where there is a need to consider the cumulative impact on children of neglect and the 'toxic trio' of domestic abuse, drug and alcohol misuse and parental mental ill-health. The local authority's own case auditing highlights the need to strengthen its work with children in need, for many of whom such issues are the main concern. This picture has recently improved with the appointment of more permanent social workers and managers, less staff turnover and a reduced reliance on temporary agency staff. There has also been a general improvement in decision making and practice over the last four to six months, although further improvement and consistency are required.
51. Although still overly narrative and lacking reflection, the regularity and quality of management oversight and supervision has also improved over the same timeframe. Additionally, social workers report that the CARP acts not only as a route to access resources but also as a forum for gaining high quality consultation and advice on complex cases.

52. Domestic abuse continues to be a central concern for a high proportion of children subject to protection plans in Devon, but the local authority and its partner agencies have not been sufficiently joined up in this area of work. Although the police, who chair Devon's MARAC, report significantly improved attendance and engagement by the local authority over the last six to 12 months, gaps remain in the quality of information sharing and specialist advice available to social workers. Only one of the local authority's four areas has a specialist domestic abuse social worker to support best practice or a MARAC representative with access to the MASH electronic record system. This limits the quality of work and depth of relevant information that local authority attendees are able to bring to the MARAC. The need for better attendance and engagement by all agencies was highlighted in the CAADA (Coordinated Action Against Domestic Abuse) review of the MARAC in Devon carried out in September 2014.
53. Regular multi-agency public protection arrangements (MAPPA) meetings are consistently attended by senior local authority managers. The police chair reports that the local authority's commitment to, and engagement with, the MAPPA process has significantly strengthened over the last six to 12 months. Evidence that proactive communication between agencies is leading to earlier identification of risk was seen by inspectors.
54. The quality of assessments and reports to child protection conferences is not consistently good enough. Many lack clarity, consideration of key issues, an adequate analysis of the impact of concerns on children's welfare and what needs to change to improve things. The use of the 'RISK 2' assessment tool by social workers is embedded in practice and is helping to sharpen the focus on risk and protective factors. However, social workers currently lack clarity about whether the RISK 2 assessment or the social worker's report is the main document for child protection conferences. Social workers' reports are often overly brief and lacking in analysis, although risk and protective factors are listed. This does not best support informed and clear decision making and planning for children and young people.
55. Although the local authority has a sharp focus on improving the timeliness of single assessments, they are not yet completing assessments within a timescale to meet the child's needs and are also not meeting their own target of 45 days. The most up to date figure, from the local authority's own data, of 63% for January 2015 is below the 2013–14 average figures for similar councils of 82%. This means that some children are experiencing delay in having their needs assessed and met.
56. At 31 March 2014, the proportion of children subject to child protection plans in Devon was slightly higher than the figure for similar local authorities (42 against 41 per 10,000). Neglect is the key concern for 67% of children and young people subject to child protection plans at January 2015. This is an increase from 2014 and reflects the local authority's increasing focus in recent months on robustly addressing issues of neglect for children.

57. Child protection conferences and core groups are held regularly, and this is also increasingly true for child in need meetings. However, plans are not always clear about what needs to change, by when and who is responsible. They are not used routinely to drive or measure progress. The local authority has created an improved planning template; however, it is not yet being used consistently. Although meetings are generally well run, their effectiveness is hampered by the variable quality of inter-agency working. Some meetings are not attended by all key professionals, so the information needed to plan and measure progress is not always fully available. In December 2014, 42% of relevant health professionals, including GPs, CAMHS and adult mental health practitioners, did not attend child protection conferences. A particular difficulty is also reported regarding attendance by adult mental health and drug and alcohol professionals.
58. Unborn children for whom there are concerns are referred through the MASH process. In January 2015, 47 (3%) of MASH contacts were from midwives and 16 child protection plans (3% of children subject to plans) were in place for unborn children. Assessments of risks and needs for these children are consistently carried out. However, the local authority's risk assessment tool for pre-birth assessments does not focus sufficiently on the specific risks and considerations for these children and so does not support clear analysis and planning for them.
59. The quality of practice for safeguarding disabled children is inconsistent, with some delay and a lack of clarity when considering risk. However, children are not left at risk of significant harm or without the provision of appropriate services. Transition arrangements between children's and adults' services are not clear, and the local authority is working with partners to develop agreed pathways to streamline processes for disabled young people and their families.
60. Almost all children are seen regularly by social workers and seen alone when this is appropriate. The voice of the child is increasingly evident in case recording, which is kept up to date in most cases. Purposeful recording of visits to children is supported by a template introduced within the last six months that has specific sections to record the purpose of the visit, the child or young person's wishes and feelings and an analysis of the visit. A number of examples of good direct work were seen during the inspection, particularly in the work of family practitioners who work with families alongside social workers, and in that of the specialist REACH team.

61. The REACH team provides a range of effective interventions with young people at risk of child sexual exploitation and was providing such support to 70 young people at the time of the inspection. The team's work is well integrated into wider planning and work with children and young people. Young people say that they value the service, and inspectors saw evidence that risk for young people is reduced as a result of interventions. Although not always completed with sufficient clarity by social workers, the child sexual exploitation indicator tool, which is repeated at regular intervals during interventions, acts as a helpful measure of risk and of progress made in reducing it. The resource for the REACH team is being increased, as they are currently working to capacity and have a waiting list of 15 young people.
62. The REACH team also provides return home interviews to children and young people who do not meet the threshold for statutory social work intervention and have been missing from home. The team's current staffing level means that they are struggling to meet their standard of providing return home interviews within 72 hours of the end of a missing episode. Consequently, of the 45 return home interviews completed in January 2015, only 50% were achieved within 72 hours.
63. Return home interviews for children and young people receiving a statutory social work service who have been missing from home or care are carried out by their allocated social worker. In most cases, although it is clear from records that return home interviews are being conducted, there are some gaps that may limit their impact, such as missing documents, poor analysis or delay in conducting interviews. Learning from return interviews and child sexual exploitation risk assessments for individual children is being used to inform planning, and evidence was seen of the risk of sexual exploitation being reduced for children and young people. In a number of cases, complex strategy discussions with the police have been used effectively to consider groups of young people. This has led to the conviction of offenders and proactive measures to disrupt perpetrator activity, such as sex offender prevention orders (SOPOs) and the issuing of child abduction notices.
64. Recently established weekly 'Missing Monday' meetings, which include children's social care, attendance and education staff, and the virtual headteacher, review and monitor the progress of vulnerable children. They are an effective forum for ensuring that children missing education (CME) are swiftly identified, tracked and returned to education in Devon or elsewhere. This meeting considers electively home educated children and those attending part-time for whom a safeguarding concern has been identified. The meeting also monitors those in alternative provision to ensure they are in receipt of their 25 hour entitlement.

65. Local authority officers work with the commissioned school improvement provider to monitor the use of alternative provision in maintained schools. This is an agenda item for the regular meetings between school improvement professionals and headteachers. Any concerns are reviewed by the Head of Education and Learning. Education, health and care plans are reviewed as part of the regular annual monitoring of pupils with a statement of special needs. The commissioned provider for school improvement is responsible for working with maintained schools in evaluating the outcomes for children with special education needs and disability (SEND) pupils through its regular monitoring cycle.
66. Themes and patterns from return interviews and missing information, child sexual exploitation and CME data are not yet brought together to create a holistic picture to inform strategic planning, prevention and disruption activity across Devon. Multi-agency child sexual exploitation (MACSE) meetings are held monthly in venues across Devon to consider risk to children and young people who do not receive a social work service; these and complex strategy discussions provide information sharing and planning forums to reduce risk for individual children and some linked groups of children and young people. The local authority and partners do not yet have a mechanism for sharing themes across the local authority, nor a single list cross-referencing relevant data that identifies Devon's most vulnerable children and young people. During the inspection, the local authority reacted swiftly to concerns raised by inspectors about the lack of oversight of themes for children at risk of sexual exploitation who are subject to a child protection plan, and established a Vulnerable Children's Panel. The local authority and partners are aware of the need to further develop their approach to child sexual exploitation and missing.
67. The local authority's private fostering team provides a high quality and effective service that helps to promote the welfare of privately fostered children and young people. The service has been proactive in building links with language schools and guardianship agencies, children from which currently account for 41 of 52 private fostering arrangements. Consideration of children's identity needs arising from their ethnicity, culture and religion was a recommendation from the last inspection and although still not routinely considered, some examples of good practice were seen by inspectors. The private fostering team has shown considered and creative practice in ensuring that privately fostered young people are supported in their religious beliefs and, when placed trans-nationally, in maintaining the language and culture of their native country. This has helped young people to settle in their private foster homes and enhanced their welfare.

