Cumbria County Council

Inspection of services for children in need of help and protection, children looked after and care leavers

and

Review of the effectiveness of the Local Safeguarding Children Board[1]

Inspection date: 3 March – 25 March 2015

Report published: 13 May 2015

The overall judgement is that children's services are inadequate
There are widespread or serious failures in the delivery of services for looked after children which result in their welfare not being safeguarded and promoted. Leaders and managers have not been able to demonstrate sufficient understanding of failures in services for looked after children, and have been ineffective in prioritising, challenging and making improvements in relation to looked after children services. It is Ofsted's expectation that, as a minimum, all children and young people receive good help, care and protection.[2]

The judgements on areas of the service that contribute to overall effectiveness are:		
1. Children who need help and protection		Requires improvement
2. Children looked after and achieving permanence		Inadequate
	2.1 Adoption performance	Requires improvement
	2.2 Experiences and progress of care leavers	Requires improvement
3. Leadership, management and governance		Inadequate

[1] Ofsted produces this report under its power to combine reports in accordance with section 152 of the Education and Inspections Act 2006. This report includes the report of the inspection of local authority functions carried out under section 136 of the Education and Inspections Act 2006 and the report of the review of the Local Safeguarding Children Board carried out under the Local Safeguarding Children Boards (Review) Regulations 2013.

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

Contents

The local authority

Summary of findings

Children's services in Cumbria are inadequate because:

Leadership and management

- From a low base, leaders and managers have made progress in improving safeguarding services. They have not yet been as effective in tackling the serious failures in relation to the experiences of looked after children, although there are examples of positive achievements. Too many looked after children have experienced unacceptable drift in decision-making and delay in the progress of their plans.
- Management oversight across all areas of work is weak. This leaves poor practice unchallenged, and too many children's needs are unmet and plans not progressed within the child's timescale.
- The Independent Reviewing Officer (IRO) service is not effectively championing the needs of looked after children; nor is their practice consistently robust when considering the risks to children subject to child protection plans.
- There are insufficient resources to meet the emotional well-being needs of looked after children.
- Strategic planning to respond to both child sexual exploitation and domestic abuse is underdeveloped.

Quality of practice

- Social work practice is too variable, and too often children's plans, including those for looked after children, are not reviewed and progressed in a timely manner.
- Assessments to inform decision-making and plans for looked after children are not always completed in a timescale that meets the child's needs.
- Some child protection assessments are too long, and do not focus sufficiently on risk in a way that enables families and professionals to understand exactly what the concern is.
- When safeguarding concerns have reduced, in some cases step-down arrangements are not robust and are closed prematurely by children's social care.
- Not all homeless 16 and 17 year olds in Cumbria are provided with a service that effectively meets their needs.
- Care leavers do not receive the minimum £2,000 setting up home grant as recommended in statutory guidance.

What does the local authority need to improve?

Priority and immediate action

Leadership and management

1. Develop a coherent, overarching strategy and action plan to drive the improvement of the looked after children's service. Ensure that robust arrangements are in place to monitor the progress of the action plan.

2. Complete the review of the care planning arrangements for all looked after children and care leavers to ensure that plans are progressing promptly and improving outcomes for children and young people.

3. Strengthen the management oversight of all cases to ensure that children's plans prioritise risk and that their welfare is promoted. Frontline managers should systematically check and record that all agreed actions in respect of individual children and young people are followed up within agreed timescales.

4. Ensure that performance information and strategic assessments appropriately consider the actual experience of children and young people in Cumbria.

5. With partners, review current strategies and action plans for child sexual exploitation to ensure that plans are progressing with the required urgency.

Looked after children

6. Ensure that IROs fulfil all aspects of the IRO Handbook. In particular they should track the progress of care plans between statutory reviews and take prompt action when concerns arise.

Areas for improvement

Leadership and management

7. With partners, ensure that professionals are fully aware of their responsibilities to identify and respond to the early help needs of families.

8. Review outcomes for children who receive early help to ensure that the help provided is effective in the short and long term.

9. Ensure that the emotional and mental health needs of looked after children can be met and that there is prompt access to specialist services.

