30 January 2024

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Dear Torbay Safeguarding Children Partnership

Joint targeted area inspection of Torbay

This letter summarises the findings of the joint targeted area inspection (JTAI) of the multi-agency response to identification of initial need and risk in Torbay.

This inspection took place from 13 November 2023 to 17 November 2023. It was carried out by inspectors from Ofsted, the Care Quality Commission (CQC) and His Majesty's Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS).

Headline findings

The Torbay Safeguarding Children Partnership (TSCP) was reconstituted in 2020 following a short period of alignment with a neighbouring local authority. Since that time, a clearer focus on the children of Torbay has resulted in a more targeted and cohesive approach to both strategic oversight and the identification and delivery of services to children who may be in need or at risk of harm. The TSCP Executive Group functions effectively and benefits from healthy challenge from independent scrutiny. There have, however, been several changes of senior personnel across the partnership, which has hampered progress against some key strategic priorities, especially children's mental health. Reliable, disaggregated data for Torbay from an integrated care board (ICB) on behalf of health providers and a police force that cover much larger geographical areas is not available to the partnership. Allied with delays in establishing a children's mental health subgroup and insufficient quality assurance, both of which the partner agencies are fully aware of, it is difficult to chart the impact of the partnership on Torbay's children in some key strategic areas.

That said, operationally, partner agencies work well together. Information-sharing and attendance at meetings in the multi-agency safeguarding hub (MASH), child protection strategy discussions and in child protection enquiries is consistently timely and effective. Thresholds for different levels of intervention are jointly understood

across partner agencies and, for the majority of children, risks and support needs are identified early, resulting in the right support at the right time.

Families have direct access to support under the umbrella of early help services, including from the well-regarded family hubs in each of Torbay's three main towns. These make a positive difference to their lives. The risk to missing children and the link to exploitation are well understood and the partnership has made significant progress in this complex area of practice. Practitioners are growing in confidence and expertise, but, in some key areas, such as using new information to understand the impact on children of long-term neglect and domestic abuse, could be more consistent in challenging each other when insufficient progress has been made. This lack of professional curiosity for a small number of children on the part of professionals from local agencies is a more acute and systemic problem within health services. This manifests as insufficient safeguarding oversight by both the Devon ICB and the Torbay and South Devon NHS Foundation Trust. In particular, this relates to poor safeguarding decisions within the trust when the reasons given by parents or carers for bruises and injuries to children are accepted too readily, and without adequate reference to previous history or wider concerns. The safeguarding partnership has insufficient oversight of these failings.

Area for priority action

Urgent action is required by the Torbay and South Devon NHS Foundation Trust to assure themselves of the quality and effectiveness of their own safeguarding practice. Too many children remain in situations of risk and harm. Priority action should be taken to address the following areas:

- The failure of senior leaders to have sufficient oversight and assurance of professional curiosity across practice to safeguard children.
- The variable quality of scrutiny and supervision by health staff leading to safeguarding risks in children not being consistently identified and responded to appropriately. A particular area of concern is the management of unexplained injuries to children.

What needs to improve?

- The consistency with which professional curiosity and challenge are applied, particularly in situations in which children living with chronic domestic abuse or neglect are not making progress and situations in which children have unexplained injuries.
- Performance information across the partnership to inform needs analysis and measure the impact of strategic approaches to areas of concern.

- The partnership's strategic approach to children with poor emotional and mental health.
- The length of time children have to wait for support from child and adolescent mental health services (CAMHS) when categorised by the service as low risk.
- Communication between partner agencies when new information is gathered about families where there are existing safeguarding concerns.
- The rigour of the partnership's quality assurance function.
- The meaningful involvement of children, families and the wider Torbay community in the development and delivery of strategic priorities and services.

Strengths

- A strong partnership approach to providing early help is making a positive difference for many children.
- The development of family hubs and the access families have to immediate support.
- Consistently good multi-agency attendance and information-sharing in the MASH supports and protects children. Strategy meetings include the partners that are most important to understanding children's situations.
- The effectiveness of the pre-birth panel to safeguard children.
- The effectiveness of the partnership's response to missing and exploited children.
- The quality of public protection notices (PPNs) and their focus on children's wide-ranging needs.
- Flexibility within midwifery and 0 to 19 services to be responsive to the needs of children and their families.
- The high quality of partnership working when a child is in significant mental health crisis and requires a safeguarding response.
- The positive difference that support to schools from the Torbay Education Support Service (TESS) is making for children.

Main findings

In the MASH, hosted by children's social care, decision-making is timely, and thresholds that trigger appropriate responses are well understood and applied consistently. Relevant background information is gathered about families, including about fathers who are not living with their children, and from agencies outside of Torbay. The co-location of social workers, early help practitioners, health representatives and the TESS facilitates valuable discussion about initial planning. The more limited physical presence of police officers results in them responding to

requests for information rather than actively contributing to decision-making about patterns of concern, and so limits their effectiveness.

