Inspection of safeguarding and looked after children services

Cornwall

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About this inspection

1. The purpose of the inspection is to evaluate the contribution made by relevant services in the local area towards ensuring that children and young people are properly safeguarded and to determine the quality of service provision for looked after children and care leavers. The inspection team consisted of four of Her Majesty's Inspectors (HMI), one additional inspector and one inspector from the Care Quality Commission. The inspection was carried out under the Children Act 2004.

2. The evidence evaluated by inspectors included:

   - discussions with 44 children and young people receiving services, 10 parents and carers, front line managers, senior officers including the Director of Children's Services and the Chair of the Local Safeguarding Children Board, elected members and a range of community representatives

   - interviews with health professionals, managers and senior staff from Cornwall and Isles of Scilly Primary Care Trust, Royal Cornwall Hospitals NHS Trust and Cornwall Partnership NHS Foundation Trust

   - analysing and evaluating reports from a variety of sources including a review of the Children and Young People's Plan, performance data, information from the inspection of local settings, such as schools and day care provision and the evaluations of a serious case review undertaken by Ofsted in accordance with *'Working Together To Safeguard Children'*, 2010

   - a review of 90 case files for children and young people with a range of need. This provided a view of services provided over time and the quality of reporting, recording and decision making undertaken

   - visits to over 20 services and teams throughout the county to inspect services, speak to staff and assess practice

   - the outcomes of the most recent annual inspection of local authority and partner agencies' safeguarding and looked after children services undertaken in September 2009

   - a review of evidence of the contribution of health agencies since the last safeguarding and looked after children inspection in September 2009.

The inspection judgements and what they mean

3. All inspection judgements are made using the following four point scale.

Outstanding (Grade 1)	A service that significantly exceeds minimum requirements
Good (Grade 2)	A service that exceeds minimum requirements
Adequate (Grade 3)	A service that only meets minimum requirements
Inadequate (Grade 4)	A service that does not meet minimum requirements

Service information

4. Cornwall has approximately 117,000 children and young people up to the age of 19 years. This is approximately 22% of the total population in the county. In January 2010, there were 69,950 children in 274 local authority maintained schools: two nursery schools with 145 pupils, 237 primary schools with 37,482 pupils, 31 secondary schools with 31,952 pupils and four special schools with 371 pupils. In Cornwall, 13.5% of pupils in primary schools and 11% in secondary schools are eligible for free school meals, in comparison with 18.5% of primary pupils and 15.4% of secondary pupils respectively in England. The proportion of all pupils from black and minority ethnic (BME) background is 4.9% in primary schools and 4.0% in secondary schools, in comparison with approximately 25.5% in primary schools and 21.4% in secondary schools in England. There are 350-400 Gypsy and Traveller children living in Cornwall, which includes Gypsies, Roma, Irish Travellers, New Travellers, Fairground, Circus and Market Traders. In January 2010, the proportion of pupils whose first language is known or believed to be other than English is 1.5% in primary schools and 1.1% in secondary schools, in comparison with 16.0% in primary schools and 11.6% in secondary schools in England.

5. The Cornwall Children and Young People's Strategic Partnership was set up initially in 2004 and the Children's Trust established in 2009. The Trust includes representatives of the NHS Cornwall & Isles of Scilly Primary Care Trust (PCT), Devon and Cornwall Police, the Police Authority, Careers South West (formerly Cornwall and Devon Connexions), community and voluntary organisations, primary and secondary schools and the further education sector. The Independent Chair of the Local Safeguarding Children Board (LSCB) is a member of the Trust as an observer. The Children's Trust Board is chaired by the Director of Children, Schools and Families from Cornwall Council and brings together the main organisations working with children, young people and families in Cornwall to develop a

Children and Young People's Plan and improve services delivered to children and young people.

6. Social care services for children have 262 foster carers, five children's homes, six short break residential resources, an assessment unit for children with disabilities and a family assessment unit. Social Work Services are provided in different locations across Cornwall but are managed by functions: Referral and Assessment, Child Protection and Children in Care. All new referrals are handled by a new Single Referral Unit (SRU). There is also a Leaving Care service. Private fostering services are included within the Family Placement Team. There is a Quality Assurance and Safeguarding unit. Other family support services are delivered by eight locality-based integrated early intervention 0–19 years teams which incorporate early years support through 40 children's centres, family support and both centre based and detached youth work.

7. At the end of December 2010 there were 460 children in care. They comprise 78 children under five years of age, 99 children of primary school age (5–10) and 283 children of secondary school age or above (11+). The leaving care service is a partnership between the local authority and Action for Children. It aims to ensure suitable accommodation and education, training and employment outcomes for those care leavers over 16 years of age. Cornwall has established a virtual school (Children in Care Education Support Service, CiCESS) to raise standards of attainment and increase the rates of progress made by children in care. CiCESS provides support, challenge and monitoring for schools and providers of services to children in care.

8. Commissioning and planning of National Health Services is carried out by the NHS Cornwall and Isles of Scilly PCT. Universal and children's community nursing services are provided by the Cornwall and Isles of Scilly Community Health Services. The acute hospital services are provided by Royal Cornwall Hospitals NHS Trust and Plymouth Hospital NHS Trust. Mental health and learning disabilities services are provided by the Cornwall Partnership NHS Foundation Trust. Child and Adolescent Mental Health Services (CAMHS) are provided by Cornwall Partnership NHS Foundation Trust, NHS Plymouth and Cornwall Children, Schools and Family Services. Services provided by NHS Plymouth and the Plymouth Hospitals NHS Trust were outside the scope of this inspection.

Safeguarding services

Overall effectiveness Grade 4 (inadequate)

9. The overall effectiveness of safeguarding services is inadequate. The safeguarding and looked after children inspection in September 2009 assessed the contribution of services to improving staying safe outcomes for children and young people in Cornwall as inadequate. This resulted in the then Department for Children, Schools and Families (DCSF) issuing a statutory direction requiring the establishment of an improvement board and the production of an improvement plan to address the inspection findings together with key targets set by the DCSF and agreed with the council. The resulting plan covered 15 key priorities for improvement. The board's action plan covered the key areas for improvement identified in the 2009 inspection. There is evidence of some significant improvement in the areas of strategic and structural weakness identified in the previous inspection. However, the extent and rigour of focus on operational child protection procedures and practice has been insufficient. There is substantial evidence that children's social care does not ensure that consistent and robust risk assessment is undertaken, due to a lack of adherence to some key statutory child protection guidance. Partner agencies have not sufficiently challenged these failures. These practices lead to an unsafe child protection system which causes drift and delay and leaves some children at risk of significant harm. The management and practice of too many cases were assessed to be inadequate by inspectors, including children who were at risk of significant harm.

10. The improvement board, the council and LSCB place undue reliance on the overly positive findings in the external review of the contact referral and assessment service, undertaken in September 2010 by the Government Office South West. The improvement board receives inaccurate performance management data on assessments, numbers of section 47 inquiries and promptness of initial child protections conferences. As a result the monitoring and quality assurance of front line practice has been inconsistent and uncertain, leading to unjustified optimism about the safety of risk assessment. There is acknowledgement by some of the LSCB members that the board has not sufficiently met its statutory function of monitoring the effectiveness of child protection practice. While the improvement board does not have any executive function, some LSCB members and staff from partner agencies expressed confusion about the respective accountabilities of the board, the Director of Children's Services and the LSCB.

11. The previous inspection of safeguarding and looked after children services in 2009 found that senior managers were ineffective in ensuring that quality assurance and performance management arrangements were used to ensure robust safeguarding systems and practice. Significant

improvements in performance management and audit systems have been introduced since that inspection. However these systems are not yet sufficiently robust to identify and tackle poor practice. The previous inspection also found that management support for staff was inconsistent in ensuring that policies, procedures and guidance are followed. Additionally, managers did not provide sufficiently effective challenge about the quality of child protection and child in need plans. This remains the case, despite significant increases in the number of social workers and management capacity, and the structural reorganisation in children's social care services.

