Plymouth City 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 board[1]

Inspection date: 22 October – 12 November 2014

Report published: 6 January 2015

The overall judgement is that children's services require improvement
The authority is not yet delivering good protection, 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

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	Requires improvement
	2.2 Experiences and progress of care leavers	Requires improvement
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 Inspection 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.

Contents

The local authority

Summary of findings

Children's services in Plymouth require improvement because:

Leadership, management and quality assurance

- Strategic leadership is driving forward an early help offer that meets the needs of children, young people and their families. Although recent improvements are evident, the pace of change needs to accelerate. The number of children receiving early help via the common assessment framework (CAF) has declined. Partner agencies do not fully understand thresholds, which results in a high number of inappropriate referrals to children's social care.
- High caseloads inhibit workers' ability to fully assess children's needs and to plan help effectively. Frequent changes in social worker inhibit the building of effective relationships with children, young people and parents.
- The supervision and oversight of social workers is not sufficiently challenging and does not encourage reflective practice.
- Management oversight, performance management and quality assurance processes are not yet robust enough. In some scrutiny activity by senior managers, an over optimistic approach is evident. IROs are not fully carrying out their roles and responsibilities.

Care leavers

- Services for care leavers do not do enough to help and support young people. Too many (47%) are not in education, employment or training (NEET).
- The quality of plans for care leavers is poor. Young people are not always actively involved in their creation or review. Plans do not ensure accountability for timely action.

Quality of practice

- The quality of most social work assessments, plans and recording is not good enough.
- The majority of looked after and adopted children do not receive good quality life story work. This means that they do not have relevant information to make sense of their life history.
- Over one third of looked after children do not benefit from timely initial health assessments. There has been a decline in the take up of dental provision.

Missing children and child sexual exploitation

- The quality of the recording of interviews carried out when children return after going missing is poor. Information derived from the interviews is not used adequately to analyse patterns and trends.

- The development of multi-agency arrangements to protect children from sexual exploitation (CSE) is relatively recent and, while there are signs that they are effective, it is too early to see the full impact.

Partnerships

- Attendance by police and general practitioners at child protection conferences is poor. This means that important information about children's lives is not always shared.
- Children who require child protection medical examinations wait too long for them. Neither the local authority nor the Local Safeguarding Children's Board (LSCB) has been effective in challenging health commissioners to remedy this deficit.

What does the local authority need to improve?

Priority and immediate action

Leadership, management and governance

1. Ensure that practitioners have reasonable workloads.

2. Improve management oversight on casework and the quality of staff supervision.

3. Improve the electronic social care record system so that it delivers accurate and timely data and performance information to improve the quality of service.

Child protection medicals

4. Robustly challenge commissioners to ensure that child protection medical examinations are conducted without undue delay.

Areas for improvement

Missing children

5. Improve the quality and analysis of return interviews of missing children so that they are an effective tool to safeguard individual young people and inform the strategic response.

Leadership, management and governance

6. Accelerate the implementation of the early help framework to prevent the need for escalation to children's social care and ensure that children get help at the earliest opportunity.

7. Conduct a further test of assurance, including a risk assessment, of the dual role of the Director of Children's Services (DCS).

8. Ensure that IROs and child protection conference chairs carry out their quality assurance roles in a way that provides robust scrutiny of practice and, where necessary, strong challenge.

9. Ensure that short-term placement stability is improved for looked after children.

10. Improve analysis to identify trends and ensure sufficiency of placements for children who require adoption.

11. Develop robust arrangements to monitor decision-making and progress of care planning for children who require adoption.

Care leavers

12. Take action to increase the number of care leavers in education, employment and training (EET).

13. Ensure that care leavers have detailed pathway plans that are up to date and set out clearly significant steps that will help them in their transition to independence.

14. Work with care leavers and looked after children to develop a local care leaver 'pledge' that reflects their needs and that is in clear and accessible language.

Quality of practice

15. Ensure that assessments are consistently of good quality, analytical, child-focused, and take into account risk and protective factors.

16. Ensure that children's plans are outcome-focused, specific and include timescales; are reviewed and updated following significant events; and are written in straightforward language that parents, carers and children can understand.

17. Take action to ensure that child protection conferences are held within statutory timescales and are attended by relevant partners.

The local authority's strengths

18. Family Group Conferences are well established and routinely used to support families and prevent children from coming into care. During 2013–14, these conferences prevented 108 children from entering care by helping extended families to make safe, alternative plans for them.

19. The voice of the child and young person is kept at the centre of all work. This is demonstrated at both strategic planning and commissioning levels, and in direct front line practice.

20. The workforce are skilled, committed and passionate about working in Plymouth, despite high workloads they are positive about the support they experience from their managers and each other.

21. On average, care proceedings in Plymouth are concluded in 27 weeks. The local authority's most recent unvalidated data shows 24.4 weeks. This is good performance and helps to reduce uncertainty for children.

22. The local authority has more children leaving care through adoption than the England average. In 2013–14, the total was 40.

23. The local authority has a strong partnership with the local Clinical Commissioning Group (CCG). Staff are located together and plans for pooled budgets are at an advanced stage. There is a plan to take forward the joint commissioning of early help, which will include the remodelling of family support services and the creation of a single point of contact.

24. A range of innovative work supports children and their families. This includes highly effective psychological interventions in the Parent and Child Assessment Team and the Family Intervention Project (FIP).

25. The Children with Disabilities Team and SEND Service demonstrate good quality, child-focused work.

26. The Parent and Child Assessment Team offers independent, professional assessments alongside specialist fostering provision. This manages the potential risk of harm while assessing parents' capacity. The assessments are of high quality, with good analysis, and are well regarded by the courts.

27. The local authority has a wide range of commissioned and in-house services for young people and families. Strategic commissioning is informed by a well-developed joint strategic needs assessment (JSNA), which includes key information on child safeguarding issues and vulnerability.

28. Corporate parenting is well embedded across the authority, with a strong commitment to the needs of looked after children from elected members and senior leaders.

29. A clear professional development framework is in place for newly qualified social workers during their assessed and supported year in employment (ASYE), and for staff in their second and third years after qualification. This includes a range of mandatory training and opportunities to gain advanced qualifications, including a postgraduate diploma in child and family studies.

30. The targeted youth support team provides a high level of support to young people over 11 years old, and has prevented young people aged 16 and above coming into care.

Progress since the last inspection

31. The last inspection of Plymouth's safeguarding arrangements and looked after children was in May 2010. The local authority was judged to be good for both services.

32. A number of areas requiring improvement identified at the last inspection remained evident during the current inspection. These include the need to improve management oversight and to improve the quality of chronologies and case recording. Nevertheless, action plans following the last inspection have led to some practice improvements particularly in the identification of chronic neglect.

33. The local authority is tackling the known weaknesses. Work is currently going on to pilot a reconfiguration of services that if successful will reduce the number of changes of social worker children and young people work with during their involvement with children's social care. Under the Council's transformation agenda, some improvements are being achieved in the early help offer and the Early Intervention and Partnership Board is reviewing priorities and the operational plan.

34. Work is well advanced to create a Multi-Agency Safeguarding Hub (MASH) and the police and health service have committed resources for this to be achieved. The impact of this is yet to be realised, though it will seek to address the ongoing uncertainties in relation to thresholds. The inspection team saw much evidence of committed and ambitious staff who wish to contribute to the improvement of services. Issues of capacity and workload remain stubborn obstacles for more rapid and substantive change.

35. The authority has established links between the Health and Wellbeing Board (HWB), the Children's Partnership and the Local Safeguarding Children's Board (LSCB), with the Director of Children's Services (DCS) a member of all three.

Summary for children and young people

- Inspectors found that services for children and young people in Plymouth require improvement to be good.
- Social workers have too much to do, which means that they do not spend enough time with children and young people.
- Some children have too many changes of social worker. This makes it hard for children to get to know and trust them.
- Improvements need to be made so that children can contact their social worker when they need to speak to them.
- When children need help and protection, social workers act quickly.
- When children need support to live within their family, in most cases children's services hold a Family Group Conference. This helps families to try to find their own solutions to any problems they may have.
- Children and young people only become looked after by Plymouth City Council if this is the right decision for them.
- There are not enough foster carers in or near to Plymouth. This means that some children have too many changes of foster carer when they first become looked after.
- Most looked after children go to good schools and have good attendance. When they do not attend, this is followed up to see what the problem is.
- When young people aged 16 or 17 have nowhere to live, for whatever reason, youth workers and social workers provide them with good support, including accommodation or foster care if they need this.