10. Strengthen the challenge role of the Corporate Parenting Panel for looked after children.

11. Improve the timeliness in conducting return interviews when children and young people return from a missing episode.

Looked after children and care leavers

12. Ensure that reviews for looked after children and young people are timely and informed by up-to-date social work reports detailing the progress made by the young person. Minutes and plans should be distributed quickly to relevant parties so that everyone is clear about their part in supporting the child or young person.

13. Ensure that when permanency is an option for children, effective systems are in place to track and monitor the progress of those plans. Where there is a range of different permanency options for children, these must be considered at the earliest opportunity and plans expedited to ensure permanency is secured.

14. Ensure that the Legal and Gateway panel monitors all decisions to their completion to improve robustness of planning and avoid drift and delay.

15. Ensure that all looked after children's records are up to date and include clear chronologies, up-to-date plans, risk assessments and other key documents pertaining to children's individual circumstances.

Help and protection

16. Ensure 'step down' arrangements are applied consistently to meet the needs of children when child protection planning ceases. This should include consideration of thresholds and ensuring that the right level of help is provided by the right professionals.

17. Ensure that decisions to return children to their family home from care are informed by robust risk assessments.

18. Fully explore with homeless 16 and 17 year olds the benefits of becoming looked after. Where they refuse this they should be supported by a multi-agency child in need plan to ensure that their needs are met.

Care leavers

19. Improve the quality of pathway plans to ensure that actions are meaningful to young people and the progress they are making towards independence is clearly charted and regularly reviewed.

20. Ensure that all young people who would benefit from remaining with their foster carers after the age of 18 are able to do so. This includes young people placed in foster homes which are managed by independent fostering agencies.

21. Improve the availability of suitable accommodation for care leavers and reduce the length of time they have to wait to secure it. Provide better support to care leavers to prevent tenancy breakdowns.

Participation of looked after children and care leavers

22. Support all looked after children and young people and care leavers to understand their rights and entitlements and know about the 'Pledge'. Actively encourage them to participate in the children in care and care leaver forums, and to be informed of their work.

Adoption

23. Ensure that the time taken to approve adopters improves to at least meet the current requirements at stage one and stage two.

The local authority's strengths

24. The Chief Executive and the Corporate Director for Children's Services, in a relatively short period of time, and from a low base, have improved safeguarding arrangements for the most vulnerable children in Cumbria. The local authority is in a stronger place now to take forward improvements and build on the progress that has been made in the recent months to tackle the shortfalls identified in this inspection.

25. Leaders have welcomed external scrutiny and promoted a positive learning culture within the local authority and across the partnership.

26. Significant progress has been made to engage partners in a collaborative response to meeting the needs of children locally, and this is making a difference across the county.

27. The local authority's political leadership has prioritised and invested in children's services at a time of financial austerity. This has resulted in the creation of additional social worker posts, expansion of the Edge of Care service model, creation of the early help team, and development of the social work academy.

28. Direct work with children is of good quality. This is helping children to understand their life experiences and share their wishes and feelings. The child's voice is consistently heard and is increasingly having a positive impact on the work undertaken with all family members.

29. Good attention is given by staff to exploring the impact of children's identity within assessments and this results in plans that are influenced by the child's unique identity and culture.

30. The quality of personal education plans is a strength, particularly those for young children.

31. Adoption is actively considered for a wide range of children, with particularly successful outcomes for older children, those with complex needs and larger sibling groups.

Progress since the last inspection

32. The last Ofsted inspection of Cumbria's arrangements for the protection of children was undertaken in May 2013. The local authority was judged to be inadequate. The help and protection of children is now judged to require improvement.

33. The current Corporate Director of Children's Services was permanently appointed in September 2014 following an interim period in the role from the end of February 2014. Since his interim appointment, Children's Services has made significant progress, from a low base, in tackling critical issues around the help and protection of children, culture change, social work capacity and working to effectively engage the wider partnership that helps and protects children. However, services for looked after children have not had the same level of prioritisation and focus.

34. Many of the areas for improvement identified in the inspection in May 2013 have been tackled and improvement is evident. Most significantly, the introduction of a multi-agency safeguarding hub in November 2014 and the engagement of partners in early help assessments have improved the range of responses to children when concerns are first identified. When there are child protection concerns, effective multi-agency strategy meetings and where necessary, child protection investigations are now initiated promptly. The wishes and feelings of children are routinely obtained, with much evidence of effective direct work undertaken with children and young people. Core group meetings are now held regularly. Advocacy support is available to all children and young people known to children's social care.