Capacity for improvement Grade 3 (adequate)

12. Capacity for improvement is adequate. Following the Ofsted inspection in September 2009, there is a record of improvement in some areas. Recruitment processes are safe. The recruitment and retention of staff within children's social care services have improved significantly and there is now less reliance on agency staff. Social work caseloads, which have generally reduced since the last inspection, are now more manageable and staff morale has improved significantly. The reorganised management structure in children's social care services reflects clear functional responsibilities.

13. Engagement with partners, including the voluntary sector, is improving the consistency in the application of thresholds for referrals to children's social care, in combination with the more effective SRU. Statutory child protection visits are now undertaken regularly. Timeliness and attendance at child protection conferences and core groups by members of partner agencies are improved. The sharing of child protection reports leads to greater participation by parents at child protection conferences. The co-location of some services is improving communication and information sharing within children's services and with partner agencies.

14. Although some attention has been given to improving the management of casework, senior management has not focused sufficiently on the key improvements needed in operational and front line practice. As a result there are some significant failures in practice due to non compliance with *'Working Together to Safeguard Children'* 2010 guidance. These failures were overlooked by senior managers, the improvement board and the LSCB. However, once these concerns were brought to the attention of the Director of Children's Services and senior managers by inspectors, they were acknowledged and prompt remedial action was taken to ensure that children at significant risk of harm are protected.

15. Progress is still at an early stage with a number of recent areas of improvement not yet embedded, or only recently acknowledged. In particular, improvement has been held back by the delay in the permanent recruitment of key senior management posts, including the Director of

Children's Services and the Head of Children's Social Care. The council had previously appointed an interim Director of Children's Services and an interim Head of Social Work after the 2009 inspection. Permanent appointments to these posts were taken up in June 2010 and January 2011 respectively. These key, permanent appointments, combined with the continuing drive and prioritisation through the improvement board, provide sufficient strengthening of workforce capacity. The performance management systems that have been introduced since that last inspection do have the capacity to improve practice, once leadership and 'challenge' are more embedded.

Areas for improvement

16. In order to improve the quality of provision and services for safeguarding children and young people in Cornwall, the local authority and its partners should take the following action.

- Ensure that the recommendations made in the last inspection of safeguarding services in 2009 are fully implemented, and in addition:

Immediately:

- ensure that management oversight improves practice effectively
- ensure that management decisions are clearly recorded on individual cases with clear timescales for action
- ensure improvement in the timeliness of assessments
- ensure that assessments include full historical information, sufficient information from other agencies, are analytical, child focussed, and robustly and explicitly identify risk and protective factors
- ensure that statutory child protection guidance is followed and where section 47 enquiries are carried out, that core assessments are always undertaken
- ensure that thresholds for section 47 enquiries are appropriately and robustly applied, that statutory checks are undertaken, and that enquiries are timely and clearly assess risk
- ensure that strategy discussions and meetings are timely and follow statutory guidance
- ensure that recording is timely and comprehensive and that chronologies are in place and up-to-date
- ensure that all child protection and child in need plans have specific objectives with clear and measurable outcomes.

Within three months:

- ensure that the LSCB effectively monitors front line child protection practice, that robust auditing arrangements are put in place, and that information gathered is regularly analysed and reviewed by the board
- ensure that children's social care services have robust auditing arrangements to develop the safety and consistency of front line child protection practice
- ensure that the full information from audits is appropriately shared and results in effective action plans, which are robustly monitored, and result in improvements in practice
- ensure that robust systems are in place to enable full and accurate monitoring and reporting of safeguarding performance in children's social care to senior managers, the LSCB, and to the improvement board
- ensure that there is clarity of responsibility and accountability for child protection practice between the LSCB, the improvement board and the Director of Children's Services
- ensure that staff in all agencies understand child protection procedures and thresholds for referral, and that partner agencies make timely referrals where children are identified at risk of harm
- ensure that escalation processes are used appropriately to ensure that thresholds are consistently applied
- ensure that poor practice or non-compliance with safeguarding procedures is challenged
- ensure that there are clear and appropriate standards of practice for child protection which are consistently monitored and implemented by managers and child protection chairs
- ensure that the common assessment framework (CAF) is used in an appropriate and consistent way by all agencies
- that the NHS Cornwall and Isles of Scilly PCT and the NHS trusts should ensure that the Healthy Child Programme is fully implemented
- that the Royal Cornwall Hospitals NHS Trust should review resourcing of the named safeguarding midwife, and ensure that the named midwife role is explicitly defined in job descriptions. The trust should review reporting arrangements to ensure that the named nurse works closely with the trust board's executive lead for children's

safeguarding, to ensure that all services are aware of their responsibilities

- ensure that the Royal Cornwall Hospitals NHS Trust reviews the named link safeguarding role and function to ensure its effectiveness in supporting safeguarding for children
- that the Royal Cornwall Hospitals NHS Trust should fully implement its policy on safeguarding supervision, and ensure appropriate monitoring and reporting of the effectiveness of supervision.

Within six months:

- Ensure that all front line social care managers have the appropriate knowledge and skills to effectively manage front line child protection services and that staff follow statutory guidance

Safeguarding outcomes for children and young people

Children and young people are safe and feel safe

Grade 4 (inadequate)

17. Services to ensure children and young people are safe are inadequate. Child protection processes do not follow statutory guidance, which has led to an unsafe child protection system and in particular, delays in protecting the most vulnerable children. Consequently, the council cannot ensure that all young people who are referred to children's social care are adequately safeguarded. In too many cases inspectors found that it was not possible to identify whether concerns about children being at risk of significant harm are safely assessed or case managed. In some cases there is little evidence that any action has been taken to assess or protect children at potential risk of harm, and some cases are closed without a recorded analysis of risk. Among these cases there is a range of poor practice. For example, many assessments fail to take into account, relevant historical information. There is significant drift and delay in assessment, failure to see children, to monitor their circumstances, and a failure to work proactively with the family. Many assessments are insufficiently analytical and fail to identify risks. Many assessments are unwarrantedly optimistic about the child's situation and the parent's capacity and commitment to care for their children. Additionally, case recording is frequently inadequate and lacks clearly defined decision making or management direction. In some cases partner agencies were aware of serious concerns but failed to promptly refer these to children's social care.

18. Most children seen in this inspection and those that responded to questionnaires indicate that they feel safe in their schools and home communities. Through liaison with parents and carers, incidents of bullying are managed well by the schools visited during the inspection. Some children and young people are involved in peer mentoring schemes which provide support to other pupils. Schemes such as 'play time pals' and 'our time' are effective in developing children's self-esteem and resilience to bullying. A high number of schools have Healthy Schools status and are engaged in the Healthy Schools Plus scheme, which includes work on children's emotional health and well-being. The last year has seen a reduction in exclusions related to bullying and a reduction in the number of racist incidents within primary schools. A clear overarching anti-bullying strategy continues to be developed through a multi-agency group, using a wide range of data and surveys. However the strategy has yet to be evaluated. The strategy group are currently exploring issues of cyber-bullying and bullying in the community, and are working to ensure that young carers and children with special educational needs and

disabilities are able to express their concerns regarding bullying is at an early stage.

19. Robust multi-agency public protection arrangements are established with good attendance by well prepared partner agencies. Actions decided in the meetings are monitored effectively. A wide range of initiatives to raise awareness of domestic abuse has resulted in increasing numbers of people involved in domestic abuse accessing effective support, for example through the independent domestic violence advisor service. There are clear pathways to services for families suffering domestic abuse, with a range of effective and creative interventions. Specialist domestic violence courts are having a positive impact. The timeliness of police notifications of domestic abuse to children's services is improving, as are the mechanisms for sharing this information between agencies. A process for sharing this information with health agencies is being developed alongside plans for co-location of staff. The multi-agency risk assessment conference process is well established and is well attended by partner agencies. However referrals from agencies remain low, in particular referrals from services for health, education and social care. This is recognised and a plan has been developed to tackle this, which has yet to be implemented.