Information about this local authority area[2]

Children living in this area

- Approximately 51,000 children and young people under the age of 18 years live in Plymouth. This is 20% of the total population in the area.
- Approximately 22% of the local authority's children are living in poverty.
- The proportion of children entitled to free school meals:
  - in primary schools is 21% (the national average is 18%)
  - in secondary schools is 16% (the national average is 15%).
- Children and young people from minority ethnic groups account for 5% 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 5% (the national average is 18%)
  - in secondary schools is 5% (the national average is 14%).
- The Black and Minority ethnic (BME) population in Plymouth is small but growing rapidly. The latest census information (2011) shows that just under 4% of Plymouth's population were not of White British or White Irish descent compared with just under 15% nationally.

Child protection in this area

- At 30 September 2014, 1,734 children had been identified through assessment as being formally in need of a specialist children's service. This is a 16% decrease from 2,067 at 31 March 2013.
- At 30 September 2014, 423 children and young people were the subject of a child protection plan. This is a 41% increase from 300 at 31 March 2013.
- At 30 September 2014, 50 children lived in a privately arranged fostering placement. This is a 72% increase from 29 at 31 March 2013.

Children looked after in this area

- At 30 September 2014, 425 children are being looked after by the local authority (a rate of 83 per 10,000 children). This is a 14% increase from 372 (73 per 10,000 children) at 31 March 2013. Of this number:

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

- 137 (or 32%) live outside the local authority area
- 25 live in residential children's homes, of whom 72% live out of the authority area
- 2 live in residential special schools, both of whom live within the authority area
- 300 live with foster families, of whom 32% live out of the authority area
- 11 live with parents, all within Plymouth
- 5 children are unaccompanied asylum-seeking children.

- In the last 12 months:
  - there have been 29 adoptions
  - 15 children became subjects of special guardianship orders
  - 168 children have ceased to be looked after, of whom 8% subsequently returned to be looked after
  - 29 children and young people have ceased to be looked after and moved on to independent living
  - 10 children and young people have ceased to be looked after and are now living in houses of multiple occupation.

Other Ofsted inspections

- The local authority operates two children's homes. One was judged to be good and one to be adequate in the most recent Ofsted inspection.
- The previous inspection of Plymouth's safeguarding arrangements and arrangements for the protection of children was in May 2010. The local authority was judged to be good.
- The previous inspection of Plymouth's services for looked after children was in May 2010. The local authority was judged to be good.

Other information about this area

- The Director of Children's Services has been in post since January 2012.
- The Chair of the LSCB retired in August 2014. An interim Chair has been in post since October 2014. A new Chair has been appointed and is due to take up post in January 2015.

Inspection judgements about the local authority

Key judgement	Judgement grade
The experiences and progress of children who need help and protection	Requires improvement

Summary

The local authority and its partners know that improvements are needed in early help services, and they are working together to ensure better coordination and targeting. However, work remains to be done to achieve this. As yet, thresholds are not fully understood by all partners, which means that not all children receive the right help at the right time. This has contributed to high levels of inappropriate referrals to children's social care.

Nevertheless, children and young people who are at risk of harm are identified appropriately and swift action is taken to make sure they are safe. Strategy discussions make the right decisions about how to proceed when there are concerns about risk to children, but they do not always involve all of those they should, and they are not well recorded.

There is widespread awareness of CSE, and the response of the local authority and its partners to children who are or may be experiencing CSE is good. However, records of return interviews for children who go missing from home and care are not thorough enough and information from these is not collated or analysed to form a clear picture of prevalence or patterns in this area.

There are delays in convening child protection conferences, and multi-agency attendance is low. Child protection reports and minutes are written by professionals for professionals; therefore, they are difficult for young people, parents or carers to understand. Most children who are on child protection plans are visited regularly by their social workers, though in 10% of cases visiting was not frequent enough.

Caseloads of individual social workers are too high and this compromises the quality of practice. Management oversight of casework is not sufficiently robust or challenging. The quality of assessments is not consistently good and records of decisions are not always clear or detailed enough.

Family Group Conferences are well established and have helped extended families to find their own solutions and prevent children from coming into care.

Arrangements to identify and assess children and young people who are privately fostered are good. Awareness raising and training have resulted in a 72% increase in the number of private fostering arrangements known to the authority in the last 12 months.

36. Plymouth has seen a significant rise in the number of contacts (66%) and referrals (21.5%) in the last 12 months. Staff providing universal services do not fully understand the thresholds framework introduced at the end of last year. This has led to a rise in inappropriate contacts and referrals to social care, particularly to the advice and assessment service. This can make decision-making and prioritisation more difficult and means that not all children and young people in need of help have access to the support they need at the right time.

37. Troubled Families work in Plymouth is implemented through the 'Families with a Future' service. To date, 415 of the 650 families it has worked with have shown improvement. There is a wide range of early help services, including the family nurse partnership, infant mental health services, rapid response and early intervention. Children's centres play a key role in providing early help to children and families in the city. For example, 'Safe at Home' is a city-wide project supporting vulnerable families to keep their children safe at home – with 480 home safety visits completed during the last 12 months.

38. The number of assessments completed under the Common Assessment Framework (CAF) has decreased by a third in the last 12 months, dropping from 1,271 to 872. The local authority attributes this to strengthening the criteria for the completion of a CAF to ensure they are not completed solely as a tool for referral to children's social care but rather to promote 'team around the family' work. The quality of CAFs is variable, and the monitoring of quality requires improvement. Six (46%) of the 13 CAFs sampled were incomplete, lacked clear analysis of the child's and family's needs and did not set out how these needs would be met. The local authority has increasingly robust data to measure the impact of the range of early help services. However, work remains ongoing to establish a fully integrated outcomes framework.

39. Cases sampled by inspectors demonstrated that children who were at greater need or at risk are effectively escalated from early help to child in need, and then to child in need of protection, where appropriate. Similarly, evidence was seen of the effective 'stepping down' of cases, supported by the established use of Family Group Conferences (FGCs). Professionals working with children and families seek parental consent prior to sharing of information with children's social care. In all sampled CAFs, parents had both consented and signed assessments.

40. Arrangements are in place to respond to requests to children's services for information and help. Contacts and referrals are received by the advice and assessment screening team. An experienced, qualified team manager undertakes all decisions in the team. However, these decisions are not clearly recorded, lack a written rationale and do not establish next steps. Consequently, social workers are sometimes unsure of the action required of them.

41. Re-referral rates are high at 33%. In a small minority of cases seen by inspectors, children should have received a service when first referred but instead their cases were closed. It was only on re-referral that their needs were properly assessed. These decisions led to delays in children receiving the service they needed, but did not leave them at risk of significant harm.

42. Referrals progress to one of four advice and assessment teams for further work or assessment, and are allocated promptly to social workers. However, systems for allocation do not ensure that social workers are immediately made aware that a new case requires their attention. In a small minority of cases sampled, social workers were unaware that they had been allocated new work. This has the potential to cause delay in visiting children and responding to their needs.

43. Where child protection referrals require a strategy discussion, this generally takes place between police and children's social care team manager. Other agencies are not always involved. This means that potentially significant information from other agencies is not always considered at an early stage. This sometimes compromises opportunities to understand risks to children and young people. The outcome of strategy discussions, including grounds for decision, identified actions and timescales are clearly recorded but not sent out to partner agencies, leading to a lack of clarity about what actions should be taken.

44. By contrast the majority (62%) of strategy meetings are timely with appropriate agencies present. They result in good quality decisions and subsequent work, which considers risk and prioritises the needs of children.

45. Child protection medical examinations in the city are not prioritised. This means that children and young people who may be victims of abuse are required to wait for long periods, which adds unnecessary stress and delay to what is already a distressing experience for a child.

46. The number of children subject to child protection plans has increased by 41% since March 2013. Audits undertaken in 2013 by the local authority suggest that this is partly due to a greater recognition of disguised compliance and the significance and impact of chronic neglect following targeted work and training to raise awareness. The local authority is monitoring this trend to gain a fuller understanding of the reasons behind it.

47. Too many initial child protection conferences (56% in the year to date) are not convened within 15 working days of strategy discussions. The local authority is aware of the issue but little sustained improvement has been made. This means that children are experiencing delay between risk being identified, and multi-agency consideration of plans to protect them. The delay is a result of a lack of capacity to chair the conferences, and social workers not requesting conferences in a timely manner.