68. The LADO provides well considered and safe management of the investigation of allegations against professionals who work with children. However, the timeliness with which this work is carried out is poor in most cases. The local authority conducted a review in late 2014, and is considering options to increase the capacity within the LADO service to improve this. Although risk is reduced by prioritising cases based on risk assessment of their gravity and urgency, this remains a significant concern.
69. When 16 and 17 year old young people present as homeless, appropriate decision making and improved outcomes were seen in most cases looked at by inspectors. However, the local authority does not have the ability to track performance in this area as they do not consistently share information with partners and most data are held by housing services. This means the local authority does not have a clear picture of how well it is improving outcomes for this group of young people.
70. CAMHS provision is a weakness in Devon. It is characterised by lack of engagement with broader multi-agency work with children and limited service provision. Plans currently out to tender for a new 'tier 2' emotional wellbeing service for schools are positive, but not yet in place. 'Tier 4' in-patient provision is also limited. This has been highlighted by Devon's government appointed Children Improvement Board.

Key judgement	Judgement grade
The experiences and progress of children looked after and achieving permanence	Requires improvement
<p>Summary</p> <p>Decisions for children to become looked after have not always been timely. This means that a small number of children have been left in situations where their needs were not being met. The local authority has been working proactively to address this and ensure that children become looked after at the appropriate time. Once looked after, some children have experienced changes of placement. This has made it more difficult for them to feel settled or develop sustained relationships with their carers.</p> <p>Children spoken with say they have good relationships with their social worker. However, some have had changes of social worker. Currently only half of children looked after have contact with their IRO prior to reviews. Both of these factors make it harder for children to develop trusting relationships with key adults involved in planning for their care.</p> <p>The quality of work with children looked after is too variable. Whilst most assessments were of good quality, many plans lack clear detail about what is being addressed and in what timescale. Children and their families now benefit more routinely from family group conferences, with 142 being completed since April 2014.</p> <p>When children return home after going missing from care, they have an interview with their social worker in the majority of cases, and risk of child sexual exploitation is also explored. This ensures that effective plans are put in place to reduce risks for children.</p> <p>A lack of accurate health data for children looked after means the local authority cannot be confident about how well the health needs of these children are being met. The provision of CAMHS is currently insufficient to meet the needs of Devon’s young people, and half of children looked after requiring the service are not receiving it. Education progress for primary age children looked after is above the national average, but current outcomes at Key Stage 4 are poor. The adoption service is strong and is managed effectively to ensure that the majority of children requiring adoption are identified early and placed with suitable and skilled adopters.</p> <p>The local authority cannot evidence that it is in touch with approximately half of its care leavers and, as a result, young people leaving care do not consistently receive the support they are entitled to in order to help them make a successful transition to adulthood. Too many care leavers aged between 19 and 21 are not in education, employment or training, and too many do not live in suitable accommodation.</p>	

71. The local authority was looking after 684 children as at 16 March 2015. Numbers have remained stable for the past year, with 669 recorded as the highest figure in April 2014, dropping to 634 in September. No cases were seen where children have become looked after inappropriately. However, decisions for children to come into care are not always timely. Of 11 newly looked after children whose cases were seen by inspectors, three should have come into care earlier but were left in situations of increasing concern. The local authority has recently refreshed its approach to CARP to consider requests for children to become looked after and ensure that the right children enter the looked after system at the right time. It has access to legal advice, considers thresholds and can initiate requests for the PLO to commence. However, the evidence of these three children suggests that it is too early to see full impact.
72. Permanency and Legal Tracking Panels are held monthly in each area to track the progress of a child's journey to permanency. These have only been in operation for three months, so it is too soon to assess their impact. Children in need of adoption are being appropriately monitored. However, managers acknowledge that they are not yet confident that they know about all children who require other forms of permanency.
73. PLO processes do not always ensure that children become looked after in a timely manner. Inspectors saw cases with a clear PLO pathway, but in two cases seen there was evidence of delay. Devon has a higher proportion of children voluntarily accommodated (under section 20 of the Children Act 1989) than comparable authorities. The local authority believes this is due to legacy cases, but some cases are still presented to the CARP with a recommendation for Section 20 accommodation where a care order might be more appropriate. Information from the local judiciary indicates that too many cases of children accommodated under section 20 change into care proceedings without sufficient planning.
74. Children and their families are increasingly benefiting from family group conferences (FGC), with a rise from 103 in 2013–2014 to 142 in the year to date. However, FGC managers reported that these conferences are often recommended too late, for example when families are in crisis, and this was seen in one case viewed by inspectors. The FGC report (November 2014) shows that there have been 103 recommendations from CARP for a FGC since February 2014 when this became a mandatory offer for all families with a risk of a child becoming looked after. Of these, 26 had already been referred for a FGC prior to the CARP. Of the 77 new recommendations, only 17 were followed up by a referral for a FGC. The local authority has not explored the reasons why social workers are not promoting family group conferences more. The lack of referrals can cause delay in the court process and opportunities for children to be placed within their family or friends network may be missed.

75. Children confirm that they see their social workers regularly and their views are listened to. This includes those young people who live outside the local authority area. Children spoken to by inspectors all reported a change of social worker in the past year. In the year to January 2015, almost 30% of children had experienced a change in social worker. This limits their opportunity to develop a trusting relationship with a worker who has an in-depth understanding of their history and circumstances. The LA has taken action over the past year to reduce changes of social worker for children looked after and the figure for the year to Feb 2015 showed a big improvement at 12%.
76. Some good examples of direct work with children were seen which helped them to express their views and to understand their current circumstances. However, life story work is not carried out with children who are in long-term foster care to help them understand their histories.
77. Children said that they were happy where they lived and received a good service from their social worker. They said they were happy with their foster carers, who supported them with their education and hobbies. One young person said "we get a lot of support" and this was echoed by others. Children know how to complain, and one child had done so and received an appropriate response from the local authority. The children's guide is currently being refreshed; children said that they do not yet have a copy. This means that they may not have information regarding entitlements and relevant contact numbers for complaints, advocacy and support services.
78. Four children were missing from care at the time of the inspection. Two of these children had been placed in Devon by other local authorities and two were Devon children. They were all successfully located and returned to their placements as a result of coordinated work by social workers and police. Social workers are responsible for undertaking return home interviews, and arrangements are in place for those young people who live out of area, with effective liaison established with the relevant police service. These interviews inform effective planning to reduce future missing episodes. However, they are not always completed after each missing episode for some children who regularly go missing. In the majority of cases, multi-agency meetings discuss the risks associated with children who go missing repeatedly. These identify risks associated with going missing, including the potential risk of child sexual exploitation, and put effective plans in place to reduce them.

79. Foster carers reported that they have information and contact details for a range of useful services for young people. They have a fast route into services, including a local young people's drug and alcohol resource, and have recently received information regarding legal highs. They also said that they are clear about Devon's expectations regarding reporting children missing. Foster carers have received training on bullying and cyber bullying, and know that when bullying occurs in school they should make contact with education staff to ensure that the issue is addressed. Foster carers confirmed that delegated authority arrangements are in place and they are aware of their responsibilities. They believe that they are well matched with the children who are living with them.
80. The completion of health assessments recorded in the February Looked After Children Health Report 2015 is low, with only 19% of initial assessments completed within 20 days of the child becoming looked after and 42.4% of review health assessments completed on time. The local authority acknowledges that data on health assessments are not reliable, so it cannot assure itself that all children looked after are having their health needs met. The quality of health assessments viewed ranged from being comprehensive to having limited recording and evaluation. Plans identify health needs but are not always specific about what needs to be done and in what timescale. Too few children looked after have had dental checks (56%) and only 75% have had their emotional health needs assessed using the strengths and difficulties scale. Effective arrangements are made to ensure the health needs of those children looked after who are placed outside Devon are met by local services in their placement area.
81. Availability of CAMHS is a particular concern: the Independent Review Unit's January report notes that services are not available for 50% of children looked after who need them. The lack of CAMHS services may affect the outcomes for children in other areas of their lives, such as education and the development of friendship groups. In most cases seen, children with disabilities who are looked after have a good range of services provided, with agencies working well together to meet children's needs.
82. Children looked after achieve better education outcomes while in their primary schools than they do in their secondary schools, where their outcomes are poor. The number of children receiving fixed term exclusions has been reducing. Only 32 children looked after were subject to fixed term exclusions in 2013–14, with no permanent exclusions.