35. Some areas for improvement identified in the previous child protection inspection still require improvement. The rationale for managers' decisions is not always clearly recorded in files. Managers' supervision of social workers does not always allow opportunities for critical reflection. Parents are not always provided with reports in sufficient time before child protection conferences. The quality and use of chronologies remain inconsistent.

36. The last Ofsted inspection of Cumbria's services for looked after children was in April 2012. The local authority was judged to be adequate.

37. Some areas for improvement identified in that inspection have not been effectively tackled; some have deteriorated and some still require improvement. Most significantly, a coherent overarching strategy for looked after children's services is still not in place to effectively drive improvement of the looked after children's service. Health assessments for many children when they first become looked after are not timely. Services to meet the emotional, mental health and behavioural needs of looked after children are not available quickly enough.

38. Although the local authority has prioritised action to improve previously inadequate safeguarding arrangements, services for looked after children have not been afforded the same priority by senior leaders to drive forward required improvements. Management oversight is not identifying and tackling practice deficits promptly. As a result, too many looked after children experience delay in having their long-term needs assessed and met.

39. Line management arrangements for independent reviewing officers are now in line with statutory guidance. Despite this, the IRO service is not fulfilling the full range of responsibilities set out in the IRO handbook. As a result, plans for too many looked after children are drifting.

Summary for children and young people

- Senior managers have not always identified quickly enough when children are not getting a good enough service. This means that too many looked after children do not receive the service they need.
- Independent reviewing officers that chair looked after children's reviews do not always make sure that children get all the help they need quickly enough.
- When children are not safe, professionals such as social workers, teachers and the police act quickly to protect them.
- Too many managers do not always make sure that staff are doing what they should be doing. This means that too many children do not receive the help and support they need, when they need it.
- Some children have had too many social workers. This means that it is hard for them to build trusting relationships when the social worker keeps changing.
- When children have a social worker they see them regularly. Social workers are now better at listening to the children they work with than they used to be.
- Some good arrangements have been put in place to try and help children when they first have problems at home or at school. However, children and families have not been asked if this help is working and making things better for them.
- Sometimes professionals could help children and young people who may be at risk of child sexual exploitation earlier. When children, young people and their families do get a service, it helps keep them safe from child sexual exploitation.
- When children go missing, new arrangements mean that an independent professional will offer to visit them when they come home so that they can support them and help keep them safe.
- Children who need help with their emotional health do not always get it, and this can cause more problems for them and their family.
- Personal advisers keep in touch with almost all young people when they leave care. However, in the last year, young people have not been given enough money to help them set up their own home when they left care.
- When some r young people leaving care drop out of college or their first job, they do not get the help they need quickly enough to make other arrangements.
- The adoption team works hard to find new families for children who cannot stay at home. However, the adoption team are not told early enough by social workers that this is what some children need.

Information about this local authority area[3]

Children living in this area

- Approximately 94,000 children and young people under the age of 18 years live in Cumbria. This is 19% of the total population in the area.
- Approximately 15% of the local authority's children are living in poverty.
- The proportion of children entitled to free school meals:
  - in primary schools is 12% (the national average is 17%)
  - in secondary schools is 9% (the national average is 15%).
- Children and young people from minority ethnic groups account for 2% of all children living in the area, compared with 22% in the country as a whole.
- The proportion of children and young people with English as an additional language:
  - in primary schools is 2% (the national average is 19%)
  - in secondary schools is 2% (the national average is 14%).
- Cumbria is the second largest geographic county in England. Children live in communities which range from isolated rural settlements and farms to market towns and larger urban conurbations. Of the county's population, 51% live in rural areas, compared with 19% of the population in England and Wales.

Child protection in this area

- At 31 January 2015, 3,374 children had been identified through assessment as being formally in need of a specialist children's service. This is a reduction from 3,888 at 31 March 2014.
- At 31 January 2015, 348 children and young people were the subject of a child protection plan. This is a reduction from 595 at 31 March 2014.
- At 31 January 2015, eight children lived in a privately arranged fostering placement. This is the same as at 31 March 2014.