48. Multi-agency attendance at child protection conferences is poor. Police attended 34% of initial conferences and 2% of review conferences during the month of September 2014, with general practitioners (GPs) attending just 2% of reviews in the same period. This means that information about children is not always available to inform decisions about how they should be protected. In a number of cases seen by inspectors, conferences were not quorate and the chair had to contact agencies outside the conference. This compromises opportunities to fully understand risks to children and young people. Further work is required to improve contributions and attendance, in particular of police and GPs.

49. Plymouth's independent reviewing officers (IROs) also chair child protection conferences. They have high caseloads (80-100) which include both looked after children and children subject to child protection plans and additional responsibilities, including the chairing of complex strategy meetings and those where concerns are raised involving professionals who work with children. This limits their capacity to track and monitor cases between reviews and to provide effective quality assurance. The vast majority (96%) of child protection review conferences are held on time. Evidence was seen that children and adults in the child protection process had good access to advocates.

50. At the time of the inspection, 409 children and young people were subject to child protection plans. Neglect features in 54% of plans, emotional abuse in 29%, physical abuse in 15% and sexual abuse in 2%. Domestic abuse and unsafe parenting (64%) are the most commonly recorded risk factors, parental mental health features in 12% of plans and substance misuse in 19%.

51. The Multi-Agency Risk Assessment Conference (MARAC) considers cases of children living in households where there is domestic abuse. It is well established and attended by partner agencies. A good range of domestic abuse services is effectively co-ordinated by Plymouth Domestic Abuse Partnership. The Freedom Project supported 131 families during 2014. All staff working within Children's Centres have domestic abuse, stalking and honour-based violence (DASH) risk assessment training, and health services demonstrate innovation in creating opportunities to 'ask the question'. The Encompass early help initiative promotes the effective sharing with schools of domestic abuse incidents. Work with families where there is domestic abuse is appropriately aligned to a wide range of services in response to drug, alcohol and mental ill-health concerns. For example, the parental alcohol treatment service works with adults whose children are subject to a child protection plan.

52. The Family Intervention Service offers intensive long-term family support to families with multiple and complex issues. It works effectively on a multi-agency basis at all levels of need. Evaluations evidence improved outcomes for children where domestic abuse has been an issue.

53. The quality of the large majority (88%) of child protection plans and all child in need plans seen by inspectors required improvement. Plans for children do not identify clear outcomes, and the majority do not have specific, achievable targets with timescales and contingency plans. They are not clear enough to be used as effective documents for families.

54. Reports and minutes prepared for child protection conferences are unclear and are not written in language that is accessible to parents and carers. In most cases considered by inspectors, there was evidence of working agreements with parents being used alongside plans. Although simpler to understand than other reports or records, in a few cases sampled (12%) these were not monitored or reviewed. They were also used with some families who are unlikely to comply with stated objectives, which diluted their effectiveness.

55. Social workers do not always visit children subject to child protection plans in line with the local authority's requirement for fortnightly visiting. According to the authority's figures, the frequency has improved in recent months (August 64%, September 77% and October 88%), but this still means that more than one child in ten is not seen as often as needed.

56. Management decision-making is evident in the majority of case files, but the rationale for decisions and the actions required are rarely documented. This makes it difficult for social workers to understand what actions are required of them. Supervision is evident in the majority of case records but is not always purposeful as it lacks opportunities for staff to reflect on their practice. Case recording is not effective in providing evidence of the work done. This was particularly apparent in the advice and assessment teams, where records do not always make clear the reason for visits and lack evidence of challenge to parents.

57. Chronologies are present in the majority (80%) of cases, but are not comprehensive or regularly updated. In 19% of cases seen by inspectors, some significant events held within the wider electronic record were not recorded within the child's chronology. As a result, important information is not immediately available to social workers to inform decision-making, assessments and plans.

58. The single assessment, introduced in September 2014, is used across all social work teams. The quality of the assessments is variable, with the majority (71%) requiring improvement. Assessments are too descriptive, lack analysis and do not recognise or consider all risk factors. Very few of those reviewed (11%) use research to inform social work practice. Within nearly all assessments, the voice of the child was present and their wishes were known. Assessments completed by the Parent and Child Assessment Team were of good quality, clearly identified risks and provided a good level of analysis.

59. A specialist team works with disabled children, and provides good quality, child-focused work. There is a strong ethos of partnership working. The Special Educational Needs and Disabilities (SEND) service has a comprehensive online advice and information facility which signposts parents and young people to the range of services available from health, education and children's social care. Service user feedback comes from a parents' forum, 'Your Voice Your Child', which is represented on the strategic SEND implementation group.

60. Inspectors saw examples of children and families receiving services responsive to language, culture and ethnicity. This includes good use of interpreters and the translation of letters, assessments and reports. Learning from a recent police operation led to specific training to ensure understanding of the cultural needs of a group of children from a specific minority group who required foster care. However, these strengths are not consistent and further improvement is required: in the past month, the records of 49 contacts and referrals (approximately 9%) did not include details of the ethnicity of the child or young person.

61. The out of hours (OOH) social work service is effective in safeguarding children and young people. Legal advice is available to the team and there are clear criteria for authorisations. For example, independent fostering agency placements must be agreed by the Assistant Director. Communication between the OOH service and daytime services is effective in ensuring that emergency activity is followed up.

62. The 'Missing from Education Project' was launched in March 2014 and has developed well. Effective action is now in place to locate children who have not taken up their school place or who are no longer accessing education, and to increase access to education for those on a reduced timetable. The inclusion manager regularly reviews the list of children, and partnership with the Reducing Absence for Children in Care or Home (REACH) Team is developing to ensure that children at risk are known. Currently the list includes 18 children and young people on a reduced timetable, 32 children who were born in the city but did not take up a school place in reception and six children and young people who are considered missing from education. A range of activities and further checks are completed to establish the whereabouts of children and young people. These include contacting schools, home visits and checks with other agencies. One case sampled during the inspection demonstrated persistent and successful efforts to locate a child missing from education. The local authority reports some difficulties in data collection and work is underway to formalise local information sharing protocols with the NHS, Department for Work and Pensions and border control agencies.

63. The Local Authority, through a Service Level Agreement with the Alternative Complementary Education Service (ACE) provides an effective monitoring and support service to ensure the appropriateness of elective home education (EHE) through regular home visits. Where there are concerns, prompt referrals are made to the multi-agency Exceptional Provision Panel (EPP) to encourage children to return to school or to consider more formal action. The number of children on the EHE register is falling slightly year-on-year, from 158 in 2011–12 to 147 in 2013–14. There are 92 children on the register to date for 2014 – 15. No looked after children are home educated.

64. Multi-agency arrangements for the delivery of services in response to CSE have improved following national reports. Training and awareness has been co-ordinated by the LSCB Missing and Child Sexual Exploitation (MACSE) sub-group. Work has proved successful in promoting an increased use of a CSE screening tool for those who are at risk or are victims of CSE, and this is well supported by a wide range of voluntary sector, local authority and partnership services. Evidence was seen that these activities are having a positive impact on reducing risk and keeping children and young people safe. A number of targeted police operations have protected young people and led to prosecutions.

65. REACH staff make contact with all children and young people who go missing, and undertake return interviews within 72 hours. The team received 584 referrals in the first nine months of 2014. Forty two per cent (246) were children in care, 19% (132) were children in need and 41% (290) were not known to children's social care. However, the majority of return interview records sampled in the inspection were of poor quality. For example, of six return interview records reviewed by inspectors none clearly identified when the young person had gone missing, or when the interview had taken place. The interviews are not routinely transferred to children's social care records in a timely manner. This means that information is not readily available to inform decision-making. This also restricts the gathering of intelligence that may help to identify patterns and trends in activity, and identify vulnerable young people and potential perpetrators.

66. REACH holds a weekly panel to discuss all children and young people who have been reported missing or are vulnerable or at risk of CSE. The panel shares appropriate and timely information and targets additional support to improve early intervention and prevention. Protect and Respect (NSPCC) and BASE (Barnardo's Against Sexual Exploitation) attend the REACH panel and provide help and support to young people who have been or are at risk of CSE. Staff provide individual and group work programmes for young people, as well as offering sessions to raise awareness to both young people and professionals.