20. Good, multi-agency arrangements are in place for children who go missing from home, care or school, with a clear protocol which is effectively put into practice. This results in good monitoring and risk assessment of missing children. Currently, only one young person is missing from care. Exit interviews are routinely conducted and a system is being developed to monitor the impact of support provided, following episodes of children going missing. Good arrangements are in place to support children who are educated at home.

21. The impact of the Local Authority Designated Officer (LADO) role is improving significantly from a low base, with clear systems now in place. However a lack of awareness remains amongst partner agencies about this role, which is being systematically addressed. For example, the reason for the low number of referrals to LADO from the fostering service is currently being audited. The previously poor timeliness of responses by LADO to allegations against people working with children, has recently improved. A tracking system for allegations against people working with children has yet to be developed.

22. Private fostering arrangements are good. Regulatory inspections by Ofsted of fostering and adoption services assess 'staying safe' to be good. The large majority of the local authority children's homes are assessed to be at least good for 'staying safe'.

23. The council has significantly improved its processes to ensure safe recruitment of its staff and for agencies contracted to provide services for children. Recruitment processes are now adequate or better.

24. Young carers interviewed by inspectors state that they value the young carers' service. It enables them to have contact with other young people who have similar life experiences, engage in activities to build positive relationships and increase their personal confidence. However young carers indicate that they are bullied at school and that the schools do not understand or appropriately respond to their concerns. Young carers expressed a concern about many professionals' lack of awareness of the responsibilities they face.

Quality of provision Grade 4 (inadequate)

25. The quality of safeguarding provision is inadequate. The council's child protection procedures and processes do not comply with statutory requirements within *'Working Together to Safeguard Children'* 2010 in relation to undertaking section 47 inquiries, the use of core assessments and strategy discussions. The council accepts this finding, and promptly issued new procedures during the inspection. However, as a result of non compliance, many referrals were not responded to safely or appropriately.

26. The introduction of the SRU improves consistency in the response to contacts and decisions on referrals. The SRU is welcomed by partners as an accessible single point of access for advice, support and referral. New guidance on thresholds has been issued and partner agencies, such as schools, report that thresholds are generally clearer, although these are not fully understood by all partnership staff. Responses to referrals are improved overall. In some instances, agencies view the response of the SRU as inadequate although they have been able to challenge and resolve their concerns with the unit. For example, some schools have challenged responses to referrals, in accordance with lessons learnt from serious case reviews. The SRU continues to develop, with planned co-location of some partner agencies, for example the Police, to improve communication and collaboration.

27. Processes and practices to ensure that referrals to social care services are appropriately assessed and case-managed are inadequate. These include concerns that children may be at risk of significant harm. A significant number of cases audited by inspectors were assessed to be inadequate. In too many cases it was not possible to identify whether concerns that children were at risk of significant harm had been safely assessed or case managed. Most safeguarding cases seen by inspectors contained either individual elements or combinations of inadequate practices. For example, historical information is not taken fully into account in decision making and planning. There is significant drift and delay in assessments and a failure to see children or inconsistent monitoring of their circumstances. Work

with the family is insufficiently focused or proactive. Recording of work is insufficient, or not up-to-date, and records lack clearly defined decision making. In some cases, partner agencies had been aware of serious concerns but had failed to promptly refer to children's social care. Some cases showed little evidence that any action had been taken to assess or protect children at potential risk of harm and in others, plans and assessments had not been completed. In addition, in too many cases management direction was either not recorded or insufficiently explicit to provide evidence of case planning or the rationale for actions.

28. Agencies are confused as to whether strategy discussions are undertaken as part of section 47 or section 17 enquiries. This impacts negatively on their ability to appropriately share confidential information, with or without permission from families. Not all strategy discussions/meetings are held promptly and this sometimes leads to significant delay. Overall strategy meetings do focus on the needs of the child and the attendance of partners is appropriate. However, actions from strategy discussions and meetings are not followed up promptly. In some cases the decisions and outcome of the strategy meeting and discussion are not appropriate and it is unclear how the outcome relates to the risks identified. Sometimes, repeated strategy discussions or meetings are being used for assessment and planning rather than to identify whether the case meets the threshold for child protection investigation, and agreeing what action should be taken. In other cases, section 47 enquiries are undertaken through an initial assessment instead of through core assessments. In some cases statutory checks of information held by partner agencies are not evident. In other cases the decision to commence section 47 investigations is recorded after the information has been gathered, as a means to proceed to the initial child protection conference rather than to commence enquiries. On occasion, where strategy meetings identified that section 47 enquiries should be undertaken, this did not subsequently happen. In some strategy meetings high levels of potential risk to the child are identified and result in child in need support plans, but no section 47 enquiries are agreed or undertaken.

29. Some cases are closed by social care services without an explicit analysis of risk and therefore these decisions are not always clearly justified. The number of re-referrals is very high compared with national average levels. Managers are aware of this but have not audited these cases to analyse whether previous decisions on the case were sufficiently rigorous, or whether children have been placed at risk in the interim.

30. The quality of assessments is too variable. Some are adequate or better. However, a significant number of assessments do not sufficiently challenge parents' views and do not include sufficient information from other agencies. Similarly they do not focus sufficiently on the impact for children of key issues, such as lack of parenting capacity, domestic violence and parental mental health issues. Too many assessments are

overly optimistic about the child's situation and the parents' capacity and commitment to improving the care of their children. Assessments are often insufficiently analytical and many do not effectively identify risk factors. Challenge from managers about the quality of assessments is beginning to improve but remains too variable. Some managers acknowledge this to be an area in which they need to be more robust.

31. There is limited evidence of a clear and concise approach to planning and risk assessment in child protection investigations. In some cases the length of time between a child protection referral and the child being protected by a child protection plan is unacceptably delayed. In addition, during the period between the referral and the initial child protection conference, the plan to safeguard the child is often unclear.

32. In most cases, core assessments are not initiated when section 47 enquiries are undertaken. In some cases there are significant delays in core assessments being undertaken with little evidence that this has been tackled by managers. As a result, reports to initial child protection conferences are too often not informed by the core assessment and are frequently of a poor quality. Core assessments are not being used consistently to inform child protection plans at review conferences.

33. Once requested, initial child protection conferences are timely. However there is too often a delay between the child protection referral and an initial child protection conference being requested. Most child protection review conferences are timely. However, reports to child protection conferences are not sufficiently specific in identifying risks and do not include chronologies of sufficient depth or quality. They are often not sufficiently focussed on the child. Reports from partner agencies are also often too variable in quality. This has been recognised by partner agencies, who are taking action to improve the quality and consistency of reports. Child protection reports have not been consistently shared with parents before the initial child protection conference. However this is beginning to improve significantly.

34. The outline child protection plan, devised at the initial child protection conference, does not always clearly identify the actions to be taken to protect the child. As a result the plans subsequently developed by the core groups are often poor. Too many child protection plans are not specific and do not have clear measurable outcomes. They do not cover identified risks comprehensively and seldom enable parents to understand what they need to do to have their children removed from the plan or the consequence of failing to achieve this. Some plans are insufficiently focussed on the child and some do not evidence contingency planning in the event of changes in the level of risks.

35. The structure and content of some child protection plans do not enable core groups to evidence that they are being rigorously implemented and

monitored. Most core groups are held regularly and take place within appropriate timescales. Attendance by partners is good overall, but tends to decrease the longer that the plan is in place. Partner agencies do not consistently take on sufficient responsibility for implementing child protection plans. The Police do not attend core groups, even when domestic violence is an issue. In the majority of cases children on child protection plans are regularly visited and are seen and visits to children are now being more effectively monitored by managers. However, it is often not clear whether visits had been announced or unannounced.

36. Minutes of child protection conferences are seldom sufficiently clear about the reason for initial concerns, work undertaken to protect the children, the impact of the work undertaken, the change in the child's situation or the level of risk to children. Consequently where a plan is discontinued the reasons for this are not always sufficiently clear.