Children looked after in this area

- At 31 January 2015, 664 children are being looked after by the local authority (a rate of 70.6 per 10,000 children). This is a marginal increase from 663 (70.5 per 10,000 children) at 31 March 2014. Of this number:
  - 160 (or 24.1%) live outside the local authority area

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

- 52 live in residential children's homes, of whom 51.9% live out of the authority area
- five live in residential special schools[4], of whom 100% live out of the authority area
- 513 live with foster families, of whom 22.8% live out of the authority area
- 32 live with parents, of whom 9.4% live out of the authority area
- there are no unaccompanied asylum-seeking children.

- In the 12 months to 31 January 2015:
  - there have been 41 adoptions
  - 37 children became subjects of special guardianship orders
  - 214 children ceased to be looked after, of whom 7.5% subsequently returned to be looked after
  - 15 children and young people ceased to be looked after and moved on to independent living
  - 25 young people have ceased to be looked after and are now living in houses of multiple occupation.

Other Ofsted inspections

- The local authority operates five children's homes. Three were judged to be good or outstanding, two were judged to be adequate and none rated as inadequate in their most recent Ofsted inspection.

Other information about this area

- The Director of Children's Services has been in post permanently since September 2014 following his interim appointment in February 2014.
- The chair of the LSCB has been in post since April 2014.

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

Inspection judgements about the local authority

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

Summary

Progress has been made to tackle identified deficits in services for children who need help and protection, but services are not yet good.

An extensive range of early help services supports children and families. An increase in the number of early help assessments means that more children have their needs identified earlier. However, the impact of early help assessments and intervention has not been systematically measured and not all children who need an assessment receive one. This means that the local authority and partners do not know whether all children who need early help receive it, or how much difference it makes.

Partner agencies' understanding of thresholds for children's social care are inconsistent, and there are too many inappropriate contacts to the safeguarding hub.

Information sharing in the safeguarding hub is timely. Children and young people at risk of immediate harm are swiftly identified. Strategy meetings take place promptly to make decisions about investigations and agree actions required to protect children.

The re-referral rate remains high. Practice in judging which cases can be 'stepped down' to early help is inconsistent. For some children this results in their needs not being met at the right time or level and result in re-referral to the local authority.

Most child protection and child in need plans are reviewed regularly. Most child protection conferences and core groups are well attended by a range of agencies. Children on child protection plans are mostly well supported. Plans are not always robustly reviewed to ensure that progress is made in the child's timescale. In a small number of cases this has resulted in drift. Recent action by managers has ensured that children in these cases are safe and their needs met.

Investment in additional social work capacity has reduced social work caseloads, affording some social workers more time to engage in direct work. This helps them understand the needs of children and is leading to positive outcomes.

Where child sexual exploitation is identified, the response from agencies is appropriate. However, social workers and managers have not had formal training in recognising child sexual exploitation. This means that the local authority cannot be assured there is a consistent response to it or that risks are always recognised early enough.

Not all children who go missing receive a return interview. The local authority has only recently introduced a system to track that return interviews are completed.

40. The multi-agency safeguarding hub (MASH) established in November 2014, has representatives from the police, children's social care, health and early help advisers. This new arrangement is leading to improved signposting of families to early help and reducing the number of referrals to children's social care. There were 443 early help assessments (EHAs) in 2013–14 and 706 in the last six months following investment by the local authority, which is a significant improvement and demonstrates that many more children are receiving an early help assessment when needs are first identified.

41. The Early Help Strategic Team has raised awareness of the range of services available to support children and young people, including the introduction of the early help directory to promote them. Services commissioned by the local authority, that are offered to families through children's centres and the voluntary sector were noted by inspectors to be making a positive difference to families.

42. Early help advisers provide advice and guidance to practitioners undertaking early help assessments and useful training for staff. Many partners involved in Team Around the Family (TAF) meetings also provide effective oversight and monitoring of children and young people's progress. However, a small number of schools report that they do not undertake early help assessments because they do not have the capacity to manage the lead role. Children do not always have the continuing help they need when their case is closed to children's social care.

43. The impact and outcome of early help intervention is not systematically measured. This, together with the inconsistent approach to early help, means the local authority cannot be confident that all children who need early help are receiving it, nor know how much difference early help is making to children. The local authority acknowledges that there is more work to do to improve the early help offer to children and families in Cumbria.