67. Children and young people who are privately fostered are well monitored, and have their needs assessed effectively by a dedicated private fostering social worker. Significant publicity and training have taken place, resulting in a 72% increase in the number of private fostering arrangements known to the authority since March 2013. During the period of inspection, 50 children were living in private fostering arrangements, with 43 of these being children attending language schools. Children and young people in these arrangements are assessed and visits take place as required. The private fostering social worker attends the Multi-agency Child Sexual Exploitation group (MACSE) in order to assess whether any private fostering arrangements can be identified through this work.

68. The local authority designated officer (LADO) role is well embedded. Effective reporting and investigative processes are in place to respond to allegations of abuse or poor practice. Associated strategy meetings are well attended and most of them are timely. The majority result in robust action plans and arrangements to protect the child and support the professional. Strategy meetings are chaired by IROs with the LADO in attendance. In 2013–14, there were 88 LADO cases including 17 allegations against foster carers, 14 of physical abuse, two of sexual abuse and one of emotional abuse.

69. Effective arrangements are in place for young people aged 16 to 17 years who become homeless. The intensive support team (IST) offers support and mediation between parents and young people in a bid to resolve problems and return the young person home. In all cases sampled, young people were offered placements appropriate to their needs. These included foster care and supported accommodation.

Key judgement	Judgement grade
The experiences and progress of children looked after and achieving permanence	Requires improvement

Summary

Children and young people only become looked after when it meets their needs and in circumstances where they can no longer live with their family. Decision-making and application of thresholds are consistent and robust.

The time taken for care proceedings to be completed is better than average and in the past year has been well within government targets. This ensures that children are clear about their permanent placements as soon as possible. The number of looked after children living in or close to their home town is high, enabling them to maintain links with their friends, family and local community.

Care plans are variable in quality and while a minority were good, most were not explicit enough about the child's needs. Reviews take place within required timescales, but the level of scrutiny and challenge provided by IROs is not sufficient to ensure that plans are always implemented fully and promptly.

Children and young people experience too many changes of social worker and in the early stages of their time in care they have too many changes in foster placement. This is unsettling for them at a time when they are particularly vulnerable and need to be able to build enduring relationships with adults who are important in their life. Children report that they feel safe in their long-term placements and described their foster carers as supportive, caring and committed to their needs.

A high number of children leave care through adoption, and many are placed without undue delay. However, too many children do not have good quality life story books and 'later life' letters. Although support is available when children are placed, once they are adopted it is less available and is not always effective in improving their outcomes.

Too many care leavers are not in education, employment or training. Plans to support these young people through the re-introduction of mentors are well advanced, although yet to show impact. More work is required to ensure that all care leavers are aware of both their medical histories and their entitlements.

70. Plymouth has seen an increase in the number of looked after children from 381 in September 2013 to 425 in September 2014. The local authority attributes this to greater recognition of the significance and impact of chronic neglect. Consistent thresholds for entering care are ensured through effective management oversight and decision-making at legal planning meetings. Inspectors saw no cases where children had entered care inappropriately.

71. Good working relationships with the local court and the Children and Family Court Advisory and Support Service (Cafcass) have supported effective use of the Public Law Outline to reduce the average length of care proceedings, which was 27 weeks in the first quarter of this year. This has partly been achieved by the increased and high use of supervision orders (59) to assess and monitor children living with their families where there are still concerns. Inspectors saw no cases during the inspection where this was inappropriate. However, it is a practice that has the potential to cause delay in securing permanence for children, something that the local authority has not yet analysed. Cafcass and the court report that applications are appropriate, and that high quality assessments by the parenting assessment team have reduced the use of expert independent assessments.

72. Good use is made of family group conferences (FGC), with positive examples of families helped to make their own support plans. In 2013–14, FGCs helped divert 108 children from entering care.

73. In the large majority (90%) of cases where the care plan is for children and young people to return home from care, decision-making is based on a clear assessment that considers and addresses risk. Children and families benefit from a range of support on their return home. Only two out of 21 children and young people who went home under a care plan to return home in the last six months have returned to the care of the local authority. This compares well with similar authorities and the national average, and shows that support provided to prevent readmission to care is effective. Assessments to determine whether relatives or other connected persons could look after a child are comprehensive and timely, with clear evidence and a rationale for recommendations and decisions.

74. Performance for short-term stability of placements is not good, with 14% of children experiencing three moves in a 12-month period. The local authority has identified the need to increase placement choice for children who come into care in an emergency, in order to reduce the number of moves. They have developed contracts with providers that include emergency access to foster placements, to increase resources. Placement stability meetings are held for any child where there is a risk of a placement ending in an unplanned way.

75. In contrast, performance for long-term placement stability is good, with 73% of looked after children remaining in the same placement for over two years. This is the result of good matching of children with carers. When children cannot return to live with their families, plans are made for permanence through adoption or foster care. Long-term foster placements are identified for children based on their needs. Children have been matched with suitable carers, often together with their brothers and sisters, and their outcomes have improved because of the stability this brings.

76. While there are some examples of effective work by social workers, a minority of children and young people told inspectors that they were unhappy about the frequent changes of social worker. This had resulted in them having to re-tell their story, and meant that they had not been able to build trusting and meaningful relationships with a social worker. They also described difficulties in making contact with their social worker by telephone.

77. Parents are actively encouraged to access advocacy and legal services. Case recording reflects some persistent and sensitive work with parents by social workers to ensure that they are well engaged and understand planning arrangements.

78. The quality of care plans is inconsistent. The majority of care plans seen do not effectively demonstrate a robust analysis of the child's needs. Care plans are not routinely updated following significant events. Issues of equality and diversity such as ethnicity, sexual orientation and faith are not always recorded or effectively considered within assessment and care planning stages.

79. Nearly all (98.8%) looked after reviews are completed on time. The views and feelings of looked after children are well considered and reflected in their reviews. The number of children and young people attending their reviews is improving (68%); good advocacy arrangements are in place and IROs actively encourage children and young people to attend. Looked after children are encouraged to chair their own review, and effective arrangements are in place to support and encourage this, but take-up is low. The local authority has not undertaken an evaluation to learn from the experiences of children and young people who have chaired their reviews in order to improve practice. In the majority of cases, there is little evidence of documented IRO challenge within review and case records.

80. Minutes of looked after reviews are not distributed promptly, with 42% noted as experiencing a delay of more than one month at the time of the inspection. This means that children, parents, carers and professionals do not have a formal copy of any actions that may need to be completed. This has the potential to lead to drift.

81. Social workers do not always visit looked after children in line with regulations. According to the local authority's own figures, the frequency has improved in recent months (August 62%, September 69% and October 95%) but this still means that a small number of children are not seen as required by regulations or in line with an assessment of the child's needs.

82. Children and young people have access to advocacy and independent visiting services. At the time of the inspection, 28 young people were receiving effective support from an independent visitor.

83. Contact between looked after children and their families is supervised by family support workers where necessary, who provide comprehensive reports to social workers. Children and young people spoken to during the inspection report that contact takes place in venues that are child-friendly and meet their needs.

84. Data for 2013–14 indicates an improvement in health assessments but a decline in dental checks. The majority of children and young people (84%) have timely health assessments. However, dental checks are low at 63%. Further work is required to ensure that all children and young people have access to timely health and dental assessments.

85. A designated fast-track referral route to child and adolescent mental health services (CAMHS) ensures that looked after children and young people receive a timely response. A dedicated Plymouth CAMHS nurse ensures that young people, including those placed outside Plymouth, have access to the support they need.

86. A large number (109) of looked after children and young people are placed outside Plymouth. However, only 13% of these are placed 20 miles or more from home. In the large majority of these cases, arrangements are closely monitored and access to education and health services is timely. One young person placed a long distance from Plymouth was visited by an inspector and seen to be making good progress and to be well looked after by the carers.

87. Most foster carers feel well supported and describe regular and productive contact and oversight from their supervising social worker. Regular foster carer support groups help to ensure that foster carers are able to share experiences and skills and to support one another. Assessment processes and panel arrangements to approve foster carers are robust and well organised. Foster carers have good access to training. All 'connected person' carers have a supervising social worker, are funded in line with the Fostering Network allowance rates and have access to support and training offered by the fostering service.

88. Plymouth's foster carer recruitment strategy has not resulted in increased placement choice or improved outcomes for looked after children. The number of approved foster carers is stable and, while 16 have been approved in the last year, 11 left the service. There are 158 approved fostering households, providing 325 places. There is an identified shortage of fosters carers for groups of brothers and sisters and for children with complex needs. The local authority has recognised this deficit and procured services from external providers to increase sufficiency, to ensure that brothers and sisters are placed together and to meet the needs of children with complex needs. There is very recent evidence of increased placement choice for young people who need urgent fostering placements, but it is not yet possible to demonstrate if these developments will be sufficient to meet children's needs.