37. Managers and child protection chairs are increasingly beginning to challenge poor practice in cases. However in too many cases insufficient challenge to ineffective practice by managers results in a lack of clarity about risk to children, and needs and strengths within families. This impacts negatively on the development of plans and undermines the effectiveness of subsequent intervention. In too many cases no effective challenge is given by child protection chairs where the quality of the work is poor and statutory guidance has not been followed. There has been a significant reduction in the number of children with child protection plans, including a significant reduction of looked after children with child protection plans. The decisions to remove these children from child protection plans are now being audited by a multi-agency group to ensure that the removal of the plans has been appropriate.

38. All cases are now allocated to suitably qualified social workers. Overall, most caseloads are manageable and many are significantly reduced although caseloads do fluctuate and some remain high. Very recently there has been improved focus on workflow. This means that case transfer arrangements have improved since the last inspection and cases are more promptly closed or transferred to locality teams. However, such decisions are not always appropriate and a lack of capacity in some locality teams does not enable prompt transfer to be effected consistently.

39. Case recording in children's social care services is inadequate overall. Chronologies are often either not in place or up-to-date, and their quality is often poor. As a result it is difficult to understand the case history to inform risk assessment and planning. There is no single record for children and young people and some information is kept on paper files, which are not used consistently. Important documents are not always accessible. In some cases key information, such as strategy meetings, core group minutes and supervision notes, is not recorded promptly or is not available. In some instances there is significant delay in case recording

being completed. Although there are some examples of good recording the quality of case recording is too variable. For example in some cases the purpose and outcome of a visit is unclear and observations of the child and their family are not sufficiently recorded. The recording and inclusion of children's views about their case is also too variable.

40. A positive finding is that some good and adequate work is undertaken by children's social care. This is reflected in the views of parents met during the inspection who are very positive about the intervention by children's social care which has been effective and made a positive difference to their children. In particular, parents are positive about the accessibility and effectiveness of social work, are listened too and feel that social workers shared information effectively. Support provided to families in some cases is highly effective, for example, one parent described the support provided by the crisis intervention service as "brilliant".

41. The quality of management oversight in social care services is inadequate. Supervision has recently become more regular, however most management oversight on individual cases is too limited, with decisions and case planning being insufficiently specific and lacking in the measurement of outcomes. Where clear actions are identified in supervision, these frequently lack timescales, and subsequent supervision seldom demonstrates that agreed actions have been followed through. Too often management oversight does not consistently reflect challenge to intervention, identification of risk and focus on impact and outcome of the intervention for children and young people. However, in some recent cases, there is evidence of greater challenge. In some cases it is not always clear exactly what decisions are made, or the reasons for decisions.

42. Where children in need plans are made, many are too limited, not specific and lack measurable outcomes. However a few children in need plans are of a good standard.

43. Early intervention and preventive work continues to develop in localities. The move to locality working has improved the understanding of roles between partner agencies, as well as joint working and staff awareness of the range of preventative services available to support children and families across the county. Information sharing and early intervention improves transition arrangements between early year's services, primary and secondary schools, including those supporting children with special educational needs and disabilities.

44. The CAF and Team Around the Child (TAC) processes are not implemented consistently across localities or services. However, in some cases the CAF and TAC are working well in improving attendance and behaviour. They also encourage parents to engage with schools and children's centres. Some services are not yet sufficiently engaged with the

CAF process and do not consistently attend TAC meetings, which impacts negatively on the effectiveness of these interventions. A lack of clarity continues about the thresholds for the involvement of either the CAF process or social care services. Concerns were raised by partner agencies about the adequacy of support for those children and young people who do not meet the threshold for social care involvement. For example some higher level cases, including children who previously were subject to a child protection plan, are not managed effectively in the CAF process. In some cases where either the CAF is not effective or concerns for children are escalating, partner agencies do not promptly refer concerns to the prevention panel or to social care services. In other cases where the TAC breaks down or is not proving successful, drift in case planning results with a lack of clear accountability for corrective action.

45. A wide range of agencies, including voluntary sector partners, provide effective support for children and young people with special educational needs and disabilities. Some services have been redesigned well since the last inspection. Despite high demand, waiting times for speech and language therapy services have improved. The consultant community paediatricians now have a countywide remit with specific responsibilities, for example, for children and young people with complex needs in special schools. Each special school has a designated nurse and frequent meetings take place between community consultant paediatricians and designated nurses to review safeguarding issues. Occupational and physiotherapy services for children and young people are currently relocating into special schools, to provide support to mainstream schools, enabling greater equity in the provision of services across the county and less travelling for parents and children. Health assessments for children involved in the statementing process are timely. Work is in progress to ensure that health assessments are completed regularly for children placed out of county.

46. Effective partnership working continues to have a positive impact on reducing the proportion of children and young people being excluded from schools. Performance is above the national average with an overall trend of reduction for both fixed term and permanent exclusions. Since 2004/05 there has been a 91% reduction in permanent exclusions and 49% reduction in fixed term exclusions in all schools. Pupil referral units across the county are of good quality overall and parents of children who find school difficult praised the improvement in outcomes achieved for the whole family.

47. Arrangements for children, young people and their families to make a complaint are good. All children who make a complaint are offered an advocate, and the majority of complaints made are resolved in a timely manner at stage one of the procedure. Parents are supported in making complaints and the Cornwall advocacy service for adults is made available where appropriate. New leaflets have been devised to ensure children and

young people and their families are aware of how to complain and who to contact throughout the process. The management of complaints is appropriately overseen by the complaints team to ensure consistency and transparency. Social care staff are briefed on the complaints policy on a regular basis through training, and lessons learned from complaints are disseminated through workshops. The monitoring and reporting arrangements to senior managers at all levels are clear. New arrangements provide for all stage one complaints to be read by senior managers which ensure issues raised are tackled and any lessons learned are taken forward to inform the revision of practice or procedures.

The contribution of health agencies to keeping children and young people safe Grade 3 (adequate)

48. The contribution of health agencies to keeping children and young people safe is adequate. Governance arrangements for safeguarding are well established throughout most NHS commissioners and providers. Health partners are appropriately represented on the LSCB and its sub-committees. A children and adult safeguarding executive group provides a collective health view on serious case reviews, update on action plans and responses to national initiatives. Levels of safeguarding training across health partners are variable. The trusts have appropriate plans in place to mitigate risk and address gaps. Cornwall and the Isles of Scilly PCT provides good support and training for general practitioners to help them fulfil their responsibilities in child protection.

49. Referrals made by health partners to children's social care are routinely audited and monitored to ensure consistency in the quality of information provided. Where decisions made by children and families services are challenged, appropriate processes are in place to ensure a swift resolution. Most health staff report good engagement in child protection and child in need conferences and planning. However, the substance misuse team is not engaged fully with children and families services. The team reports that they are not routinely invited to attend initial case conferences where this is appropriate, which limits information sharing on an individual case basis.

50. Health visiting and school nursing services are being redeveloped to deliver the full Healthy Child Programme. Following a comprehensive analysis of needs and caseloads, geographical based working has been introduced to manage capacity in the areas of higher need, although it is too early to measure the impact, and the full co-location of staff with other agencies is not yet achieved. The capacity of school nursing services in special schools supporting children with complex health needs has been increased although the outcome of this increase has not been measured.

51. Arrangements for supervision of safeguarding practice across NHS providers are variable. There is excellent practice within the child and

family services provided by Cornwall and the Isles of Scilly PCT, Community Health Services and the Cornwall Partnership Foundation NHS Trust. Arrangements for a coordinated approach to supervision in the Royal Cornwall Hospitals NHS Trust have been agreed and are scheduled for implementation by April 2011.

52. The funding, supervision and support arrangements for named professionals are variable across health providers. Arrangements for the named professional roles at the Royal Cornwall Hospital NHS Trust are inadequate. The named midwife has no formal job plan and there has been no allocation of resource to the role, contrary to requirements in *'Working Together to Safeguard Children'* 2010. The safeguarding link role in the trust is not effective, with poor attendance at safeguarding strategic boards and no priority or resource allocated to the post.