83. The proportion of children looked after attending good or better schools is 76%, which is below the figure for all Devon pupils of 84%. A higher proportion (82%) of children looked after attend primary schools that are good or better than secondary schools (72%). The latest figures show that 74 children looked after attend schools judged to require improvement and seven attend schools that are inadequate. The authority closely monitors the most appropriate school placement for children currently placed within inadequate schools and takes action to ensure they are receiving a good education.
84. Achievement data for the Early Years Foundation Stage in 2014 show that a lower proportion of children looked after attain a good level of development compared with all children in Devon. Similarly, Year 1 phonics screening checks show children looked after achieving less well than all children, and this has declined since 2013.
85. In 2014, children looked after were performing better than the national averages for this group between Key Stages 1 and 2 for reading, mathematics and particularly for writing. However, there continue to be significant gaps in the progress made by children looked after in these subjects when compared with all other Devon children. At Key Stage 2, the attainment gap has been narrowing between children looked after and other pupils since 2010. The proportion of Devon children looked after achieving the expected level in reading, writing and mathematics all show improving trends and in 2014 were above national figures in each subject.
86. Progress between Key Stages 2 and 4 for children looked after in Devon in 2014 is below comparable national data in English and mathematics and is well below progress against all pupils nationally. In 2014, 26% of Devon children looked after made expected progress in English compared with 39% for children looked after nationally. In mathematics, the proportion of Devon children looked after making expected progress in 2014 was 21%, compared to the national figure of 29% for this group.
87. The 2014 results for children looked after at Key Stage 4 were particularly weak. The proportion of children looked after gaining 5 A*- C GCSE's including English and mathematics fell to 6%, from a figure of 15.8% in 2011. This is now half the national average figure. The gap in attainment for 5 A*- C GCSE's including English and mathematics between Devon children looked after and other pupils remains significantly greater than the national figure. The local authority has identified this as an area for urgent action and has begun to take measures to improve outcomes for children looked after in secondary schools. Young people who live outside the local authority area have experienced difficulty engaging with education. For one, this had resulted in a reduced timetable for a period.

88. The proportion of children with up to date personal education plans (PEPs) is 93%. All plans are subject to robust quality assurance. The quality of PEPs seen was good; they were comprehensive, contained clear information on attainment with sharply focused targets, and also included responses from children, their teachers and parents or carers.
89. The education service for children looked after is well led, with the virtual school able to provide a comprehensive analysis of outcome data for children. A clear tracking system is in place for all children looked after, both within and outside the local authority, noting outcomes for their attainment and progress. As a result of this tracking system, during 2014, the local authority restructured the virtual school and introduced a multi-agency education panel to address the poorer educational outcomes for children during 2013/14. This structure is still too new to evidence sustained impact.
90. Placement instability indicated by children experiencing three or more moves within 12 months is 14%, which is higher than the England average of 11%. The local authority has recognised that this is an area of concern and has developed a number of initiatives to support placements. These include a service around the child approach offering CAMHS support and strategies to carers. The Placement Review Panel is attended by a number of agencies to agree plans of support to prevent potential placement breakdown. The role of fostering support workers is also being broadened in order to provide more support services, such as play therapy and solution-focused therapy for children in placements at risk of breakdown.
91. Assessments for children looked after are updated as part of the social workers' report to the review meeting; the quality of these assessments was variable. In the majority of cases seen, assessments were of good quality, with risks identified, impact of parental behaviour analysed and options for the future well covered. In half of the assessments, the voice of the child was captured well, giving full accounts of views regarding placements, education and wishes for the future. However, a minority of assessments lacked a robust assessment of risk, consideration of the quality of attachments and detailed analysis. The variability of assessments means that not all children's needs are properly addressed and that resulting plans are not all based on robust analysis of the child's circumstances.
92. Care plans effectively set out children's circumstances and they record detailed consideration of contact arrangements. Young people confirmed that they are able to maintain contact with family and friends. However, plans lack detail regarding actions and timescales to secure change.

93. Placements for children looked after are commissioned through a well-developed Peninsula Commissioning and Procurement Partnership. This includes a paper-based pre-qualification process, contracts and a site visit. The Commissioning team knows the Ofsted rating for all placements, and if a service is graded as inadequate, the local authority will suspend any new placements and review all existing placements, taking the children's cases to the placement resource panel for consideration.
94. The local authority has access to a large number of emergency residential placements. The brokerage team and the fostering service work well together to ensure that the most suitable placement is identified, but there can be compatibility issues if other children are already in placement. The local authority has met with residential providers to develop a service for four emergency singleton placements and this is under development. There are also 30 local authority foster carers available to take emergency placements out of hours.
95. Fostering managers monitor placement requests each month to ensure that they are recruiting the right carers to meet their demands. Currently the local authority is aware of its need to recruit carers to work with children with complex needs, those with disabilities and also parent and child placements. It has revised its foster carer recruitment plans over recent months to ensure that it can best meet the needs of Devon's children looked after. It has recruited 49 new foster placements. Taking into account placements lost, there has been a net gain of 26, still well short of its target figure of 73. However, the local authority is reviewing its current requirements for placements to establish a revised figure which is based on current needs. The local authority's figures show that just over half of Devon's children looked after are currently placed in its own provision.
96. The assessment, training and support of foster carers are effective. Assessments are comprehensive, clear, analytical and completed within timescales. Foster carers receive regular visits every four to six weeks from their allocated worker. These are effectively used to identify training needs and address any issues of concern. The skills and knowledge of Devon foster carers are being developed to equip them to manage children with more complex needs, teenagers and sibling groups. Fostering panel chairs and foster carers are positive about the service and the level of training and support offered to carers.
97. Plans for permanency are now being tracked by Permanency and Legal Tracking Panels to ensure that children are in appropriate placements, and without delay. Permanency planning meetings are held to coincide with review timescales and, for the majority of children, permanency options are addressed well. However, permanency discussions were not well replicated at the looked after review and it is not clear whether the review or the permanency planning meeting is the main driver to achieve permanency.

98. Legal advice is routinely available for social workers at the CARP panel and effective legal planning meetings are held when necessary. Court statements and letters before proceedings are clear, setting out the local authority's concerns and what needs to change. Local authority solicitors recognise that further work is required to ensure consistency in cases, drafting of PLO letters, use of chronologies, research and analysis.
99. Cafcass and the local judiciary report that the quality of assessments in care proceedings is variable. On occasions they have been incomplete or even absent, and this has resulted in delays for children. The local authority agrees with this view and is reviewing its current arrangements for completion of these assessments. It is not aware of how many cases are returned by the court as requiring further work nor of when local authority recommendations are not accepted by the court. This is an area of concern recently identified by senior managers and they have plans in place to analyse it.
100. Cafcass and representatives from the local judiciary report very good working relationships with the local authority. The average duration for care proceedings has shown an improving picture over time. The figure for 2012–2013 was 35 weeks, with the year to date figure for 2014–2015 showing as 31 weeks at the time of the inspection. Although timescales have improved, Devon remains behind other regional local authorities in the area that perform well within the target of 26 weeks but is now only slightly behind the national average of 30 weeks. A newly appointed judge is working with the local authority to identify the reasons for delays in order to improve practice.
101. In a majority of cases seen where children have been placed at home with parents, records do not clearly show how well risks for the children are assessed. However, social workers spoken to were able to describe the involvement of a number of multi-agency professionals who were working together to support placements and manage risks.
102. The local authority supports 196 children who are the subject of Special Guardianship Orders (SGOs). This is a growing area, and a new team will join the adoption service shortly to complete SGO assessments and offer support. The local authority is scoping how many long term foster carers (internal and external) will consider SGOs or adoption for children placed long term. The quality of SGO assessments is good, with careful consideration given to whether this option is the best for the children concerned. Support needs including finance and contact arrangements are addressed well.