89. Looked after children and young people are able to enjoy a variety of social and recreational opportunities in Plymouth. Those young people spoken to by inspectors described access to The Life Centre and gave examples of activities enjoyed, including rock climbing, swimming, caving and diving.

90. Corporate parenting is embedded across the local authority, with a strong commitment from elected members and senior leaders to meeting the needs of looked after children. The Corporate Parenting Group (CPG) meets bi-monthly, receives a good level of quantitative and qualitative performance information, and challenges performance effectively. The impact of scrutiny from the CPG is evident, with examples including increased advocacy services and CAMHS provision for looked after children.

91. The virtual school drives educational achievements of looked after children and ensures that they attend school regularly. The Virtual School Management Board set a target of at least 95% attendance, and attendance for all children in care is currently at 92% and just below the attendance level for all Plymouth children. Attendance is not a concern for primary aged children, but gives cause for concern for pupils in years 9, 10 and 11; for example, the average attendance for Year 10 pupils was around 90% in 2013/4. As a result, individual action plans have been developed for each student where there is a concern. There have been no permanent exclusions from school for any looked after child and 2013-14 saw a slight decline in the number of fixed-term exclusions from 25 to 23 students, with the average number of days falling from six to four. Most school-age looked after children (70%) attend a school that is judged good or better by Ofsted. If a school is downgraded at inspection, careful consideration is given to the individual needs of the child to ensure that it is right for them to stay at the school.

92. The quality of personal education plans (PEPs) is inconsistent. In a sample of 23, eight failed to address key targets, and in three cases the PEP had not been completed. An electronic system (e-PEP), introduced in September 2014, is helping designated teachers to improve the quality of target setting and check the progress children make. The virtual school head now signs off each PEP and authorises the appropriate use of pupil premium funding. PEPs that are not good enough are returned to the school with identification of the improvements required. Currently, 15% of PEPs (17) are overdue.

93. The progress made by looked after children educated in primary schools continues to improve. Over the last two years, the attainment gap between them and their peers has narrowed. For example, provisional data for 2014 show that the attainment gap reduced by 7.5% in reading at the end of Key Stage 1, with 71% of children in care gaining a Level 2 compared with 87% of all Plymouth pupils. At the end of Key Stage 2, 67% of children in care gained a Level 4 or above in maths, compared with 83% of their peers, which means the gap has reduced from 26% to 16%. However, provisional 2014 data show the number of children in care achieving five GCSEs grade A*– C (including mathematics and English) has declined significantly, from 16.7% in 2013 to 7.3% in 2014. While the gap in 2013 between secondary age children in care and their peers showed signs of reducing, the gap has increased in 2014. The virtual school and the local authority, while recognising the small cohort size and high number of children with special educational needs, are looking carefully at the reasons for this decline in order to identify the lessons to be learnt.

94. An Intervention budget is used well by the virtual school to provide young people with vocational taster sessions. Requests for funding are made to the post-16 Single Multi-agency Panel (SMAP), ensuring that young people with a statement of special needs can access appropriate training and education. Currently 63% of children in care and care leavers in year 13 are participating in education and training, and the virtual school keeps a close check on the 34% who are not yet engaged. It makes regular contact with young people and looks for opportunities that are of interest to encourage their engagement in training.

The graded judgment for adoption performance is that it requires improvement

95. Plymouth's 'adoption scorecard' performance is good. More children leave care through adoption than in comparable authorities and the rate is also better than the England average. In 2013–14, some 40 children were adopted. Current performance indicates that 16% of children leaving care are doing so via adoption. This is a reduction from the performance for 2011 to 2014, which was 21%, but is still above similar authorities and the England average. The figure includes some older children and some with very complex needs, who are harder to place. In 2011 to 2014, children aged over five years made up 8% of the total of children adopted.

96. Most children do not experience delay in going to live with their adoptive families. In 2011 to 14, children waited an average 525 days between coming into care and moving in with their adopters, which meets the national targets. There has been an apparent decline in performance during early 2014–15, but this is due to the local authority's success in placing some children with complex needs who had been waiting for a longer period. This is now improving but will affect the performance figures for 2014–15.

97. The time between children being made subject to placement orders and being matched with adoptive families has also been an area of good performance. The average for 2011 to 2014 was 99 days, which was within national targets. Again, as a result of the placement of some children with more complex needs who have waited longer, current in-year performance has declined to 281 days.

98. Despite success in placing some children, the local authority does not apply enough robust management oversight to care planning and decision-making for all children with complex needs. As a result, care plans are not always realistic and deliverable within an acceptable timescale for all children. There is a lack of detailed analysis at a strategic level of children's needs, insufficient availability of adoptive placements and ineffective use of alternative permanence options.

99. During the period 2011 to 2014, only 3% of children had their adoption plan changed. Current performance information indicates that this figure has risen and is now 13%. This is a result of the local authority undertaking a review of 15 children who were subject to placement orders but whom the authority had not been able to place for adoption. Despite this increase, performance remains close to the England average of 12% for 2011 to 2014.

100. The arrangements for family finding for adoption are appropriate with specific members of staff responsible for co-ordinating this work. A wide range of options are used, including links with adopters approved by Plymouth, use of the South West Adoption Consortium (SWAC), and the use of national and regional events. The local authority has taken part in three adoption activity days, resulting in nine children being matched and placed with adopters. The commissioning arrangements with a voluntary adoption agency help to find placements for harder to place children.

101. There are currently 32 children who have a placement order but are not yet placed. Of these, seven children have a plan to discharge their placement order and seek alternative permanence options. Of the remaining 25 children, seven currently have no link or match to an adoptive family and four of these are to have a review of progress. There are an additional seven children with 'should be placed for adoption' (SHOBPA) decisions but no placement order, where family finding is underway.

102. Plymouth currently does not have enough prospective adopters to meet demand. There was a decline in enquiries from adopters during 2013–14, and the number of adopters approved in 2013–14 remained at the same level as the previous year. There are currently 15 adopters approved in Plymouth, all for single children under the age of five. 'Fostering to Adopt' is only in the early stages of development; two children have been placed in a fostering to adopt placement. The local authority is actively engaged in a range of activities and partnerships to increase sufficiency, including for specific children who are hard to place and for sibling groups. However, the authority does not know whether this work will meet the needs of their children and therefore plans to review the strategy in December 2014.

103. Enquiries from prospective adopters receive a prompt response from a dedicated worker in the team. The two-stage adoption process to assess adopters has been implemented and timescales have improved. The required checks and references are undertaken and adopters attend appropriate training. Most assessments are completed in the required timescales. Adopters spoken to report that assessment processes are thorough and professional and that workers are experienced and support them well.

104. The rationale for decisions taken by the Agency Decision Maker (ADM) for SHOBPA cases is not set out clearly in children's records. This means that important information about how and why decisions were made may be unavailable to children who wish to read their files later in life.

105. The Adoption Panel is appropriately constituted, independently chaired and has a good range of experience amongst its members. There is evidence of access to appropriate legal and medical advice. Workers and adopters describe the panel as robust in its challenge to the matters it considers. Despite identifying areas that require improvement in practice, particularly life story work, the adoption panel chair and the ADM have not yet been able to ensure positive change.

106. Assessments of adopters result in good quality reports. Information gathered is well recorded and analysed. The quality of children's permanence reports is getting better, but still requires improvement. Matching processes are appropriate, with placement planning meetings ensuring information is shared with adopters. Adoption support plans sampled (three) all demonstrated appropriate support in place for children at the point of being matched, which underpins low disruption rates.

107. Important therapeutic materials, such as life storybooks and later life letters, are not routinely available for children being placed for adoption. Life history work is not always undertaken when it should be, and when it is, the quality is not good enough. As a result, children live in adoptive placements where their adopters do not have material available to support them to understand their life story.

108. Post-adoption support is not routinely provided in an effective or timely way that improves outcomes for children and families. However, there is a monthly adoption support group facilitated by an independent clinical psychologist experienced in adoption and with a member of the adoption support team in attendance. The team also works with adopted adults who wish to access their records. During 2013–14 a commissioned service supported 47 birth parents, some adopters and adult adoptees with independent counselling advice and support.