53. The provision of advice and education to children and young people about sex and relationships is adequate. Teenage conception rates have shown a consistent downward trend over the past 9 months. Adequate access to contraception and sexual health services is available for young people. An effective, jointly funded mobile young people's information, advice and guidance service visits hard to reach communities and local 'hot spots' where there are high rates of conception. Emergency contraception is readily available from general practitioners or from most of the minor injuries units. There is no specific teenage pregnancy support midwife; however community midwifery services deliver bespoke individualised holistic ante-natal care for teenage parents. An effective family nurse partnership pilot programme works with 88 first time young parents.

54. Access to CAMHS has improved following recent financial investment. While performance monitoring information submitted during the inspection is not sufficient to show how this has impacted on service users, performance systems have been implemented that enable outcome measures to be monitored. The CAMHS specification from July 2010 is for countywide, 0–18 provision, with multi-disciplinary working at a joint Tier 2/3. The single assessment process is now established and is starting to work well. Services for looked after children and those in transition, as well as the learning disabilities service are well established. An effective mainstream team is in place providing Tier 2 services as well as a 24 hour, 7 day on-call emergency service. Targeted mental health services are provided appropriately in schools. The Tier 4 provision is contracted across the county, on a per case basis based on individual needs.

55. Good arrangements are in place for child protection medicals and for the examination of those children and young people who may have been subject to alleged sexual abuse. Examinations take place in a well equipped purpose built forensic unit, staffed by fully trained paediatricians and paediatric nurses.

56. Services available to children and young people with complex care needs are improving, with good services for children and young people with learning disabilities. Provision of respite care to children with highly complex health needs and challenging behaviour is good and an effective disabled children's team supports parents, carers and other professionals.

57. Appropriate arrangements are in place to safeguard children and young people who attend accident and emergency departments (A&E), at the hospitals or minor injury units in Cornwall. All children and young people who attend A&E are checked for patterns of repeat attendance and an electronic information system identifies any children who are subject to a child protection plan or looked after. Systems are in place to refer to children and families where there are concerns about adults who attend A&E following domestic violence or risk-taking behaviour. However, compliance with this requirement has not been audited.

58. Staff are increasingly aware of the implications for children of patients who access adult mental health and substance misuse services and the potential impact on their parenting capacity. Staff employed by the Cornwall Partnership Foundation NHS Trust are well trained, and there is a comprehensive risk assessment to identify potential risk to children and young people that is completed on admission and is regularly audited.

59. An effective Child Death Overview Panel is well resourced, with recommendations from this panel clearly influencing change to local policies, such as in midwifery services.

Ambition and prioritisation Grade 3 (adequate)

60. Ambition and prioritisation are adequate. Safeguarding children is a clear priority for the council and its partners. Communication and collaboration with staff across the partnership have improved significantly since the last inspection in 2009. Staff spoken to during this inspection stated that management are involving them in the development of services. There is a strong commitment to improving services to children across the partnership by staff at all levels.

61. The improvement plan reflects the recommendations identified in the last inspection appropriately. Progress on implementation of the improvement plan is regularly monitored through the improvement board, which has representation from key partners at the most senior level. Performance management systems have been developed to enable the board to monitor progress of the plan. However these have not proved effective to enable the board to identify and tackle concerns in relation to front line child protection practice and services. Whilst the council has demonstrated a clear ambition for children and young people this is not yet reflected in its impact in improving services for children at greatest risk.

Leadership and management Grade 4 (inadequate)

62. Leadership and management are inadequate. Strong commitment is evident across the partnership at all levels to improve safeguarding and this is particularly evident in the profile of senior membership on the improvement board. However, this has not yet consistently assured the safeguarding of vulnerable children, which is a fundamental priority for the council and its partners, the improvement board and the LSCB.

63. Leadership and management are effective at the strategic level, and their impact is visible in the improvements to some aspects of joint working, structural reorganisation, and the development of workforce capacity. Weaknesses and resource deficits are generally well understood by senior managers who have been proactive in tackling known deficits from the last inspection. However the assessment of risk in front line services is too positive and consequently the management action taken is insufficiently robust to correct inadequate child protection practice. Despite clear evidence of external and internal auditing activity, including some negative audit evidence, strategic managers have not identified the substantial failings at operational and front line level in safeguarding and child protection services. As a result, children have been placed at risk. An inspection of contact, referral and assessment practice conducted by the Government Office South West (GOSW), and commissioned by the Director of Children's Services, took place in September 2010. Government office staff did not find serious child protection concerns in any of the case files they examined or in interviews with staff and managers. The independent chair of the improvement board noted this in her report to the Under Secretary of State for Children and Families in November 2010, identifying it as a positive report. Prior to the inspection by GOSW two generally positive internal audits of practice were conducted and a third was conducted in November 2010. The third audit raised a number of the serious concerns also identified in this inspection. However, a summary of this audit was provided to the improvement board which minimised the concerns and the board members did not have the benefit of the full audit report.

64. Since the last safeguarding and looked after children inspection, children's social care services have been restructured to provide clear lines of accountability. Third tier managers now have clear functional responsibilities which provide the potential for much more consistency of management. Staff and managers indicate that these new arrangements have led to greater clarity in their roles and better access to managers. Social workers state that the new arrangements have led to their feeling more supported and confident in their work. The majority of social workers spoken to state that morale is improved from a low base and that senior managers are now better at sharing information about developments.

65. The serious case review process is now more robust, with good dissemination of lessons learned across the partnership. However, this has not led to consistent improvements in practice. The LSCB is undertaking an audit of how agencies have improved practice and service delivery, following the dissemination of lessons learned to ensure that action plans are effective. Following the inspection findings of serious child protection failings there is acknowledgement by some of the LSCB members that the board has not sufficiently performed its statutory duty to monitor the effectiveness of child protection practice. While the improvement board does not have any executive function, some LSCB members and representatives of partner agencies expressed confusion over the respective accountabilities of the Director of Children's Services, the LSCB and the improvement board.

66. The recruitment and retention of staff have improved. The council has been successful in attracting social work students and supporting internal staff to become qualified social workers; there are currently six traineeships. There is now less reliance on agency staff. The council has recently been successful at recruiting a head of social work. Social workers state that in their view practice is significantly improved. Social workers demonstrate a strong commitment to improving practice. The quality of training and the regularity of supervision are valued by staff and are areas that social workers indicate are now much improved.

67. Outcomes and leadership on equality and diversity in safeguarding are adequate overall. The newly formed Directorate Equality Action Group, chaired by the Director of Children's Services is working towards the Equality Framework for Local Government. The recently developed action plan has a strong focus on the need for equality and diversity to underpin all children's services. Casework demonstrates that diversity issues are routinely considered in assessment and care planning to at least an adequate level. However the degree to which cultural and ethnic needs are understood and are impacting on service provision is less evident.

68. Clear commitment and prioritisation of training is evident for the development of front line social care managers. However, prioritisation of training and development, focused on the key skills and knowledge required to ensure effective management of front line child protection, has not yet occurred.

Performance management and quality assurance
Grade 4 (inadequate)

69. Performance management and quality assurance are inadequate. Although a substantial improvement plan has been developed, underpinned by performance management systems, this is yet to be implemented effectively. Performance management systems are now in place with a much greater focus on performance monitoring and managers have

greater access to performance information. However, this is undermined by the lack of robust challenge, an overly positive picture of performance and by the inaccuracy of some key management information.

70. Issues about the accuracy of management information relate to: the timeliness of assessments; numbers of core assessments which should have been undertaken; numbers of section 47 enquiries and the timeliness of initial child protection conferences. The inaccuracy of key management information had not been identified by the council or its partners prior to this inspection. As a result, the basis of analysis and performance management by managers, the improvement board and strategic planning groups is flawed.

71. Auditing arrangements in children's social care services are beginning to show some impact on individual cases. Front line managers are beginning to audit cases in their own services, which in some cases undermines their objective analysis. Audits are of variable quality, ranging from poor to good, with some audit activity clearly demonstrating critical challenge. Senior managers are not consistently involved in auditing cases.