Children are visited with appropriate consent from parents or when this has been overridden because of safeguarding concerns. Social workers, police officers and teachers coordinate these visits well so that they are at a time and place where children feel most comfortable. In the interim, the voice of children is evident in the records, as are their wishes. Police notifications to the MASH (PPNs) are detailed and child-focused and capture the presentation and lived experience of children.

Referrals are largely of a high quality. Those made by schools and the information they share are increasingly well focused on the help that will make a difference for children, in part due to the guidance of TESS and by links built at partnership training events. Most contacts and referrals indicate a shared understanding of thresholds by staff across agencies and clearly focus on what information is most valuable. For example, PPNs are submitted once a child goes missing and when they have been found, and research is added to police systems once they have had a return home discussion. This adds richness and detail about the children who go missing and other children and adults who may be at risk or of concern, and about possible 'hot spots'.

The quality of communication, information and decision-making across health services varies significantly, and overall is not good enough. Some of this is attributable to IT systems and practitioners not being able to access information which may include vulnerabilities or relevant family history. However, there is early identification of risk by the midwifery team and effective sharing of this information with health partners and the MASH.

When children are at risk of immediate harm, decisions to proceed to child protection strategy meetings are timely and appropriate and differentiate the risks to individual children in the family clearly. This is also the case when immediate risk is considered outside of office hours by the emergency duty service. Key partner agencies relevant to the child and including schools, colleges, the local authority designated officer and the most relevant health practitioners contribute to decision-making that is recorded clearly. The use of a specialist panel to discuss risks to unborn children also works particularly well in identifying and responding to increased risk. On the few occasions when decisions are taken not to proceed to strategy discussions or not to request child protection medicals for injured children, the rationale for this is not always recorded. These decisions are rarely challenged by partners, even when they are not consistent with what is known about children's level of risk.

Child protection enquiries are mostly thorough. Stronger investigations and assessments are informed by the child's history and incorporate previous involvement by most agencies. Risks and strengths are identified and analysed well, and good management oversight ensures that assessments are concluded quickly

and safely. Support is triggered during these enquiries without delay, and workers show tenacity in making sure that they see the children as soon as possible. The wider partnership includes housing, border patrol and those with specialist knowledge about disability who routinely contribute valuable information. Considerate and sensitive work with most disabled children helps them to understand what professionals are worried about and helps them communicate in the way that they choose. For a few disabled children, key members of the wider family network are not always consulted. Child protection medicals to ensure children's safety are underused and decisions to proceed to strategy discussions rely too heavily on social workers when partner agencies have enough information of concern to initiate those steps.

On those limited number of occasions when practice is weaker, it is usually when more enduring or complex situations need an extra level of assertive and inquisitive practice from one or more of the partner agencies. This is most apparent when children have lived through cycles of domestic abuse or neglect and have parents who struggle with their own mental health. These children are known to agencies in Torbay and are getting support, predominantly from their school and from early help services. When new information is gathered through referrals into the MASH, it is not consistently pieced together with what is already known. Matching this information to threshold criteria in isolation, and a lack of collective reflection, can result in repeated signposting to the same services with little chance of a better outcome. For these same children, information from the paediatric liaison team to health visitors and school nurses is poor, and information from the police is not always fully explored to identify risks to children when family composition changes.

For a small number of children, there is insufficient consideration of safeguarding concerns by partner agencies, particularly when mobile and older children have bruises or injuries. Explanations from parents or carers are often either too readily believed or not sought at all. For these children, child protection medicals are not considered when there are clear benefits to doing so, and medical staff, including consultants, are not challenged by health colleagues or partner agencies. The policy for escalation is easy to follow but rarely applied or used to inform changes to these decisions, leaving children at risk of harm.

For most families receiving support from early help services, there is considerable progress. Schools and the local community have welcomed the family hubs. Families are increasingly able to access early help directly and immediately instead of waiting, including practical support regarding finance, child development and appointments to register births, enabling quick and easy access to wider family-focused services. Early help assessments identify a family's strengths and vulnerabilities well, and the range of support available to respond to these is steadily increasing. The early help panel provides a multi-agency response commensurate with need. Recent increases in

need have led to short delays in consideration by the panel for some families but there is no reduction in support to children in the interim.

Despite some technical glitches that slow down information-sharing in some children's cases, Operation Encompass works well, ensuring that schools and early years settings in Torbay have an increased awareness of the impact on children of living in homes where there is domestic abuse.