109. The adoption support team is also responsible for support to children placed under special guardianship orders (SGO) arrangements. It currently has 172 children identified as receiving support (including SGO and adoption), which includes 53 new requests for assessment in the last six months. When children and families are referred for post-adoption and special guardianship support, the assessment and planning processes to support this are unclear and ineffective.

110. Children's contact needs are addressed in adoption support plans completed at the point of matching. There are currently 312 letterbox arrangements in place and a further 54 in the process of being established. In addition, there is evidence of direct post-adoption contact being well supported, including direct contact for siblings.

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

111. The 18+ Care Leavers Team currently supports 181 young people who have left care. In addition, the children in care team supports 104 looked after 16- and 17-year-olds who are still looked after and eligible by age for care leaving services and seven 16- and 17-year-olds who have left care. The children with disability team supports a small number of children in transition to adult social care.

112. The care leavers service is set to move from the Homes and Communities Department to children's social care. The assistant director for children's social care will have full responsibility for the service and intends to implement the well-considered and robust action plan for improvement.

113. Inspectors met with a group of care leavers, who said they were generally well supported by their personal advisors (PAs), whom they described as knowledgeable and accessible. Direct practice observed during the inspection demonstrated purposeful and trusting professional relationships. PAs work with individual young people to promote their independence, providing opportunities for them to learn about budgeting, cooking and healthy lifestyles.

114. The staff and managers have experience of working with older young people, and staff know the young people well. The team has held a number of staff vacancies. This has led to high caseloads, but these have recently been filled. The impact of this is that workers have not always had enough time to spend with their care leavers. A further consequence is that the quality of pathway plans is too variable and not all young people have had the opportunity to contribute to their plans. The majority of plans seen by inspectors do not reflect individual young people's goals and future needs in a meaningful way.

115. Although not all care leavers spoken to by inspectors could articulate their entitlement to services, it was apparent that they receive appropriate financial support. The local authority has doubled the care leaver grant to the national recommended grant of £2,000. Care leavers demonstrated limited knowledge of their entitlement to health information. A Health Passport system for care leavers was introduced in September 2014, but to date only five have been issued to care leavers. The majority of care leavers do not have access to important information about their health histories, which means that they may be unaware of important details when seeking treatment.

116. The LAC nurse has identified a need to develop an outreach service to work with young people aged 16 and 17 in care and with care leavers who have complex health and social needs, and who are in need of targeted intervention. This has led to the development of a weekly 'drop in' clinic that care leavers can use to receive help and advice, for example on sexual health, and to complete and receive their health passports.

117. The number of 19-year-old care leavers who are in education, employment and training (EET) is showing a downward trend. In 2012, 73% of care leavers were in EET. This dropped to 60% in 2013 and only 53% in September 2014. The local authority is looking to introduce mentoring programmes supported by Jobcentre Plus, and has also recruited 36 students from Plymouth University to support care leavers individually, while acting as positive role models. Training for these roles is ongoing, so the impact is yet to be seen. Currently six care leavers are at university. All receive financial assistance, including access to bursaries to support learning, and other support. Five care leavers have apprenticeships in the local authority.

118. The virtual school and care leavers team work in close partnership with Careers Southwest to ensure that young people make a smooth transition in their education as they leave care. Currently 67% of children in care and care leavers in Year 13 are participating in education and training and the virtual school keeps a close check on the significant minority of 33% who are not yet engaged.

119. Schemes such as the Summer Mix Programme provide free 'taster' sessions for young people aged 13 to 19 years, helping them to make decisions about their future careers. Courses are accredited, with purposeful links to local employment. Priority is given to vulnerable and disadvantaged groups of young people including children in care and care leavers, who take up 25% of available places.

120. Four care leavers are currently serving custodial sentences. Some analysis has been undertaken to understand the reasons for this. Work is underway with the Youth Offending Team (YOT) to introduce protocols for reducing offending behaviours for children in care. It is intended that learning from this work will inform future work with care leavers.

121. The local authority reports that 92% of care leavers live in suitable accommodation. Young people told inspectors that they felt safe where they were living and were content with their accommodation and living arrangements. Fifteen young people are benefiting from the staying put arrangements. These arrangements are increasingly considered in commissioning placements, so that young people placed with independent fostering agencies have similar access to those young people placed in house. Some of these placements have converted to staying put arrangements.

122. A range of housing options for young people includes social housing provided by Devon Home Choice and supported lodgings appropriate to young people's needs. In partnership with Devon Home Choice, care leavers' housing needs are prioritised, and they are given Band B access to social housing, the second highest category of need. Eleven young people are living in houses of multiple occupancy. These include 'foyers' and purpose-built units, similar to halls of residence, and are not seen as permanent options. At the time of the inspection, three young people were in bed and breakfast. While this is rare, and only used in short-term emergencies, the local authority was unable to provide evidence that it draws up risk assessments to mitigate this unsatisfactory form of accommodation.

123. The care leavers' service is not in touch with 3% of care leavers. A small number of these are unaccompanied asylum seeking children who left the area without trace very soon after arrival. Staff make active efforts to trace these young people and resume contact. Young people are encouraged to keep in touch with support workers by attending a drop-in service.

124. The Listen to Care Council represents the views of looked after children, and has care leaver representation that contributes to service improvements. This includes work to identify the 'ten wishes' of children and young people in the city. A care-leaving booklet is available to all young people when they become care leavers. This contains a mission statement which indicates that Plymouth has adopted the Department for Education charter for care leavers. However, this has not been developed by managers, staff and care leavers into a bespoke Plymouth pledge. Not all care leavers are aware of the booklet and more work is required to make both the council and the statement more accessible to care leavers. The local authority took action during the inspection to ensure that copies of the charter are available to care leavers and that PAs explain the commitment to them.

125. The local authority celebrates the achievements of its young people by running a yearly award ceremony that includes care leavers. Care leavers report that they receive cards and vouchers from their PAs on their birthdays. Many were supported to attend a rock concert on Plymouth Hoe through the provision of complimentary tickets. The local authority is planning a Christmas meal for care leavers on Christmas Eve, and elected members and senior officers will join the event. For those who may feel lonely or vulnerable at this time of year, a youth centre will be open on Christmas day.

Key judgement	Judgement grade
Leadership, management and governance	Requires improvement

Summary

The local authority was already aware of the areas for development in services to children and families identified through this inspection. There is a commitment to driving improvement and plans are in place, though there now needs to be an emphasis on delivering them at pace. The local authority and its partners are committed to effective early help but have not yet succeeded in ensuring that it is making a difference in reducing demand for children's social care services.

Thresholds for services are not sufficiently well understood by partners. In both these areas, senior managers have plans in place and now need to drive the change as quickly as possible. Appropriate governance arrangements are in place, including an effective relationship between the authority and the LSCB and the DCS's membership of the Health and Wellbeing Board and the Children's Partnership.

Management oversight, performance management and quality assurance processes are not sufficiently robust. Social workers have high caseloads, and this affects their ability to ensure core standards of service, including that statutory visits to young people are undertaken within timescales. High caseloads in the independent chair/IRO service mean that this service does not offer sufficient challenge and is not effective as a quality assurance agent.

The authority has strong commissioning arrangements for placements for children in care. However, it requires a more sophisticated understanding of what it needs to do to ensure that there is a range of adoptive placements available for all those children who need them.

The local authority understands its corporate parenting responsibilities and arrangements are well embedded. There are effective arrangements to ensure that children and young people contribute and their voices are heard.

The authority, together with partners, has been able to develop a range of services to protect children and young people in Plymouth from the risks of child sexual exploitation and going missing from home, care and education.
The local authority needs to do more to ensure that outcomes for the most vulnerable young people are the best possible, in particular in relation to the educational achievement of young people in care and successful entry to education, training and employment.

Social worker vacancy rates and staff turnover have reduced and are now below the England average for 2013. There is a professional development framework in place, but the quality of supervision of staff requires improvement to ensure that there is enough time for reflection and recording of decisions.

126. Local authority senior managers, leaders and elected members discharge their individual and collective statutory responsibilities. Leaders and managers know the strengths and weaknesses of services and practice. Progress has been made in some key areas but there remain a number of weaknesses which need to be addressed as a priority. The DCS and senior managers are visible to staff, are respected and take an active role in quality assurance. There is political commitment to children's services and, despite significant overall savings having to be made in the local authority, further financial commitment has been made to meeting demand and increasing the range of placements for looked after children.