72. Auditing has also improved through the development of a quality and audit team in children's social care services and with partner agencies through a quality sub group of the LSCB. In some cases this has resulted in the identification of key issues, such as in the joint monthly audit of discontinued child protection plans. However, audits have failed to identify the significant shortfall in casework, management and safeguarding processes identified in this inspection. Where audits have identified concerns, there is not consistent evidence that this has led to effective remedial action, or that the concerns have been fully reported and acted on by senior managers and executive boards. For example, recent case audits carried out between August and November 2010 by the quality assurance team in social care services, identified some significant concerns in safeguarding operational practice, also identified in this inspection. It is not clear to what extent these concerns have been reported to the Director of Children's Services, the LSCB, or the improvement board and why these issues have not been tackled or identified in the council's self assessment.

Partnership working Grade 4 (inadequate)

73. Partnership working is inadequate. The LSCB is not adequately fulfilling its statutory function to ensure that children are adequately protected. In particular, LSCB members acknowledge that the board does not apply sufficient rigour to the quality assurance of operational child protection practice, as a result of the improvement board also undertaking some aspects of monitoring of the effectiveness of safeguarding services. This results in partner agencies failing to recognise or challenge inappropriate or unsafe practice. Examples of particular failures relate to the assessment

of risks to children, the effectiveness of core groups and the effectiveness of child protection conferences. Partners do not sufficiently promote the understanding of core statutory requirements in child protection and fail to sufficiently use escalation processes to ensure that thresholds are consistently applied and that poor practice or non-compliance with safeguarding procedures are challenged.

74. The LSCB is, however, effective in its wider safeguarding role. For example, it leads the good Newquay Safe project. It also contributes successfully to some improvements in the CAMHS. Work by the Child Death Overview Panel is effective.

75. Partnership work between staff of individual agencies is significantly improved, through closer collaboration and some co-location of staff and services. This results in improved networking and understanding of agency roles and responsibilities. Partnerships are improved through the development of locality working. Schools and children's centres visited report that they enjoy good working relationships with other agencies and that links with social care services are improved since the last inspection. Many teams are co-located, for example health visitors, CAMHS staff, family support workers and children's centre staff work alongside each other in one children's centre visited, and many other similar arrangements are in place across the county.

Services for looked after children

Overall effectiveness Grade 3 (adequate)

76. The overall effectiveness of services for looked after children is adequate. Since the last inspection in 2009 no services are deteriorating. The education outcomes for looked after children continue to be good and outcomes in the areas of health, staying safe, making a positive contribution and economic well-being are all adequate. Leadership and management across the partnership in respect of services for looked after children and care leavers have improved and are now adequate. Partnership arrangements are underpinned by improved systems and structures, better communication and clearer lines of accountability and responsibility. These measures have brought about some identifiable improvements in outcomes for looked after children and young people. The voice of children and young people is now actively sought through the development of the children in care council 'Voice 4 Us' and the care leavers' forum. Some young people told inspectors that their views are listened to and how they make a difference to services. However, a number of young people express concern about the frequent changes in their social worker.

77. Staffing levels in the looked after children and leaving care teams are sufficient to meet current demand and the vacancy rate is low. All looked after children and young people are allocated to a qualified social worker. Staff morale has improved since the last inspection. All social care staff have a personal development plan. This is a recent development and the impact of this on continuous professional development cannot yet be measured. Collaborative joint working is developing well within and across teams and co-location is providing regular access to other services such as family placement, the leaving care team, education support services and looked after children's nurses.

78. Performance management systems are significantly improved since the last inspection and are now adequate. Managers have regular access to improved information systems and routinely monitor performance information.

79. Recommendations from the previous inspection have been partly implemented, but some areas for development remain outstanding, for example risk management, planning and recording. This inspection identifies failures in compliance with safeguarding practice in some cases.

Capacity for improvement Grade 3 (adequate)

80. Capacity for improvement is adequate.

81. Recent stability in the senior management team and the development of procedures and policies across the partnership enable clear lines of communication, accountability and responsibility in the provision of services for looked after children and young people and care leavers. Staff in all agencies working with looked after children and care leavers remain committed to providing high quality services. A track record of continuing improvement in some areas is evident, for example, in the further improvements in educational attainment.

82. Improved information systems allow the partnership board to determine the impact of joint working arrangements on service delivery more effectively. Examples of improved provision include better transitional arrangements for looked after young people moving to adult services, and for young people remaining with their foster family until the end of year 13 so they can complete their education. The joint agency approach to the delivery of services for those with specialist and complex health needs ensures resources are appropriately directed and this has improved the equality of access across the county.

83. However, many new ways of working to improve the quality of outcomes for these children and young people are at an early stage of development across the partnership and are not yet fully embedded.

Areas for improvement

84. In order to improve the quality of provision and services for safeguarding children and young people in Cornwall, the local authority and its partners should take the following action.

- Ensure that the recommendations made in the last inspection of looked after children services are fully implemented. In addition:

Immediately:

- ensure that potential risks to looked after children are promptly and effectively identified
- ensure that poor practice is improved and that effective challenge to poor practice is provided by managers and by independent reviewing officers
- ensure that practice is compliant with statutory requirements for those looked after children who are placed with their parents or their families.

Within three months:

- ensure that the quality of case planning and recording are improved to a consistently adequate standard, or better
- NHS Cornwall and Isles of Scilly PCT and the council should ensure that the emotional wellbeing and mental health of looked after young people who are accessing mental health services, including access to services in accident and emergency services, are effectively monitored to ensure that the best outcomes for the young person are achieved
- NHS Cornwall and Isles of Scilly PCT and the council should ensure that health care partners are fully involved in pathway planning for provide care leavers and provide appropriate health information when they leave care
- NHS Cornwall and Isles of Scilly PCT and the council should ensure that children and young people who are looked after receive timely annual health reviews. In addition ensure that there is good identification and planning of health needs as part of the pathway planning process.

Within six months:

- improve placement stability for looked after children
- ensure that all care leavers are placed in suitable accommodation
- reduce the use of bed and breakfast accommodation and ensure that where such use is unavoidable, the length of stay is kept to a minimum
- enable a wider representation of looked after children and care leavers to have a voice and to be involved in shaping the development of services
- ensure that staff are able to identify the needs of looked after children and young people with diverse needs and that this is reflected in the planning and provision of services for looked after children
- ensure that performance management information about diversity is routinely collected and is used to inform the development of services
- ensure that the commissioning and delivery of services across partner agencies are clear, including joint commissioning arrangements at the strategic level.

How good are outcomes for looked after children and care leavers?

Being healthy **Grade 3 (adequate)**

85. Health outcomes for looked after children and care leavers are adequate. All initial health assessments for children and young people are carried out by the designated doctor for looked after children. Health reviews for looked after children and young people are not always completed within timescales, although performance is improving overall.

86. A dedicated children in care mental health and emotional wellbeing service commissioned by the local authority is provided by the Cornwall Partnerships NHS Foundation Trust. The service provides a highly valued step down service from CAMHS Tier 3. Staff in the children in care psychology service are co-located with social care staff. This results in positive and effective relations between the services which help to minimise delay in referral, consultation and advice.

87. Services in Cornwall are using the strength and difficulties questionnaires (SDQ) to inform care planning for children and young people who are looked after. Return rates of SDQs are improving and a clear referral pathway is in place where the need for therapeutic intervention is highlighted. Social workers and staff from the looked after children health team and adoption service are able to directly refer to the dedicated children in care psychology service and to CAMHS.

88. Arrangements are now in place to notify the local authority children in care social care teams when a looked after child or young person attends accident and emergency departments for urgent care, although there has not yet been any monitoring or auditing of the process to ensure compliance.

89. The identification of health needs for those young people leaving care is not sufficiently effective. Specialist nurses do not routinely contribute to pathway plans and young people are only provided with a letter that brings together basic information about their health history and immunisation status.