103. Twelve assessments for brothers and sisters have been completed in the past year to evaluate whether siblings should be placed together or apart. These assessments are of good quality. Similarly, there are some good Child Permanence Reports, though this is not consistent and other examples of this important document were of insufficient quality. Children told inspectors that they felt fully prepared for moving into a permanent placement. They had access to carer profiles to obtain basic information about potential new families and carefully planned introductions. One young person talked about how well her social worker had listened to her unhappiness about her foster placement and had enabled her to move to carers where she now feels happy and settled.
104. There is no independent reviewing officer (IRO) annual report to give an overview of the work completed during the past year. It is unclear how many looked after child reviews have been completed within timescales. Data provided to inspectors by the local authority showed that of 829 children looked after or who ceased to be looked after in the previous 6 months, only 269 had a statutory review that was on time; 350 were late and 210 had no record. This contrasts with what the IRO service told inspectors, that only 17 reviews have gone over time in the past six months. This discrepancy needs to be addressed urgently by the local authority in order to assure itself that children's plans are being reviewed in a timely manner.
105. IROs see children prior to reviews in only 51% of cases. This means that almost half of Devon's children looked after do not have opportunities to share their views with a key individual who is shaping their future. IROs are now escalating cases in accordance with a process introduced in September 2014 to challenge social workers when plans have not progressed or actions have not been taken following reviews. IRO managers collate information to analyse trends and attend managers' meetings to discuss their findings. IROs report that the escalation of cases has not always been well received by social work teams, and more needs to be done to develop a shared understanding that the escalation process is to promote the welfare of children.
106. Children looked after reviews observed by inspectors showed good engagement with young people and their families, with clear discussions and reasons for actions taken. In one case, a child had met with an advocate prior to the review and his views were shared through a comprehensive document along with the completed My Review form. In another, considerable direct work had been completed with two young children to ensure that their views were included in the meeting. The number of My Review forms completed is declining each month. This has been recognised and a new mobile phone app-based advocacy service, Mind of my Own (MOMO), has recently been commissioned by the local authority. This shows strong potential to provide a more accessible form of communication for children requiring support, and also when making complaints.

107. The number of children supported by an advocate is steadily increasing, with IRO managers reporting that 50 children now receive this support. The latest data (for October to December 2014) from the independently commissioned advocacy provider show that of 82 referrals, 11 (13%) were for children looked after reviews. Children spoken to were all aware of the advocacy service, but more needs to be done to ensure that all social work teams are promoting its use.
108. The local authority has an established Children in Care Council which has worked with the corporate parenting board to develop a Pledge for children looked after. Several young people spoken to had been involved in the artwork and design of the promotional materials but could not recall what the Pledge was, suggesting that it lacks meaning for them. Engagement with children and young people is taking place through their involvement in staff training, the production of training films giving top tips for social workers and involvement in role swap days. Children and young people also met with children from foster families to help them understand their experiences of being looked after. Children's involvement in training and informing the service has been taken forward from the 2013 inspection, and children spoke enthusiastically about the social activities they shared in the Really I'm Ordinary group (RIO) group, and their enjoyment of the annual award celebrations.
109. Diversity is not well addressed in the majority of cases. In those cases where it was not well covered, there was a lack of detailed consideration given to identity and religion. However, some good examples were seen, including a deaf young person whose foster family all learnt sign language and another child who was supported when she was rejecting her heritage. Social workers spoke confidently about meeting the needs of children with disabilities and special educational needs, along with recognition of the impact of disability and history of birth parents.

The graded judgement for adoption performance is that it is good

110. Adoption is available as the preferred permanency route for a wide range of looked after children in Devon, including older children, brothers and sisters together, disabled children and children with complex needs or serious medical issues.

111. Adoption performance has been improving. The adoption scorecard shows that the proportion of children looked after who are adopted has increased over the three-year period 2011 to 2014. In 2012–13 the proportion was only 8% and this increased to 12% in 2013–14. Although this equates to an increase from 30 to 40 children, it is still below the England average of 17%. At the time of the inspection, 13 children with a plan for adoption were awaiting permission from the court and 15 children with a placement order were waiting for a placement to be found. Matches for adoption have been made for 53 children; 44 of these have been placed and nine children are in the process of being placed. There are 28 children successfully placed awaiting an adoption order. There have been 60 adoption orders in the last 12 months, demonstrating continued good progress.
112. Measured against the 2011 to 2014 adoption scorecard, the local authority's performance is good, and shows that children in Devon move quickly into their permanent families. The average time between a child entering care and being placed with their adoptive families is 545 days; this is 83 days quicker than the England average, and continues to improve. Once the court has agreed that a child can be placed for adoption, a family is found within 153 days on average; this is 64 days quicker than the England average and on a par with the comparable authorities. While the average time over a three-year period had improved, it was longer in 2014 than in 2013 for this indicator.
113. Children in Devon receive a timely and comprehensive family finding service. This includes consideration of a significant number of in-house approved adopters; immediate referral to the adoption register; use of the South West Adoption Consortium; Voluntary Adoption Agencies and other linking services; DVD evenings; profiling events, where the foster carer was asked to attend to speak directly about the child; and regular use of adoption activity days and foster to adopt. Children's profiles seen were high quality, child centred and demonstrated the wide range of children that Devon aims to place for adoption. This included children over the age of five and placements for brothers and sisters together.
114. The local authority has been particularly proactive and successful in its development and use of foster to adopt placements, and has progressed 13 of these. Of the 13, only one child went home and one was turned down by the court. There have already been eight orders granted since national implementation of the scheme in 2013, resulting in continued placements for children and a quicker process. Assessments undertaken to provide interim approval to adopters for the scheme are of good quality. Foster to adopt was considered in all adopter assessments.

115. The adoption service makes good efforts in family finding for disabled children, brothers and sisters together, older children and for children with complex needs and developmental uncertainty. This commitment does, however, impact on scorecard performance. Some children were adopted before their first birthday, and recently an adoption order application has been submitted for a child who is only seven months old. A small number of children have been waiting too long for an adoptive family. The reasons for this vary, with some delays being due to extensive efforts to find a family for children with complex needs. However, for a very small number of children, avoidable delay was evident. Of five such cases seen, permanency had since been secured for three children but not yet for two. The local authority is aware of this and is working to ensure that it offers a timely adoptive outcome for all children who require it.
116. In 2011-14, care plans were changed from adoption to another outcome in 30 cases (14%). This is higher than the 12% England average. There is some evidence of improvement in this area, and at the time of the inspection 18 children (12%) had planned changes away from adoption. A sample of these cases showed that appropriate permanent alternatives have been identified for the majority of these children.
117. The local authority is successful in recruiting adopters, with the 2011-14 adoption scorecard showing a considerably better performance than the comparable authority average (75 compared with 42 as of 31 March 2014). A clear marketing strategy is in place for adopters, as is an up-to-date and robust statement of purpose to steer this area of work. The service is on track to reach its target of recruiting 60 adopters in 2014–15, with 55 already recruited by February 2015. All adopters spoken with were very happy with their recruitment, preparation and assessment; a number had already recommended the service to friends interested in adoption. They were equally positive about the matching process, including comments such as, '... couldn't have been matched any better and I didn't think they would get it so right' and 'had I known it was so easy, I would have done it sooner'. However, some cases showed that the initial experience of first contacting the adoption service was not universally positive.
118. All prospective adopter reports seen were of a very high quality; they were succinct, well evidenced and analytical. The use of theory and research in assessments was particularly impressive. The local authority is seeking to improve timeliness in preparation at stage 1 of the recruitment process, with the stage 2 assessment timescales being met in the majority of cases. All adopters spoken with said the pace had been the right one, and they did not consider that there had been any delay other than when this was needed or purposeful. The inspection found mixed feedback about how well the transition from foster carer to adopter is working for children, and this is an area that the local authority should review to ensure that it is getting it right consistently.

119. The local authority is well served by two adoption panels, which meet as regularly as required to ensure that timely progress is achieved. The medical adviser attends every panel, and meets adopters to provide advice and information. There is a culture of healthy challenge and learning, and a forthcoming Special Learning Panel will assist the adoption panels when considering their role in disruptions or complex cases. Disruptions are low in number and the local authority has undertaken considerable work to understand any themes over the last five years, including participating in national research. There have been two disruptions in the current year, and both had a disruption meeting and were appropriately managed. Decisions for children are appropriately considered and scrutinised by the Agency Decision Maker. An adoption agency report is completed every six months and is clear, analytical and well evidenced using clear data.
120. Training for staff, adopters and adoption panel members is excellent. An annual conference is held which focuses on current issues in adoption practice and research issues. Adopter feedback directly informs the programme for the following year.
121. Over the last year, to embed good permanency planning practice, the adoption team has trained 120 social workers on permanence, 60 on working with siblings and 60 on writing child permanence reports. The service provides a range of high quality tools and guides for social workers, adopters, children, carers, birth parents and birth relatives. Exceptional thought is given to considering the support and emotional needs of birth parents, including a settling-in letter soon after placement.
122. The adoption support service manages a high volume of work: 1,575 indirect letterbox support and 57 direct contact arrangements with families. The service has completed 125 assessments for adoption support in the past 12 months and has no waiting list. A wide range of services is offered, including advice and support from a participation worker and an educational psychologist, and the established therapeutic parenting course. Adopters spoken with who are currently in receipt of the post-adoption service were very positive about the service, describing it as 'without fault' and saying that therapeutic parenting had 'saved their family'. All adopters spoken with were aware of their entitlements regarding support, both now and in the future.
123. All children aged over two or with a complex history have a child appreciation day and 30 such days have taken place since 1 April 2014. Life story work materials are innovative and sensitive, and ensure that all people in the child's network are considered and that the child's needs are considered at different stages in their development. This includes two forms of life story books and later life letters that have been informed by input from adopted young people. In one case, the local authority had paid for a similar approach for voluntary agency adopters who were identified for a Devon child.