127. Partners recognise weaknesses in early help coordination, and there is evidence of a strong commitment to more effective early help across agencies. Phase two of the early help programme was implemented in July 2014 as part of the local authority's transformation programme to bring together the coordination of early help services across the city. Phase one of the programme pulled all the internal functions into one place to support an integrated approach. However, it is too early to see any significant impact.

128. Management oversight of practice is insufficiently well established. There are particular weaknesses in the quality of supervision of staff which, despite its regularity, demonstrates little reflection or focus on outcomes. Management sign-off of plans and casework does not demonstrate consistency of approach or rigour in ensuring an audit trail of why decisions are made. A new supervision protocol was implemented in September 2014 but has not had sufficient time to demonstrate impact and improvement in this area.

129. An established performance management information and scrutiny cycle provides appropriate information to senior leaders but has not led to consistent, proactive and timely action to address performance weaknesses. Teams also receive performance information, and work has been done to try to ensure staff ownership of data accuracy. However, the number of data errors remains high and considerable effort is required to ensure that information is amended for accuracy. This has resulted in some areas of service retaining or creating manual systems of data collection because confidence in the electronic recording system is low. Senior managers cannot be confident in the overall accuracy of the data they receive. During the inspection, there was considerable mismatch between the operational data provided by the local authority and published data.

130. The service has a programme of audit activity, including single and thematic audits, and benefits from multi-agency case audits and scrutiny of social work practice. However, the pace of improvement has not been swift enough, with significant weaknesses remaining in practice. These include, too many poor quality assessments, minimal recording on some case files, failure to meet statutory requirements for visiting young people and too high a proportion of cases showing poor recording of decision-making and management oversight. Inspectors disagreed with the local authority about the quality of work in 35% of audits of tracked cases, indicating a lack of effective management oversight and too positive a view of performance.

131. Caseloads remain high in social care, with some staff, including some newly qualified workers, responsible for more than 30 children. This has affected the overall quality of work across services and is a contributory factor in the slow pace of improvement in practice; for example, the local authority's inability to ensure statutory visiting on time. The role of the IRO and independent child protection chair in quality assurance and challenge remains ineffective, in part due to high caseloads. Management intervention has been too slow to ensure change and improvement. Senior managers have not succeeded in tackling these issues effectively and lack a clear strategy for doing so.

132. While there is an effective complaints resolution process in place, the authority does not undertake sufficient analysis of complaints made and upheld. Learning from complaints is therefore limited in scope.

133. The local authority has undertaken a test of assurance for the DCS role. However, this does not adequately scope the whole range of duties and responsibilities of the DCS and lacks an analysis of risk. This means that the authority cannot be sure that the DCS has sufficient capacity to effectively lead and manage the range of services expected.

134. The local authority has developed links with consortia and commissioned specific services to improve the sufficiency of adopters, but still has difficulties in identifying placements in a timely way for sibling groups and children with more complex needs. Further work is required to analyse gaps in provision and the authority's ability to meet need when the number of children on an adoption pathway exceeds the number of adopters available.

135. More work is required to ensure that children in care and those leaving care have the skills and educational attainment to realise the best possible outcomes. The gap between the educational attainment at secondary school level of children in care and their Plymouth peers is concerning, with a considerable deterioration between 2012/13 and 2013/14. Achievement is well below the national average and the gap within Plymouth has grown significantly. Not enough 19-year-old care leavers are in education, employment and training (EET). The local authority needs to undertake further work to ensure that it has a clear understanding of these deficits and develop robust plans to respond to them.

136. While there is a pledge for young people in care, there is no Plymouth pledge for care leavers. The care leavers' charter is the unamended national charter and is not readily accessible to care leavers. The web-link to the charter was only restored during the inspection. It does not take account of specific circumstances of care leavers in Plymouth. The local authority does have a 'Leaving Care Guide' which is distributed to and discussed with Personal Advisors. This covers the offer and young people's rights when they leave care and clearly explains what the Young Person should do if they are not happy with the service.

137. The authority demonstrates good performance on the 26-week guideline for care proceedings, and Cafcass reports good relationships with the local authority. There has been an increase in the use of supervision orders with a statement of intent for the local authority to return to court without delay if risk increases. The local authority has not completed any analysis to consider whether this may place children and young people at increased risk or result in delayed outcomes because of returns to court.

138. The authority has established links with the Health and Wellbeing Board, the Children's Partnership and the LSCB, and the DCS is a member of all three. The children's plan, although at the end of its cycle, is focused on a range of key priorities for children and young people and those most vulnerable, including those in care and those experiencing the transition to adult services. It has not ensured or delivered improved outcomes for all targeted groups.There is a track record of development of services in conjunction with the LSCB. These include services for children at risk of sexual exploitation and those who go missing. Examples include REACH and the development of MACSE, with weekly meetings to consider children at risk of CSE and those missing from home, care and education.

139. The local authority has a range of commissioned and in-house services for young people and families. Strategic commissioning is informed by a well-developed joint strategic needs assessment, which includes key information on safeguarding issues and vulnerability. There is a focus on strategic planning on children's services, and the authority has well-developed plans with the CCG to establish pooled budgets and a joint commissioning approach to early help. This includes plans to remodel family support and create a single point of contact for early help.

140. Commissioning of services (for example through the Plymouth domestic abuse partnership) has included the Family Intervention Project, the domestic abuse advocacy service and work within schools on healthy relationships. However, despite a range of services on offer, the local authority with its partners does not yet offer an effective analysis of impact. This limits learning, and despite its positive relationship with the CCG, it has not been able to ensure sufficient GP engagement in child protection planning or that children who need child protection medicals are seen as soon as possible in a suitable environment.

141. The local authority is part of the Peninsula commissioning and placement partnership, and is able to demonstrate a focus on commissioning, through its commissioning plan for care placement provision which takes into account its sufficiency needs. New tender specifications developed in 2013 include additional capacity to place the most challenging children and a specific 16-plus specification to facilitate 'staying put'. However, there remains an insufficiency of Foster to Adopt placements.

142. Corporate parenting is well embedded across the local authority, with strong commitment to the needs of looked after children from elected members and senior leaders. Young people in care are represented on the corporate parenting panel. The panel has been able to challenge performance, leading to improved outcomes for some young people, for example, ensuring CAMHS access for young people placed out of Plymouth and an increase in the budget for advocacy.

143. A clear professional development framework is in place for newly qualified social workers' assessed and supported year in employment (ASYE), and for staff in years two and three after qualification. This includes a range of mandatory training and opportunities to gain advanced qualifications, including a postgraduate diploma in child and family studies. The local authority reports that vacancy levels at the time of the inspection were 6.9%, which compares well with the 2013 national average of 14%. At 13%, the local authority's figure for turnover of staff was also lower than the national average of 15% in 2013.

144. The proportion of newly qualified social workers is 12% across all teams. However, the proportion of newly qualified staff in some service areas is higher (23% in the Children in the Community Teams and 19% in Children and Young People in Care teams). This is a result of a strategy to place NQSW staff in teams where work is conducive to the learning and development needs of NQSW's. Arrangements for additional support for newly qualified staff include mentoring and reflection time. However, newly qualified staff interviewed during this inspection had high caseloads that included child protection cases. This limits the effectiveness of the support framework for these staff.

145. The local authority has an established Children in Care Council ('Listen and Care Council'), which is supported by the 'Young Devon' organisation and is active in terms of corporate parenting, representing children and young people's views, taking part in recruitment of staff (including the LSCB chair), and helping to develop the '10 wishes' list of expectations of staff and agency behaviour towards young people.

146. The local authority reports serious incidents appropriately. Three serious incident notifications have been received by Ofsted between 31 March 2013 and 1 April 2014; two have resulted in serious case reviews (SCRs) being commissioned by the LSCB. These were underway at the time of the inspection. The authority is able to demonstrate that it learns and acts on lessons from SCRs and serious incidents. For example, it has carried out internal social care practice reviews and delivered a programme of training for managers.

The Local Safeguarding Children Board (LSCB)

The Local Safeguarding Children Board requires improvement
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 *require improvement*

Summary of findings

The LSCB requires improvement because:

Understanding of practice

- The Board does not understand fully the quality of safeguarding practice undertaken by agencies within the partnership.
- The Board has not ensured sufficient evaluation of multi-agency training and in particular its impact on practice, in order to understand its effectiveness in keeping children safe.
- The annual report does not provide sufficient analysis of the performance or weaknesses of the partner agencies.
- The Board has not provided enough analysis of known and emerging risks in relation to CSE, so does not fully understand the local extent of the issue.
- The Board has not had a sufficient overview of deficits in social care practice in order to challenge performance effectively and require the local authority to demonstrate improvement.