Most children benefit from help provided by skilled and committed frontline early help, social care and health practitioners, police officers and school staff working collaboratively to support them and their families and to prevent risk and harm escalating. Police staff understand vulnerability well and routinely complete risk assessments, which they use in their role to protect children. When children go missing, the missing persons safeguarding officer gathers intelligence at several points that helps to build a picture of whether risks of exploitation are increasing. Research by well-trained and supervised police staff in the force control room results in officers arriving at addresses where children are present with a comprehensive understanding of family dynamics and risk. The risk to missing children and the link to exploitation is well understood using multi-agency panels, and a thorough understanding of wider networks, places and spaces where children may be vulnerable. This is noteworthy progress from the very weak understanding prior to the re-establishment of a Torbay-specific safeguarding partnership in 2020, and demonstrates how a strategic approach to systems, processes, communication and training are driving positive change for children.

Although comprehending the extent and severity of children's mental health is a clear priority for TSCP, this is yet to translate into improvements in service delivery. As a result, children are not guaranteed the right support, at the right time, by the right people. For example, where NHS mental health support teams are operational in a school, there are positive outcomes for children, but not all schools have access to this. When a child is in significant mental health crisis and requires a multi-agency safeguarding response, there is good evidence of partnership working and linking in with CAMHS. CAMHS are considered part of the professional network in these cases and engage well with multi-agency colleagues. Outside of this, those children assessed as lower risk face substantial waiting lists and no routine re-evaluation of their mental health. Partner agencies have insufficient understanding of what CAMHS can deliver, and as a result often seek this as a panacea when other support may be more effective and quickly available. Insufficient mental health triage and guidance exacerbates this situation. Schools are increasingly supporting children directly with their mental health alongside charities, and for many children this works well. However, these demands are increasing in complexity, and they do not have the capacity or knowledge to help all children. Management oversight and supervision varies in quality and impact across the partnership. Where it is stronger, for example in the MASH, the social care assessment teams, early help, midwifery and CAMHS,

supervision is systematic, and managers understand thresholds and review progress with families regularly. Conversely, in the emergency department frontline practitioners do not have enough oversight from the safeguarding team or specialist supervision of a good enough quality.

The TSCP executive group has identified a significant weakness in the quality, accuracy, and reliability of the data they can call upon when considering the prevailing needs of Torbay's children. Both the ICB and Devon and Cornwall Police rely on data that relates to areas much larger than Torbay and includes between three and five different local authorities. This severely undermines their ability to identify local needs and track the impact of services. A functioning data dashboard is taking too long to progress and is an understandable priority for the partnership. In the meantime, reliable data from children's social care performance reports alongside local intelligence from schools and the police are used well, for example to react to increased school absences and increased antisocial behaviour. Practice tools such as exploitation toolkits and structured assessments to further understand neglect are being implemented and used by staff but can give little more than a baseline rather than measuring progress for families.

In the absence of sufficient Torbay-specific data, the Quality Assurance subgroup of TSCP is not active enough to give the right level of insight and assuredness about children's safety to the partnership. This is most noticeable given the significant delay in establishing a mental health strategic group and a clear action plan, but equally applies to standards of practice relating to physical abuse. The partnership recognises the need to review how this function is best used. Although limited in number, the multi-agency audits of work with individual children that the TSCP has completed do add rich information about the quality of practice but lack enough focus on the fundamentals of safeguarding. The partnership's insufficient oversight of unexplained injuries to children is an obvious example, but this also applies to initial decision-making when children have poor mental health but are not yet at the point of crisis.

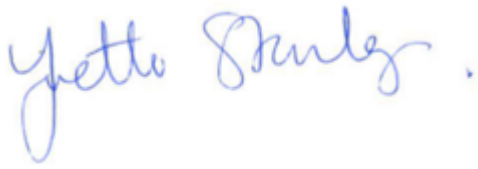
The partnership also recognises, following external review and internal reflection, that the meaningful involvement of children in reviewing and shaping strategy is underdeveloped. Equally, the development of a broader membership, including the local community and specialist health services, is a key priority. However, most staff say that they have a voice and can contribute to strategic priorities. Although the partnership collates aggregated data in relation to multi-agency training, it does not have a detailed breakdown of who attends from each agency or the impact on practice. All staff report positively about the quality and relevance of what is on offer when disciplines come together.

Next steps

We have determined that One Devon Integrated Care Board is the principal authority and should prepare a written statement of proposed action responding to the findings outlined in this letter. This should be a multi-agency response involving the individuals and agencies that this report is addressed to. The response should set out the actions for the partnership and, when appropriate, individual agencies. The local safeguarding partners should oversee implementation of the action plan through their local multi-agency safeguarding arrangements.

The ICB should send the written statement of action to ProtectionOfChildren@ofsted.gov.uk by 9 May 2024. This statement will inform the lines of enquiry at any future joint or single-agency activity by the inspectorates.

Yours sincerely



Yvette Stanley
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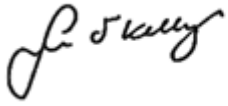

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