44. Information sharing is timely when contacts and referrals are made to the safeguarding hub; this helps to ensure that decisions about next steps are appropriate. Referrals progress to the district social work teams within 24 hours or less, and are promptly allocated. For cases referred to child protection social work teams, information gathered by the MASH is detailed and well recorded. This includes a range of background information from agency checks and good consideration of historical information, to inform decisions about actions to keep children safe.

45. Partner agencies' understanding and application of thresholds to children's social care remain inconsistent, so there continue to be a number of inappropriate contacts to the hub. This results in additional work for professionals in this service.

46. Pathways for the management of domestic abuse referrals are newly established, and are resulting in more children receiving early help. Domestic abuse notifications are effectively screened by the police and children's social care in the safeguarding hub and passed to the appropriate team to ensure that the right service is provided.

47. Strategy meetings are timely in the majority of cases and most are well attended by a range of partner agencies. In cases seen, they were well recorded and appropriately detailed. They evidence the sharing and analysis of relevant information, which informs decision-making about actions required to ensure children are safe and their needs met. Outcomes from strategy meetings are recorded and were appropriate in all cases seen by inspectors. However, responsibility for actions, timescales and consideration of whether a joint or single investigation should take place are not always recorded.

48. Child protection enquiries are mostly timely and conducted by experienced social workers. Children are consistently seen and spoken to. A wide range of agency checks are undertaken and these are considered and recorded, so that decisions about the outcome of the enquiry are well informed and appropriate action is taken to safeguard children.

49. The re-referral rate remains high and local authority data indicate that this has further increased since 2013–14 from a rate of 28.6% to an average of 33% for 2014–15 to date. The local authority has analysed the data and concluded that there is a range of causes including some double counting. However, a key finding from this inspection is the inconsistent practice in the arrangements for step-down to early help, which is not yet robust in all cases and which contributes to the high re-referral rate.

50. Recent, more effective screening of referrals and the diversion of work to early help are resulting in a significant reduction in the volume of work coming through from the safeguarding hub to the district social work teams. Referral rates are now in line with statistical neighbours and the national average. This, together with a reduction of the number of children subject to child protection plans, means that caseloads have significantly reduced for social workers in some teams and are now manageable. This enables them to spend more time working with children, getting to know them well, building positive relationships with them and understanding their family relationships.

51. Many good examples were seen of children's voices being heard by social workers and thus informing the work undertaken. For example, in the children with disabilities team there is evidence of very effective direct work with children. Social workers and child and family workers utilise a range of communication techniques to ensure that they understand children's needs, wishes and feelings.

52. Chronologies are variable; too many do not focus on key events in the child's life. Chronologies prepared within court work are mostly of a good standard.

53. Most assessments are very detailed and include consideration of historical concerns, evidence of children being seen and of their views, wishes and feelings being sought in many cases. Most assessments effectively analyse risk and protective factors; some are too lengthy and require a sharper focus on key areas of concern. Not all assessments routinely involve fathers and significant males. The timeliness of assessments seen was appropriate in all cases. All single assessments have a locally agreed timescale; they are reviewed by managers and only extended through line management agreement and with a review of the child's needs. No cases were identified where this resulted in risk to children or delay in their needs being met. Health professionals make timely referrals when pre-birth assessments are required.

54. The quality of plans is variable, ranging from good to requiring improvement. Better plans clearly set out the needs of children and the actions needed to ensure that outcomes improve and are in a format that is accessible to parents, carers and children. However, very few plans have clear timescales and most do not prioritise risks. Some plans are too long, making it difficult for parents and children to understand key areas of risk and how these will be addressed.

55. In 2013–14 the number of children subject to a child protection plan increased by 83%, to 595 by 31 March 2014. A local authority audit in the summer of 2014 found that 30% of these cases did not meet the threshold for child protection. At subsequent reviews during 2014–15 a significant number of child protection plans ceased. An independent audit of the 285 children who had come off plans between May and November 2014 found that risk had been appropriately assessed, with suitable arrangements for ongoing support in place for those children who need it. In cases sampled by inspectors, where child protection plans had ceased in the last three months this was the appropriate decision. A small number met the threshold as children in need. Despite this, these cases had been stepped down prematurely to early help and closed to children's social care.