124. The adoption service has a participation worker who focuses on supporting and undertaking direct work with adopted young people. These young people have contributed to the development of the service by sitting on recruitment interviews; advising on materials, including later life letters; and through the creation of the 'stand up, speak up' website, which includes a young person's guide to adoption. Adopted young people can meet others in a group setting for advice and support or have individual direct work. The first summer activities day for all adoptive families, planned this year, will enable adopted young people to take part in a range of activities, while adopters meet separately for support.

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

125. The local authority has responsibility for 847 care leavers. Of these, 546 young people are allocated to personal advisors and social workers in the Permanency and Transition (P&T) teams. The authority does not know what, if any, support is being provided to the remaining 301 care leavers for whom it has corporate responsibility. These care leavers may be receiving services from other parts of the local authority, such as Learning Disability Services, but the authority is unable to verify this through accurate performance data. For those care leavers allocated to the P&T teams, where the local authority has undertaken work to assure itself of the accuracy of its data, there are a further 166 care leavers with whom the authority is not in touch. As a corporate parent, the local authority has failed to assure itself that a total of 467 of its care leavers are safe or that their welfare is being promoted through receipt of the care leaving services to which these young people are entitled.

126. There has also been a corporate failure to understand the extent of these widespread and serious failures, as performance in respect of care leavers is not monitored by elected members in accordance with the action plan set out in the local authority's corporate parenting strategy.

127. Only 64% of care leavers who are allocated within the P&T teams are known to be living in suitable accommodation. It is not possible to determine the full extent of unsuitable accommodation for all care leavers in Devon due to the lack of accurate performance data for this vulnerable group. Furthermore, the local authority does not know whether any of its care leavers are living in houses of multiple occupancy and is not confident about the reliability of the information held in respect of young people's accommodation. For example, initial information provided at the start of the inspection suggested that four young people were in bed and breakfast accommodation, but this was found to be incorrect. Measures are in place to prevent care leavers being placed in bed and breakfast, but this accommodation is used on occasions when there is no alternative available. In such circumstances, risk assessments are not in place and, as a result, the local authority cannot be assured that care leavers are safe in their accommodation. Following detailed scrutiny of data by inspectors, it was clear that there were no care leavers living in bed and breakfast accommodation at the time of the inspection.
128. The number of care leavers in education, employment or training is below the national level. The proportion of care leavers aged 19, 20 or 21 years who are allocated to the P&T teams and are in education, employment or training is 37% compared with the national level of 45%. Again, it is not possible to determine the full numbers of care leavers in education, employment or training due to the poor management information. Personal advisers and social workers have high aspirations for care leavers, and provide encouragement and practical support for them to move on to higher or further education. However, whilst there are 15 care leavers studying at university, this is just 4% of the Devon total and just over half the national rate. Only 11% of the total number of Devon care leavers are in education other than higher education, which is significantly below the national comparator of 19%.
129. Care leavers' assessments had not been routinely completed in a number of cases seen by inspectors. This means that subsequent plans are not informed by an assessment of need to assist young people in making a successful transition to adulthood. Pathway planning practice is variable, with a minority of plans seen which were comprehensive and provided a real sense of the young person. The majority, however, provided insufficient detail about need and risk to enable effective planning, and many lacked actions, timescales and contingencies. A new pathway plan format has been developed and is now in use, which captures young people's views. However, training had not taken place in advance of its introduction and its use is inconsistent.

130. Reviews of pathway plans for young people aged 18 and over are predominantly completed by personal advisors with the young person, without any management oversight. This is a practice which is not compliant with the local authority's own policy, which states that pathway reviews will be carried out by team managers. The review process is further weakened by the fact that pathway reviews are not subject to managerial sign off or quality assurance. There is a plan for managers to sign off all pathway reviews and for these to be quality assured through a panel process. However, at the time of the inspection this was not in place. As a consequence, the local authority cannot be confident about the quality of its planning and review processes for care leavers and whether young people are receiving the right support to assist them in making a successful transition to adulthood.
131. Inspectors met with a group of care leavers who all reported that they felt safe. They were positive about the support they receive from the Youth Service. They were also very positive about the support they receive from Devon Young People's Accommodation Service (DYPAS – a resource provided through the local authority's Fostering Service), as well as from a local charitable organisation, which is commissioned by the local authority. These services support young people to develop independent living skills and maintain their tenancies, and they promote health and well-being and provide direct work.
132. A wide range of accommodation options is available, including accommodation with individual support packages, training flats and supported lodgings. This is in addition to private tenancies and other housing options provided through the district housing authorities. All accommodation commissioned from outside the local authority is subject to quality assurance through the South West Peninsular arrangement, and placement provision is managed robustly through the placement panel process.
133. Young people looked after are encouraged to remain in their placements after they reach their 18th birthday through the staying put scheme. Sixty-one young people are in such placements across the county. Cases seen where young people were in these arrangements were focused on the young person's long-term needs and provided consistency and stability to enable a successful transition to adulthood.
134. It is evident that personal advisors in the permanency and transition teams are actively engaging with those care leavers who are known and worked with. They see them regularly and work hard to ensure that young people receive the support that they need. Personal advisors are strong advocates, and decisions are focused on what is in young people's interests. Personal advisors are generally positive about their experience of working in the service and report that there is good support from managers. They feel listened to and that decision making is child centred.

135. Information is not readily available for care leavers in an accessible format explaining their rights and entitlements. Whether young people receive such information and the consistency with which this occurs is too dependent on individual workers. Care leavers met by inspectors confirmed this lack of consistency. The local authority has already been proactive in addressing this, and has developed a new website and mobile phone application (app) which is about to be introduced across the county. These will offer a good range of information for children looked after and care leavers and provide a creative approach to capturing young people's views and experiences, including providing a simple way to enable young people to complain if they need to. Care leavers have been fully consulted and involved in the development of these resources and they reflect young people's views. Care leavers do not consistently receive information about their health histories. Work is underway to address this deficit, but is in its infancy.
136. From the cases seen in the permanency and transition teams, it is clear that personal advisors and social workers are ambitious for the individual care leavers they are supporting. They encourage young people to identify the positive aspects of their life and promote their aspirations. Personal advisors and social workers are positive about young people's achievements, acknowledging these by referring them for recognition through the annual celebration event held by the authority.

Key judgement	Judgement grade
Leadership, management and governance	Requires improvement
<p>Summary</p> <p>Since the previous 'inadequate' inspection judgement for safeguarding and child protection, much has been achieved in ensuring that compliance with core responsibilities is met. The achievements are substantial given that, following that inspection, even further deterioration in a range of service areas is reported to have occurred. Senior managers have a sufficiently clear understanding of very many of the challenges ahead for the local authority and key partner agencies. The focus has, by necessity, been on establishing a more effective child protection service response. This includes the additional efforts to address the needs of many more children who have experienced neglectful parenting for a long time. The real improvements are yet to be sufficiently secure, with a need for greater consistency to make higher quality responses routine.</p> <p>Senior managers, the Director of Children's Services (DCS), Chief Executive and a very involved Lead Member for Children's Services have prioritised this area of activity, ensuring that greater resourcing has been applied to achieve improvement. Accountability is exercised, although this is not always explicitly recorded. The more formal arrangements for scrutiny and governance within the local authority are in place, but are not sufficiently well focused on the key areas for improvement.</p> <p>Leadership at a strategic planning and partnership level is weak. The Children and Families Alliance, Health and Wellbeing Board and the LSCB do not evidence clear leadership, resulting in limited and insufficiently well-coordinated improvements, for example, in implementing a full early help offer. These impact adversely on the pace of change in driving improvements in jointly commissioned services. While changes involving partner agencies do take place, they are often slower than needed. The pace of improvement needs to be increased following the significant success in stabilising and improving the organisation and practice of the workforce.</p> <p>Progress has clearly been made in establishing more robust social care responses to risk and harm. Practitioners now want to stay working in Devon. Reduced workloads, reductions from the previously very high volumes of activity, and the establishment of more routine measures of performance and quality assurance reporting have all been introduced, contributing strongly to staff retention. The DCS and senior officers, some of whom are long-term locum workers, have focused their energies on establishing the safer core services, and have a clear and detailed understanding of the service and continuing challenges. The need is recognised for further work to achieve better performance and quality assurance information, and consequently greater consistency in management oversight.</p>	