90. Looked after children and young people are readily able to access advice and support about sexual health and relationships through universal provision. The reducing pregnancy teenage support worker works well with the designated nurse for looked after children to refine and produce information specifically targeted towards young people who are looked after. This supports discussion at annual health reviews or in other contacts through foster carers or residential children's homes.

91. Specialist nurses in the looked after children team, alongside the local authority, have contributed well to partnership training for foster carers. However, these sessions lapsed during 2010 and are now scheduled for 2011.

Staying safe — Grade 3 (adequate)

92. Staying safe outcomes for looked after children and care leavers are adequate. Children and young people on the edge of care are adequately safeguarded and admissions to care are appropriately overseen by senior managers. Continuing development of locality working now results in a more holistic range of support for families before they reach crisis point. A wide range of agencies are involved in the recently reconfigured 'at risk of care' panel, where individual cases are discussed and alternative community options are explored. This has improved the planning and support provided to children and young people and enabled resources to be more effectively targeted to assessed need. Resource teams within each area effectively support children coming into care and provide intensive support for those whose placement is at risk of breakdown.

93. Since the last inspection, the council has tackled concerns about the matching arrangements for the placing of children, which now provide improved quality care and support to children. The local authority's performance about both long and short-term stability shows improvement, although is still below the national average and in the bottom quartile nationally. However, the local authority's performance for the proportion of children in care for two and half years and in placement for more than two years is above the national average.

94. In most cases seen by inspectors, looked after children are adequately safeguarded. However, in some cases, concerns for the welfare of looked after children are not effectively identified or managed. Some cases show an overly positive approach to safeguarding issues, which results in the inappropriate minimising of risks to children.

95. All looked after children are allocated to suitably qualified social workers. Inspectors found regular compliance with statutory visits and looked after children reviews, which are taking place within appropriate timescales. Children and young people are being seen and seen alone, where appropriate.

96. Parents of looked after children speak positively about the service they receive from social workers, support workers and foster carers. However, while parents are aware of their right to complain, they are unaware of the procedures and the support available to them.

Enjoying and achieving Grade 2 (good)

97. The impact of services to enable looked after children to enjoy and achieve is good. The CICESS in the school improvement team continues to develop in accordance with the priority set out in the Children and Young People's Plan 2008-2011. The virtual school champions effectively the achievement of looked after children and young people and is highly valued by partner agencies. Ambitious and realistic targets are set for the educational attainment of looked after children and schools are challenged on the performance of looked after children through the school improvement partners.

98. Improvements in attainment have been made in Key Stage 1 mathematics, Key Stage 2 English, mathematics and science, and Key Stage 3 English. For all subjects at each of these key stages, performance remains at least in line with the national average for looked after children and in most cases is above the national average. The large majority of looked after children, for whom data are available, are making the expected level of progress at primary school. GCSE results for looked after young people in 2010 show an overall improvement on performance in 2009, and the proportion of young people attaining five good GCSEs including English and mathematics improved and is now above the average in similar areas and nationally. However, the local authority acknowledges that overall too many 16-year-olds underachieved relative to their starting points in 2010. Work has already been identified with secondary schools to drive improvement. Overall, the gap between Cornwall's looked after children and the national average for all children and young people shows an improving trend in their attainment, although the gap at Key Stage 4 between the numbers attaining five good GCSEs and the national average for all young people widened in 2010.

99. Ensuring that looked after children and young people stay in school is a high priority for the local authority and there have been no permanent exclusions of looked after children and young people since 2008. The number of fixed term exclusions has reduced and shows an improving trend. Attendance rates for looked after children are good and above average when compared to national data for looked after children. Monitoring of exclusions remains robust.

100. All looked after children and young people have personal education plans (PEPs). However, these are of variable quality and not always up to date. Plans are quality assured annually in the autumn term and random sampling is carried out at other times. A new format for PEPs is currently being implemented, including one for use post-16. This will ensure that PEPs are more detailed and that enough significance is given to educational attainment and achievement. Good systems are in place to support looked after children at transition points, from early years provision into school and then between schools. Children placed in schools

outside of the county are visited by either the special educational needs team or the children in care educational support service team to ensure that the provision is meeting needs effectively.

101. Personal education allowances are used effectively to ensure that looked after children and young people are able to engage in a wide range of educational opportunities and benefit from one-to-one tuition. This makes a positive difference to their attainment. The achievements of looked after children and young people are celebrated at an annual awards ceremony.

Making a positive contribution, including user engagement
Grade 3 (adequate)

102. Opportunities for children and young people to make a positive contribution are adequate. Young people are effectively enabled to contribute to the annual foster care review process, participate in the training of foster carers and contribute to their PEPs. The new independent care leavers' forum, 'for care leavers run by care leavers', is still at an early stage of development and not all care leavers are yet aware of it. Young people involved in the forum have already contributed their views about the redesign of pathway plans and these views are taken into account by the local authority.

103. Less than half of the looked after children and young people who responded to a recent survey conducted by the council had heard of opportunities for groups to meet together. About one third did feel that they could express their views to the council. 'Voice 4 Us', Cornwall's looked after children council, is still in the early stages of development. The small number of children and young people involved in this are committed to widening representation within the children in care council and contributing to the improvement and design of services. They are involved in the recruitment of social workers and residential care staff and have presented to elected members as part of their training on corporate parenting. 'Voice 4 Us' members have been involved in rewriting the current six promises within the council's pledge to looked after children. However, in the recent survey of looked after children's views, the majority of those responding reported that they had not heard of the children in care pledge. While these opportunities ensure that some looked after children and care leavers do make a positive contribution they are not yet fully established, nor do they enable the wider representation of looked after children to make a positive contribution.

104. Children and young people have adequate and increased opportunity to have their views heard and engage with elected members and officers. These include a range of corporate parenting initiatives such as regular visits to children's homes by elected members, the opportunity for some looked after children to engage with the Corporate Parenting Board, and

through award ceremonies which recognise the achievement of young people.

105. The majority of care leavers spoken to during the inspection, report being involved in the completion of their pathway plans. They feel that their views are listened to by social workers. However, they would like the 'preparation for life information pack' to be available in a format easily understood by those with 'different levels of communication skills'.

106. Appropriate arrangements for looked after children and young people to make a complaint are in place. The majority of care leavers know how to make a complaint and their right to an advocacy service. At the time of admission to care, all looked after children and young people are provided with the 'listening and learning' complaints procedures. The majority of complaints are resolved in a timely manner, are overseen by a senior manager and signed off by the head of service. Lessons learned from user feedback are shared with all managers and used to inform future training for social workers, and, to revise practice, such as in issuing leaflets to young people explaining the social work assessment process. The complaints service is supported by the independent advocacy service provided by Barnados, who also provides the council's independent visiting service. Access to these services is generally good, although one of the challenges for the independent visiting service lies in matching some young people with complex needs with an independent visitor.

107. The youth offending team is currently working with five looked after children who are subject to orders. Effective partnership working with the police and social care continues to develop and locality working, including the use of CAF and TAC is assisting progress. Joint work using restorative justice models continues to be developed.

Economic well-being **Grade 3 (adequate)**

108. The impact of agencies in enabling looked after children and young people to achieve economic well-being is adequate. A focused multi-agency approach to raising aspirations and improving outcomes ensures that the proportion of young people in education, employment and training remains high at 80%, which is above the national average. An adequate range of educational options is available for young people post-16, including for those with special educational needs and disabilities. However the geography of the county means that not all can access their preferred choice of course. These barriers are overcome, where possible, through providing transport or securing a move to supported lodgings near to the chosen provision. The local authority has implemented a policy for young people to remain in foster care until they have completed their year 13 courses, and this ensures consistent support for those who wish to continue in education.

109. A countywide leaving care service works well in partnership with Action for Children to support care leavers and prepare them for transition. Some innovative work in the preparation of young people in independence and adulthood has recently begun. All looked after young people have a pathway plan in place, which is an improvement since the last inspection. Plans are of variable quality, but adequate overall. Pathway plans routinely cover health, education and accommodation needs. Young people report that they would like more coverage of their financial entitlements in pathway planning. Personal advisors and leaving care workers are beginning to bring together action plans and pathway plans to ensure information is centralised. Resources and services for young people aged 16 and over, either in care or leaving care, can be accessed through the 16+ team, which has supported over 90 young people to remain in education, employment and training.