Partnerships

- The Board is yet to assure itself that there is effective coordination of the early help offer in Plymouth and that practitioners across agencies understand and implement the thresholds for service provision.
- The Board has had only limited impact in persuading schools to engage in s.175 safeguarding audits.

Performance

- The Board has not yet ensured that data presented to it are sufficiently comprehensive or accurate in providing information on safeguarding issues, trends and activity.

What does the LSCB need to improve?

Areas for improvement

Understanding the quality of practice

147. Ensure that partners submit an annual audit of safeguarding practice, including the impact of that practice in keeping children and young people safe

148. Ensure that multi-agency training is monitored and evaluated to improve its effectiveness.

Work programme

149. Evaluate the coordination and effectiveness of early help and ensure partner agencies fully understand thresholds.

150. Ensure the Board receives timely and accurate data and performance information.

151. Review the annual report to ensure that all partners contribute, and detail the challenge offered to partners in ensuring that safeguarding practice is robust.

152. Ensure that the Board receives a regular report detailing the analysis undertaken of risks to children and young people in Plymouth related to child sexual exploitation and going missing, including responses to trends and specific areas of concern.

Inspection judgement about the LSCB

153. The LSCB meets the requirements of 'Working Together' 2013. The Board has appropriate multi-agency membership and includes faith representation and two lay members. Meetings are well attended by members, and where attendance has not been at an appropriate level this has been challenged by the Chair. The Board has a number of sub-groups, including the child death overview panel (CDOP), learning and professional practice, an SCR sub-group, a policy and procedures group and a multi-agency child sexual exploitation work stream.

154. Board members, including the Chair, are subject to appraisal, and the Chair meets regularly with the local authority Chief Executive and lead member. Written notes of these meetings evidence challenge. The Chair has had a separate appraisal completed by the Chief Executive.

155. The Chair of the Board meets regularly with the chairs of the Health and Wellbeing Board (H&WB) and the Children's Partnership Board and is able to ensure that board priorities and safeguarding issues are appropriately represented. The Chair is not a member of the H&WB and is an invited observer at the Children's Partnership.

156. The Board demonstrates some challenge to partners and agencies, including staffing issues in social care, CAMHS waiting time performance, partners' engagement with the CAF process, and challenge to the Department of Health and the Secretary of State regarding the absence of a forensic pathologist in the region. However, in a number of significant areas including the poor attendance of key agencies at ICPCs and poor practice in relation to child protection medical examinations, evidence of challenge is not apparent. This means that aspects of poor practice for the most vulnerable children and young people are yet to be addressed.

157. The Board is financially sound and members make appropriate contributions on time.

158. An established learning and improvement framework includes procedures on the initiation of serious case reviews (SCRs) and management case reviews. The board publishes reviews and ensures that lessons from local and national SCRs are disseminated to staff through multi-agency training. There are currently two serious case reviews being undertaken. The Board seeks to learn lessons before completion of reviews, including identification of issues to be the subject of multi-agency case audits, with subsequent action plans for change.

159. The child death overview panel operates effectively. The CDOP annual report provides a comprehensive overview and analysis of child deaths and recommendations for action to be monitored by the Board. The Board ensures that s11 audits are undertaken. However, the last s11 audit required only a submission or a declaration from agencies, which meant that there was no independent scrutiny of agency compliance. The Board has recognised this gap, and from 2015, there is to be an element of independent verification. The Board undertakes s175 reviews of school safeguarding procedures.

160. The Board offers a safeguarding audit to schools undertaken by the LSCB Business Manager. However, so far, in 2104, only five out of 86 schools have taken up the offer, and the Board needs to do further work to encourage schools to assure themselves that they are fully compliant.

161. The Board's business plan is well developed and focuses on key priorities. It has appropriate timescales in place. The Board has identified the need for further work to enhance its engagement with young people, and plans to develop a shadow young people's board. It also recognises the need for further scrutiny of the effectiveness of CAFs and early help, and to understand how each agency ensures that practice is robust.

162. The Board and the local authority have overseen the development of a joint training strategy and plan, setting out a comprehensive multi-agency training programme. The programme provides a wide range of training at foundation, advanced and specialist levels. However, evaluation of this training is not fully developed with regard to assessing how the training is influencing practice. The Board has completed a pilot evaluation on one of its courses to see how training has influenced practice after three months and plans to apply this to the remaining courses. On this basis the Board is not yet able to fully measure how training is influencing practice.

163. The Board's annual report is comprehensive in scope and includes lessons from management reviews, serious case reviews, child deaths, private fostering, IRO activity and s11 audits. However, it does not provide sufficient analysis of performance or weaknesses. The report also lacks specific contributions from partner agencies on safeguarding activity and analysis and comment on agency performance. On this basis, the Board does not demonstrate a sufficient overview of safeguarding.

164. The LCSB has sought to improve the range of performance data available to it by the adoption of a new framework. This requires all partners to provide a range of performance information (70-80 indicators). However, this is still in development and further work is required to ensure that the Board has a clear view on the data it requires and that all partners comply with the Board's expectations. The Board does not sufficiently scrutinise, for accuracy, children's social care data provided from the local authority, particularly as there are some data quality issues. The Board needs to assure itself that all data provided are both comprehensive and accurate if it is to have a coherent view of activity and demand.

165. The Board undertakes monitoring of front-line practice and has an established system of multi-agency case audits, which include actions arising and progress on these. Issues arising from SCRs, including chronic neglect, have informed some case audit themes. However, the Board has not been able to establish robust single agency audits among board members as routine, and does not yet have an agreed programme of themed audits in place. These absences mean that the Board will not have sufficient information to ensure that it has independently assessed the quality of practice and compliance with safeguarding procedures across partners in Plymouth.

166. The Board has been active in identifying CSE and missing children as areas for further development. It has led to the establishment of the multi-agency child sexual exploitation group (MACSE) and the development of an action plan arising from the adoption of the Peninsula CSE strategy. Further developments have included a new multi-agency service, REACH. This brings together youth workers, police and a social worker to ensure return interviews for those who go missing from home, care and education, and to map networks of children and young people who share risk-taking behaviours that make them vulnerable to sexual exploitation.

167. Work in 2014 has included two conferences on CSE. Another conference had a focus on female genital mutilation and forced marriage. Work on the new thresholds resulted in guidance, including CSE, in examples provided for practitioners in responding to these issues. Multi-agency training on CSE also includes 'early identification' for all universal service practitioners.

168. Despite considerable activity on CSE, the analysis of CSE perpetrator activity and emerging risk themes requires further work. There is no evidence that the Board receives a regular report on activity together with analysis. This gap means that the Board is not able to assess prevalence and trends, or provide sufficiently informed challenge or effective scrutiny on the response to child sexual exploitation.

169. Plymouth LSCB facilitates and leads the Peninsula LSCB group promoting Child Online Safety (COS). The group includes leading statutory and voluntary agencies, representatives from schools and youth services, and has achieved national recognition for its work.

170. The LSCB is active in trying to ensure that services providing support to adults with children regarding mental health ill-health and alcohol and drug dependency are aware of safeguarding issues. The Board has also challenged these services to show impact in relation to better outcomes for children, but these have yet to be demonstrated.

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) and a contracted inspector from Ofsted.

The inspection team

Lead inspector: Linda Steele HMI

Deputy lead inspector: Sean Tarpey HMI

Team inspectors: Peter McEntee HMI, Emmy Tomsett HMI, Paula Thomson-Jones HMI, Martin Parry HMI, Wendy Radcliffe HMI, Dominic Porter-Moore (Contracted Inspector)

Quality assurance manager: Simon Rushall SHMI

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

The Office for Standards in Education, Children's Services and Skills (Ofsted) regulates and inspects to achieve excellence in the care of children and young people, and in education and skills for learners of all ages. It regulates and inspects childcare and children's social care, and inspects the Children and Family Court Advisory and Support Service (Cafcass), schools, colleges, initial teacher training, work based learning and skills training, adult and community learning, and education and training in prisons and other secure establishments. It inspects services for looked after children and child protection.

If you would like a copy of this document in a different format, such as large print or Braille, please telephone 0300 123 4234, or email enquiries@ofsted.gov.uk.

To receive regular email alerts about new publications please visit our website and go to 'Subscribe'.

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