137. The Leader of the Council, Lead Member for Children’s Services and the Chief Executive (CE) understand the recent history of the performance and quality of services for children. They are appropriately engaged with some improvement activity. However, much improvement remains at early stages of development (for example corporate parenting, the Children & Families’ Alliance, and strategic arrangements). Senior managers in social care show an extensive and detailed knowledge of the current range of needs, risks and performance for children within their remit. A transparent and thorough understanding of the challenges across the local authority and across the partner agency network is in place. This has been well supported through a robust CIB as well as recent peer review activity. The CIB continues to perform a significant role in supporting improvement, though there is now scope for the local authority and LSCB to take up a greater role in strategic developments.
138. While lines of accountability are clear between the individual statutory roles, the leadership and governance arrangements for strategic planning, commissioning and evaluation of impact are insufficiently clear and, in some respects, not evident. The lines of influence, authority and impact between the LSCB, H&WBB and C&FA are not sufficiently evident. The lack of clarity over governance contributes to the limited effectiveness of strategic planning between the local authority and the broader partnership of agencies.
139. Leadership within children’s social care has benefited from a team that shares a commitment to robust improvement. A number of key senior roles continue to be filled by interim arrangements, however the impact of this continues to be minimised through the use of consistent, longer-term interim staff. A necessary restructuring of middle management to support work with partners within geographic areas is also in progress. The local authority has recently agreed additional resources to support the DCS role and an external review of the test of assurance has been commissioned to risk assess the continued dual role of the DCS combined with that of Director of Adult Services.
140. A considerably more stable and an increasingly able workforce is now in place. Substantial progress has been made in achieving a consistent workforce of social workers from a previously high annual turnover of over 29% during 2014 to 11% at the time of the inspection. Agency staffing had been high (at almost a third of the workforce), but is now less than half what it was in December 2014. Some staff expressed low morale, although two staff surveys held within the last 12 months indicate considerable improvements in confidence and in feeling clear and supported in their roles. A high proportion of locum staff remain, many of whom have been in position for relatively lengthy periods of up to, or more than, a year. Some locum staff have been retained above establishment to support the service with the relatively high number of newly qualified workers.

141. Senior managers in the local authority children's services have a comprehensive knowledge and understanding of the quality, variations and extent of service delivery across the area. Many arrangements are in place supporting this, including critical decision-making arrangements (through, for example, the CARP and private fostering oversight), direct personal contact with teams and practitioners across the area, proactive principal social workers, and the substantial and continuing efforts to establish effective performance reporting and quality assurance. Some of these changes are recent and all require further refinement.
142. The number and limitations of current data systems have contributed to a failure to establish a reliable platform of performance reporting data and outcome focused analysis. Performance and quality assurance reporting is increasingly understood and actively used at all levels across the area. This includes an established, routine and evaluated quality audit programme. The local authority acknowledges that the focus has, necessarily, been on achieving compliance with statutory requirements. This is changing to a consideration of indicators aimed at identifying improved service quality and better outcomes for children.
143. Effective commissioning and joint commissioning strategies are not yet in place. Strategic governance arrangements between the local authority, LSCB, H&WBB and the C&FA are not yet informing commissioning strategies. The C&FA is identified as undertaking similar functions to the previous children's partnership, which has been dissolved. Commencing in autumn 2014, it is yet to be fully functional. This means that medium and long-term strategic planning cannot be well-focused, informed or targeted. The profile of those currently most vulnerable is known, being well described through a children-specific Joint Strategic Needs Assessment (JSNA), although the trajectory of changing populations of need is less well scoped.
144. Action has been undertaken to improve the integrity and accuracy of the range of local authority data, and this is now informing some planning, for example, in recruiting sufficient carers to meet the needs of children looked after. Some service re-commissioning has been conducted, with variable success. For example, some changes are being achieved in the provision of emotional health services. After a lengthy period of challenge and negotiation, hospital provision for Tier 4 CAMHS is now more assured. An extensive investment in services for those identified with early emotional health difficulties has been secured, but this will not be in place until the autumn of 2015. There is an improving focus on contract monitoring, using more regular reporting, with feedback from those who use services. Again, this is yet to be a routine approach.

145. The corporate parenting responsibilities for children looked after and care leavers are not well established, with the formal panel arrangements still in development. Elected members and officers are active in re-establishing and promoting the commitments of the overall council. While consultations have been undertaken with children and young people on a range of issues, these are yet to be a routine part of the formal arrangements. Priorities and work plans are yet to be established, although elected members are sufficiently supported by senior officers. There is currently limited evidence of the galvanising of engagement across the whole of the local authority, for example in supporting apprenticeships within, and brokered through, the authority.
146. The local authority scrutiny function is well established in focusing on specific issues, but is yet to be sufficiently and routinely focused on the key priorities and core responsibilities in relation to safeguarding and promoting the wellbeing of children. While there is regular contact between the chief executive, independent Chair of the LSCB and the DCS, the extent of robust support, shared planning and challenge is insufficiently evidenced.
147. The weaknesses in the local authority and multi-agency strategic leadership have impaired a number of improvements and slowed progress in others. Much remains to be done to ensure consistent understanding and ownership of thresholds for service; to deliver a robust, assured early help offer; and to progress the coordination and delivery of services to those most in need. For example, it is acknowledged that there is yet to be full coordination of activity between key agencies in identifying and combating the risks of child sexual exploitation. Additionally, early support and in-patient provision for those with emotional and mental health needs have either only been recently assured or plans are still in progress. Much more remains to be done with health partners to prioritise the needs of children looked after, as well as ensuring a greater level of coordination with adult mental health services.
148. Relationships with Cafcass, the family courts and the local Family Justice Board (FJB) are effective. It is recognised by all that there has been much improvement in the decision making on thresholds and in applications brought before the family court. However, there remains much more to be achieved to produce thorough and realistic assessments, concise histories and timely filing for family proceedings. Devon remains behind national performance expectations with the most recent average duration of 31 weeks (February 2015) for completing care proceedings. The challenges brought by the substantial increase in proceedings last year, many following long-standing neglect, have necessitated a considerable increase in investment to ensure that progress is being made.

149. Performance reporting is also recognised by the local authority as requiring substantial and sustained improvement. Significant progress has been made in recent months to identify and report on a broader suite of data and information. Service deficiencies are routinely identified and followed through rigorously from service to team to individual levels of responsibility. It is, however, acknowledged by the authority that many changes are yet to be delivered to ensure meaningful monitoring that can be relied upon to provide a full understanding of the effectiveness of services.
150. A broad and increasingly balanced range of information, data and intelligence is beginning to be used to support managers in focusing on compliance and future planning. The now embedded audit activity is adding an extra focus and detail not available within the higher level data. More broadly, evaluation and general learning from complaints are taking place and being used to inform performance.
151. Surveys, the youth council and other broader consultation methods have begun to be used to inform service planning and delivery. However, so far, these have been on a one-off basis. Learning from children's as well as adults' complaints is yet to be fully taken into account within the suite of qualitative information. There is limited insight to, and learning from, the specific and overall views of children and young people about the difference that interventions have been making to their lives. While advocacy arrangements are in place, again, there is more to be done to ensure that the voices of the most vulnerable children are promoted.
152. The workforce profile shows a current imbalance in the overall spectrum of experience and expertise. There are many practitioners in their assessed and supported year in employment (ASYE) after qualifying and they have a high regard for the support and development given to them. The range of development support, through mentoring and the dedicated assistant team manager relationship, as well as the mandatory training and other development opportunities, help them towards meeting expectations. Considerable work has also been, and continues to be, undertaken in re-skilling more experienced practitioners and managers.
153. Practitioners report consistently high levels of supervision, consultation and personal, as well as professional, support provided by their managers. Formally recorded case supervision is significantly improved in recent months, with clearer guidance and direction being seen in an increasing number of cases. It is primarily action-oriented with, as yet, limited evidence of reflective supervision being undertaken. Some inconsistencies across the areas remain. Senior managers are aware of this and are active in addressing the deficits identified. Social workers state that less formal case consultation is also regularly available and managers are routinely accessible. ASYEs welcome the developmental experience, including reflective consultation, available to them through their own specific development programme.

154. Comprehensive training packages are in place and are refreshed regularly to ensure current practice standards are understood and are being applied. Evaluation of training takes place at various points, with a good focus on the difference training has made to an individual's practice. Workloads for social workers are almost universally manageable. Account is taken of numbers, complexity and the experience and skill profile of practitioners. The ambitious target of social worker caseloads below 20 is almost achieved, and while some variation remains, this has been a considerable achievement by managers.