110. Two recent projects for looked after young people post-16 are being extended. A multi-agency approach to young people in care attending St Austell College has led to better information sharing between agencies such as the college, personal advisors and the leaving care team, and improved support for these young people. Outcomes for 10 disaffected young people in supported lodgings are improved as they are now in education or training following intensive work around developing self-esteem led by Barnados.

111. The proportion of care leavers living in suitable accommodation is in line with the national average and use of bed and breakfast accommodation is always seen as a short term last resort. At the time of this inspection a total of six young people are in bed and breakfast accommodation, two of whom are less than 18 years old. The council recognises that this is not suitable accommodation and in each case a risk management assessment is conducted and the young person is encouraged to move into 'open door' supported lodgings. Care leavers continue to report that they have little choice over accommodation or where they live. Some report feeling lonely.

Quality of provision — Grade 3 (adequate)

112. The quality of provision for looked after children is adequate. Service responsiveness is adequate and the threshold for entry into care is set appropriately. However, planning for children in care is variable and not always effective or underpinned by an holistic assessment of children and young people's needs. Assessments are not always timely at the point where children are received into care or while they are looked after. This results in some decisions and plans being put in place without full knowledge of needs and risks being identified. The quality of assessments is too variable, ranging from good to inadequate.

113. In some high risk cases, practice does not always ensure full compliance with placement regulations relating to children placed with parents or families. Recording in some cases is inaccurate, making it difficult to track the progress of the case or decisions made. In some instances management oversight is not evident.

114. Electronic records of looked after children's statutory reviews are not always sufficiently completed by independent reviewing officers and the quality of records is too variable. In some cases there is an absence of challenge in the review process, particularly in relation to changes in the care plan and risk assessment.

115. In some aspects, services for looked after children and care leavers are improved. Since the last inspection significant steps have been taken to promote multi-agency working and this now ensures clearer pathways in the commissioning and delivery of services. This is leading to a shift from single agency practice towards a strengthening of joint working and a more joined up approach to meeting the diverse needs of looked after children and young people and care leavers.

116. The number of looked after children and young people in Cornwall continues to fluctuate and at December 2010 was 460. Ofsted inspections of the local authority's regulated services assessed the fostering and adoption services to be good. The quality of children's homes has improved since the last safeguarding and looked after children inspection in 2009. Of the 13 local authority children's homes, 11 are now good or better, which is a higher proportion than in similar areas and the national average. None are inadequate. Private fostering arrangements are good.

117. Permanence planning is well established across the county and has resulted in a significant number of children being able to live with their extended family members. Use of special guardianship is appropriately encouraged. A number of looked after children are placed at home under the placement with parent regulations. However in some cases seen by inspectors, practice was not always fully compliant with the regulations, which were applied retrospectively.

118. The post-adoption service provides a robust service for adopters, adoptees and birth families. The adoption team ensures appropriate matching of children and young people to prospective adoptive families. An effective duty provision is in place to assist anyone affected by adoption. This ensures families can access and receive support in their roles as adoptive parents. Feedback from users informs the development of the service. The range of prospective adopters has widened and is now more diverse, with support provided to meet the specific needs of each adoptive family. Indirect contact is provided through the council's letterbox service and adopters are assisted in managing contact between adoptees and birth parents.

Ambition and prioritisation Grade 3 (adequate)

119. Ambition and prioritisation are adequate. An explicit commitment is evident across the partnership from key agencies to deliver improved outcomes for looked after children which has begun to translate into practice. The corporate parenting and looked after children strategy is however, still in the draft stage. Some improvements in services for looked after children have taken place, such as the development of the children in care council and pledge for children in care and outcomes are gradually improving overall.

120. Recommendations from the last inspection have been implemented in part. For example, matching has improved and children and young people now receive a profile of their future foster carers and placements. However, a number of weaknesses identified at the previous inspection remain, such as case planning, recording and the identification and recording of risk. Many initiatives to support children both on the edge of care and in care are recent and it remains too early for their impact to be demonstrated fully.

121. The role of elected members in undertaking their responsibilities as corporate parents is improved. Many members have received training to improve their awareness of corporate parenting and significant numbers undertake active roles to promote the welfare of looked after children. This includes participation on key strategic groups that oversee looked after children services, such as the fostering panel. Members actively engage in a more robust Corporate Parenting Board and regularly analyse performance of looked after children services through an effective council scrutiny committee.

Leadership and management Grade 3 (adequate)

122. Leadership and management are adequate. The council is a member of the South West Peninsular Procurement Partnership. New commissioning arrangements for looked after children and care leavers are central to the local authority's approach to providing better quality services. The council's strategy to place all but the most complex cases within the county has resulted in more effective use of resources. The involvement of education and health services in the process results in a greater focus on commissioning services that provide individual care packages based on the full range of children's needs in individual cases. However, joint commissioning arrangements are not currently formalised at a strategic level.

123. Sufficient numbers of qualified and experienced social workers are now in place in the children in care teams and the leaving care team to deliver services. The vacancy rate is now low. Team managers are readily accessible to staff and monthly formal supervision is taking place, which is

routinely recorded on case files. Compliance with the supervision arrangements is monitored by senior management. Workloads are generally manageable and are being monitored by team managers. Social workers know the number of cases they are expected to hold. Morale among social workers and managers has improved since the last inspection.

124. Looked after children and care leavers continue to express concerns about changes in social worker and some have difficulties in contacting them. The allocation of a social worker is linked to the geographical area in which a child is placed. Therefore a change in placement frequently results in a change of social worker.

125. Partnership working is progressing well at both strategic and operational levels. Voluntary organisations are integral to delivering services for looked after children and young people, such as in participation work and as personal advisors in the leaving care team. There are many examples of close joint working between agencies, both in the preventative and looked after children services, which result in a shared understanding of the range of services available to meet the needs of children and young people.

126. Promotion of equality and diversity for looked after children and care leavers is adequate overall. As in the previous inspection, inspectors found some good examples of meeting individual children's needs. The number of looked after children and young people from ethnic minorities is low. Not all workers are confident in identifying and meeting the needs of those from different cultures, and the recording of how these needs are going to be met is limited. The data collected on equality and diversity are beginning to be used to inform service planning, but this is at an early stage of development.

Performance management and quality assurance

Grade 3 (adequate)

127. Performance management is adequate. Since the last inspection, the council and its partners have implemented an increasingly effective range of performance management systems. Performance information is now routinely collated and analysed at all levels in looked after children's services, to identify issues or trends and to inform service development.

128. The At Risk of Care Panel provides effective oversight of children who are most at risk of being looked after or have recently entered the care system. Audits of cases by managers in looked after children's services are increasingly being used to improve practice in individual cases and to identify wider issues. Performance management arrangements are strengthened through the monitoring of the quality and performance board.

Record of main findings: Cornwall

Safeguarding services	
Overall effectiveness	Inadequate
Capacity for improvement	Adequate
Safeguarding outcomes for children and young people	
Children and young people are safe and feel safe	Inadequate
Quality of provision	Inadequate
The contribution of health agencies to keeping children and young people safe	Adequate
Ambition and prioritisation	Adequate
Leadership and management	Inadequate
Performance management and quality assurance	Inadequate
Partnership working	Inadequate
Equality and diversity	Adequate
Services for looked after children	
Overall effectiveness	Adequate
Capacity for improvement	Adequate
How good are outcomes for looked after children and care leavers?	
Being healthy	Adequate
Staying safe	Adequate
Enjoying and achieving	Good
Making a positive contribution, including user engagement	Adequate
Economic well-being	Adequate
Quality of provision	Adequate
Ambition and prioritisation	Adequate
Leadership and management	Adequate
Performance management and quality assurance	Adequate
Equality and diversity	Adequate