The Local Safeguarding Children Board (LSCB)

The Local Safeguarding Children Board is inadequate

The arrangements in place to evaluate the effectiveness of what is done by the authority and board partners to safeguard and promote the welfare of children are inadequate.

Summary of findings

The LSCB is inadequate because:

- The Board does not yet have a strategic plan in place for domestic abuse and neglect. This means that the Board cannot effectively use learning and intelligence to improve services, coordinate activities and assure themselves that children are safe.
- The Board does not yet have effective oversight of arrangements to understand and prevent harm to missing children or those at risk of child sexual exploitation.
- The progress and oversight of learning from Serious Case Reviews is not sufficiently robust, rigorous or timely.
- The Peninsula-wide Child Death Overview Panel (CDOP) is not effective in drawing lessons from child deaths in Devon and using these to inform strategic and public health planning to reduce incidents.
- The business support for the Board has not been strong enough to ensure the delivery of the work plan and drive improvement in the partnership.
- The section 11 audit process is not sufficiently robust in holding agencies to account.
- The evaluation of the effectiveness of early help is at a very early stage.
- Strategic arrangements in respect of multi-agency intervention and support to safeguard children in Devon are not sufficiently developed. Although the Board is emerging as a potentially influential strategic player, the Children's Improvement Board (CIB) is undertaking some key functions, such as ensuring effectiveness of safeguarding services, and there is no agreed transition date.
- The Board is not currently working to promote safeguarding in faith communities and more needs to be done to strengthen awareness and understanding of safeguarding in the voluntary sector, particularly section 11 responsibilities.
- The Board does not yet have a clear data profile of safeguarding needs in its area to inform strategy and planning.
- The Board's use of the child's voice and understanding of the child's experience is at an early stage and needs further development to inform and shape operational and strategic planning.

What does the LSCB need to improve?

Priority and immediate action

Development of key functions

155. Strengthen its operational and strategic oversight of arrangements to support effective safeguarding practice for children at risk from domestic abuse, neglect, and adult mental ill-health, adult substance misuse or as a result of disability.
156. Develop a local profile of child sexual exploitation and children who go missing to inform safeguarding, disruption and prevention and to support work strategically and operationally.
157. Review governance arrangements for Serious Case Reviews to ensure tighter management, accountability and urgency in learning and implementing lessons. The Board must ensure that all decisions not to carry out a Serious Case Review (SCR) since March 2013 have been sent to the National Panel of Experts. More needs to be done to raise awareness across the children's workforce of lessons learnt.
158. Review the work of the Peninsular CDOP and Rapid Response to ensure that these forums meet statutory requirements, and ensure that learning from child deaths is used to inform public health strategy and prevention effectively.
159. Board partners need to ensure that all appropriate agencies attend key safeguarding meetings to ensure that planning and review for children is informed by all relevant information.
160. Appropriately resource the Board's business support arrangements so that it has the right skills and resources available to deliver its programme.

Data and Performance

161. Establish a list of all children at risk of child sexual exploitation, or who are missing from home, care or education, to identify those children about whom the local authority and Police are most concerned, and monitor progress and performance closely.

Areas for improvement

Development of key functions

162. Ensure that the Think Family Strategy is fully implemented to drive a coordinated approach between children's and adults' services.
163. Ensure that Early Help arrangements are bedded in and effective, that thresholds are well understood and that lead professional roles are taken up by all partners as appropriate.

164. Develop a work plan to promote safeguarding in the faith sector and the voluntary sector.
165. Develop further the work around the child's voice and experience in order to inform Board priorities, strategy, planning and scrutiny.

Data and Performance

166. Improve the use of data to understand the extent of local safeguarding need and to inform priorities and planning.
167. Develop and fully populate the multi-agency data set in order to hold all agencies to account effectively for safeguarding performance, including the police and adult services.

Governance

168. Agree a timetable between the Chair of the LSCB and the CIB for the LSCB to begin resuming responsibilities from the CIB.
169. Develop stronger links with the Family Justice Board to ensure that it jointly oversees work with children in public and private law proceedings.

Inspection judgement about the LSCB

170. The LSCB started from an exceptionally low base and has had a considerable amount of ground to make up. The Board Chair is proactive in providing leadership; he has evaluated the weaknesses of the Board and set an appropriate direction of improvement based on an accurate assessment of its weaknesses. Significant progress has been made in setting up necessary strategic and operational changes, but these are almost all very new and not yet demonstrating impact in a number of key areas. Progress has been impeded in part by insufficient skills, support and resource in the LSCB back office. This has been addressed by the creation of a new post of Safeguarding Lead for the Board, but the Board Manager post is currently vacant.
171. The overall strategic arrangements for multi-agency intervention and support to safeguard children in Devon are weak. However, the Board is showing signs that it can be a potentially strong strategic driver within the partnership. It has not yet, however, secured enough influence with partners to improve the coordination of provision and hold them to account, and further progress needs to be made. Domestic abuse, mental ill-health, substance misuse and neglect are significant issues that place children at risk. The approach of Devon's LSCB needs significant, further development in all of them.

172. There is no joined up, multi-agency strategy in relation to domestic abuse in place to enable the LSCB to effectively monitor and hold partners to account for the delivery of early help and therapeutic support for children, support for adult victims, and intervention and prevention with perpetrators. The Board has plans to develop a neglect strategy, but this is not yet in place.
173. There has been progress in developing a Think Family approach for the partnership between adults' and children's services but this is still at an early stage of implementation. Two joint adults' and children's training events occurred in November 2014, a risk assessment tool for mental health services has been implemented, an Adult Mental Health worker joined the MASH in January, and a guidance document on drug testing has been developed to improve joint work. Think Family is incorporated into the induction of Adult Mental Health services. The Think Family toolkit has been written, but not yet rolled out. These changes are recent and it is too early to demonstrate the impact.
174. The LSCB does not yet have a strong culture of learning from SCRs and the children's workforce is not sufficiently knowledgeable about the lessons from these reviews. There have been a number of delays in progressing reviews and actions. SCR action plans are not robust or SMART, nor sufficiently evidenced. Whilst there have been some areas of progress, for example, developing planning around Think Family and training on the assessment of sex offenders, the progress and implementation of other areas of key learning has been too slow. Following one recommendation from a child death two years ago, limited progress has been made to find a mechanism to monitor the risk posed by adults with fluctuating mental health needs who have the care of children and who discharge themselves from treatment. A tighter governance process for SCRs has recently been agreed to address some of these issues.
175. The section 11 audit has relied too heavily on self-reporting, and the Board has not challenged agencies sufficiently to provide evidence around the basis for these declarations. The Board recognises that more needs to be done to strengthen the cross-referencing of these declarations through audit, staff survey and scrutiny. Board agencies need to be more robust in driving through improvements at frontline level. A section 175 audit has been completed by all schools and shows evidence of much stronger compliance with safeguarding standards.

176. Multi-agency partnership working is not yet effectively established. The findings from the staff survey in 2013, multi-agency audits and learning reviews show that many staff were unsure about information sharing, that multi-agency partnership work was not robust, and that agencies did not challenge well. Some agencies did not understand that safeguarding was everyone's responsibility and did not know when or how to make safeguarding referrals. There is variable attendance and contribution from GPs and the police at children's safeguarding meetings, low take-up of the lead professional role by some agencies, and low attendance at multi-agency training. Although adult services have made recent progress, they remain behind the pace in fully embracing the safeguarding agenda.
177. The CIB currently carries out a number of the functions of the LSCB, such as auditing and monitoring performance of Children's Social Care. There are no firm plans currently in place to guide transition from the CIB to the LSCB. This needs to be reviewed to provide the Board the opportunity to take back more of its statutory responsibilities.
178. Early help is at an early stage. The strategy, step down arrangements, and thresholds were launched in April 2014, but they are still bedding in and thresholds are not yet understood well by the partnership. Training for Lead Professionals has been limited and more work is needed to equip the work force to undertake this role. There are difficulties engaging some health and adults' services to take up the Lead Professional role. Monitoring of DAFs by the LSCB is very recent and learning from this is yet to inform practice.
179. Although there is a faith group representative on the Board, there is no work in place to raise awareness of safeguarding in faith communities. This means that the LSCB is not monitoring the effectiveness of policies, practice, and awareness in these settings that safeguard children. The work with the voluntary sector is stronger, but there has been limited work to ensure that the voluntary sector is working in line with their section 11 responsibilities. This would include robust safer recruitment and ensuring that the voluntary sector knows how to identify and report cases of suspected child abuse. The Board does not have a Lay Member, with the associated benefits they would bring.
180. A number of agency partners, including the voluntary and faith sector, do not yet have a strong enough understanding of how to manage allegations against professionals in their agencies, and there is a need for more training and support. The Board has set out a plan to increase resource to the LADO function and to address this following its review of the last LADO report.

181. The work of the Peninsula-wide Child Death Overview Panel (CDOP) is not effective in drawing lessons from child deaths in Devon and using these to inform prevention in strategic and public health planning. The CDOP report shows that modifiable factors are found in 31% fewer cases in Devon than in the rest of England, which suggests that some modifiable factors are being missed. The Rapid Response service is not meeting statutory requirements because it only convenes a full Rapid Response meeting in half of unexpected child deaths. This means that the causes of these children's deaths are not thoroughly investigated at the time of death and a coroner inquiry is not necessarily triggered. This potentially limits the agencies' capacity to understand the causes of these deaths correctly and consequently reduce the risks to other children. The Chair is addressing this with partners as part of a review of commissioning arrangements.
182. The MACSE Panels and the REACH Team have been in place for some time to address risk to children who go missing or are being sexually exploited. However, these arrangements have not been fully effective. The terms of reference have recently been reviewed for the MACSE panels, to clarify the extent of their role and ensure that the risks to children who go missing and are open to early help are thoroughly considered. REACH provides return home interviews to children missing from home and those placed by other local authorities and undertakes direct work with children at risk of sexual exploitation. Social workers undertake return home interviews with children who have an allocated social worker. The LSCB has not yet undertaken an assessment of the effectiveness of this work. The Learning and Improvement subgroup monitors data around children missing. It has also developed a data set to monitor and evaluate the impact of activity around children at risk of sexual exploitation, but this is currently unpopulated, so it is not yet used to understand performance.
183. The LSCB has not yet developed an analysis of child sexual exploitation taking place in its area, or of children going missing, in order to identify trends, patterns, and hotspots. It has not yet analysed return home interviews to understand the reasons why children go missing. In addition, there has not been a process in place to systematically consider the group of children open to children's social care services who are at the highest risk of child sexual exploitation. The LSCB and its partners also do not yet share information on the children about whom they are concerned, including children at risk of sexual exploitation, or missing from home, care or education. These factors together mean that the partnership is not yet able to identify prevalence or coordinate prevention and disruption work to full effectiveness.

184. The Board has very recently reviewed its arrangements for missing children and those at risk of sexual exploitation, and is making a number of changes to improve their effectiveness. A Vulnerability Panel has just been established to ensure that children at risk of sexual exploitation open to social care receive a multi-agency review. However, there is more work to do to ensure that information from the MACSE panels, Vulnerability Panels and Missing Monday Meetings (which considers those children missing education) is joined together to form a strategic overview of themes, issues, risks and hotspots to fully inform development and planning. Last year there were 17 Child Sexual Exploitation training courses which reached 291 participants, and 2 conferences attended by 92 members of staff. The Board is aware that there is more to be done.
185. The Board does not have clear oversight of the work plan in place with all schools for the prevention of child sexual exploitation. However, every school has received at least some briefing, training or publicity around the issue. Chelsea's Choice is being delivered across all secondary schools to help children recognise potentially abusive relationships and to understand issues of control and consent. There has been no awareness raising undertaken yet in the wider community, or with taxi companies, licensed premises or local businesses. This will be taken forward within future planning.
186. The Board is appropriately constituted, the right agencies are around the table at the right level and the partnership is developing confidence. The Board is led by an effective and visible Chair who provides clear direction and challenge to partners. He is held to account by the Chief Executive, and lines of accountability are clear. There is appropriate oversight of the MARAC and MAPPA, and there are links with the Health and Wellbeing Board in place, the Adults' Safeguarding Board and the emerging Children and Families' Alliance. However the Board does not work with the Family Justice Board, which is a statutory requirement, and this means that the Board does not oversee children in public or private proceedings.
187. The Board Chair is effective in challenging partners and has focused on a number of key areas. These include challenge to commissioners and providers of CAMHS over their services at tiers 3 and 4, and agency attendance at conferences and core groups. The Board also challenges agencies around the take up of the Lead Professional role in Early Help. Robust cross-agency challenge needs to become stronger and more embedded in the culture and practice of the Board.

188. The Board has an effective learning and development framework in place around multi-agency audit. It runs a number of thematic multi-agency audits which are used to inform Board reviews of key areas. These include Early Help, Sexual Abuse, Self-Harm, and Child Sexual Exploitation, and there is one planned for Neglect. These reviews consider the strategic and operational arrangements and develop an action plan to drive improvement. This is beginning to lead to some tangible improvements in these areas (for example, early help, sexual abuse work, self-harm) but many of these improvements are still emerging or are very new and will need time to bed in.
189. The Chair has developed a data set to measure and monitor multi agency performance in key areas, such as MARAC and MAPPA attendance, young people's waiting times for tier 3 and 4 CAMHS services and case loads in children's social care. This is a recent development, but sufficiently embedded to provide evidence of challenge to partners, and the challenge is becoming increasingly robust. The data set needs to be developed to include police data, and used to monitor the effectiveness of adult mental health and substance misuse services more effectively.
190. The Board does not yet have a demographic profile of need in its area which it uses to inform strategy, and to identify need or priorities. This limits the Board's capacity to understand its population and changing trends, to prioritise and challenge the effectiveness of strategic arrangements and partners. A detailed Joint Strategic Needs Assessment (JSNA), developed by the H&WBB, is now in place which considers safeguarding.
191. The Annual Report demonstrates progress made against priorities, and is rigorous and challenging. However, its evaluation of safeguarding in Devon is limited because it is not informed by multi-agency data or the JSNA and does not draw on lessons from serious case reviews. The Business Plan focuses the work of the Board on key priorities, and addresses a number of the issues raised in this report as areas for development.
192. Training has been an area of significant concern until September last year, with too many courses cancelled, a significant overspend on budget, poor agency take-up and poor quality content. The Board has reviewed and re-launched the training programme and quality assurance arrangements are now in place. There has been better agency take up of training and the new programme is more effective in targeting skills development. Lessons from SCRs are incorporated into the training, and the new programme meets the needs of the work force better. There is, however, still a gap in the training programme about disabled children, and the offer about mental health and the 'toxic trio' remains low at 70 places each for the year.

193. Training is evaluated through self-report surveys by both the practitioner and their manager. This gives more credible independent verification of impact and is good practice. Although there needs to be much greater co-operation by managers with this process, it provides some early independent evidence of impact, and therefore meets statutory requirements. However, it could be strengthened further by expanding the number of managers who engage and by developing this process routinely within the supervision arrangements in the partnership.
194. The Board uses the child's voice to inform planning, but the overall experience of children is not yet well understood by the Board and more work is needed to ensure that this is strengthened. The Board currently incorporates children's views in its multi-agency audits, and this has informed planning. For example, the strategy now includes a focus on training staff to speak to children. Although the Board has a set of procedures in place which cover the basic requirements of safeguarding, further development is required in some areas. Guidance with greater detail and direction for staff is needed in relation to domestic abuse, neglect and children who go missing.

What the inspection judgements mean

The local authority

An **outstanding** local authority leads highly effective services that contribute to significantly improved outcomes for children and young people who need help and protection and care. Their progress exceeds expectations and is sustained over time.

A **good** local authority leads effective services that help, protect and care for children and young people and those who are looked after and care leavers have their welfare safeguarded and promoted.

In a local authority that **requires improvement**, there are no widespread or serious failures that create or leave children being harmed or at risk of harm. The welfare of looked after children is safeguarded and promoted. Minimum requirements are in place, however, the authority is not yet delivering good protection, help and care for children, young people and families.

A local authority that is **inadequate** is providing services where there are widespread or serious failures that create or leave children being harmed or at risk of harm or result in children looked after or care leavers not having their welfare safeguarded and promoted.

The LSCB

An **outstanding** LSCB is highly influential in improving the care and protection of children. Their evaluation of performance is exceptional and helps the local authority and its partners to understand the difference that services make and where they need to improve. The LSCB creates and fosters an effective learning culture.

An LSCB that is **good** coordinates the activity of statutory partners and monitors the effectiveness of local arrangements. Multi-agency training in the protection and care of children is effective and evaluated regularly for impact. The LSCB provides robust and rigorous evaluation and analysis of local performance that identifies areas for improvement and influences the planning and delivery of high-quality services.

An LSCB **requires improvement** if it does not yet demonstrate the characteristics of good.

An LSCB that is **inadequate** does not demonstrate that it has effective arrangements in place and the required skills to discharge its statutory functions. It does not understand the experiences of children and young people locally and fails to identify where improvements can be made.

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 and two additional inspectors.

The inspection team

Lead inspector: Jansy Kelly HMI

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Quality assurance manager: Christopher Sands, Senior HMI

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