56. The recording of decision-making was not always clear or up to date on some cases seen. Therefore, when cases close to children's social care the rationale for this is not always recorded. In addition, the continuing arrangements to support the family by other professionals are regularly absent from recording. The local authority put in place a range of measures to address this following the audit findings in November 2014, but the impact of this was not evident on all cases sampled, some of which were very recent.

57. The majority of child protection plans are reviewed regularly at review child protection conferences. Most of these are well attended by a range of agencies so that information is shared. Children on plans have access to a variety of services that support their different needs and those of individual family members. The quality of recording of child protection core groups and conferences is too variable, ranging from good to inadequate, with a small number that do not focus on key risks and concerns. Core groups do not routinely evidence that the plan has been robustly reviewed. Agencies are challenged when actions in plans have not been completed, with more recent evidence seen of effective, authoritative action in many cases when change is not secured and risks to children remain or intensify. In a small minority of cases, plans have drifted and independent reviewing officers have not provided challenge within the conference to address the lack of progress. The quality of social work reports to conference remains variable and parents do not routinely receive them prior to conference. This means that they are not as well prepared for these meetings as they should be.

58. Unacceptable drift and delay have been identified in a small number of cases seen during this inspection, some of which was as a result of changes of social worker. Where this has happened, it has only very recently been adequately identified and challenged by team managers and independent reviewing officers. Children had experienced delay in becoming looked after, with some children having been left in situations of unacceptable risk. However, in all cases, appropriate action has been taken in the last few months, with evidence of tighter management grip and oversight.

59. Good evidence was seen in many cases of social workers working persistently and sensitively with parents who have previously been reluctant to engage. In these cases this has resulted in positive outcomes for the children.

60. In most cases reviewed, the out-of-hours service responded appropriately and communication with the daytime service was effective. The service is not always able to access foster care provision for children out of hours. The local authority has recently undertaken a review of the out-of-hours service and plans are in place to develop an assertive outreach team to support its work with children and families.

61. The local authority is currently working with twenty young people at risk of child sexual exploitation. Cases sampled and tracked during this inspection show that when child sexual exploitation is identified, the response from agencies is appropriate. In most cases the child sexual exploitation risk assessment tool is used well to identify the level of risk and to review and monitor progress. Timely multi-agency meetings are convened, including child protection conferences, when risks meet this threshold. Young people are provided with suitable help from a commissioned service, or are supported by social workers to help them keep themselves safe and understand the risks of being exploited. Actions taken are proportionate to risk and escalated where risks increase. In all cases seen, supervision was effectively used to monitor young people and remain alert to indicators of child sexual exploitation.

62. In a small number of cases, the possible risk of child sexual exploitation had not been identified at an early enough stage. Children's services staff have not had formal training on the recognition of child sexual exploitation, although briefings have been provided. This means that the local authority cannot be assured that there is a consistent response to child sexual exploitation, or that risk of child sexual exploitation is always recognised at an early enough stage.

63. There were 90 children reported as missing in quarter two of 2014–15. Children missing from home and care and known to the local authority are offered return interviews by an independent provider, though this arrangement has only been in place since January 2015. The return interview is not routinely recorded on the child's file and the local authority has only recently introduced a system to track that return interviews are completed. Currently, the local authority reports that 85% of return interviews are completed, but only 25% of these are completed within 72 hours.

64. The strategic analysis of the information gathered from return interviews is now starting to identify hot spots and inform disruption activity in relation to child sexual exploitation. In cases sampled where children have been missing from home and care, risks are identified and in most cases adequately addressed through appropriate multi-agency plans. In a small number, these plans are failing to reduce the number of missing episodes.

65. The local authority maintains an up-to-date list of children missing education (CME), including those whose parents choose to educate them at home. At the time of the inspection there were 126 children missing education and 280 being educated at home. CME officers ensure that there is routine oversight of CME and maintain regular contact with children. Information is exchanged well between the CME officers, general advisers, inclusion officers, social care and other authorities to ascertain the whereabouts of all children. CME officers have good knowledge of the whereabouts of children without a school place and their status.

66. Almost all children in alternative provision receive 25 hours education. CME officers are involved in the small number of cases where this is not the case and the reasons for this are known. Good links between the CME officers and the equality learning officer for Gypsy, Roma and Traveller children ensure that children from these communities are well supported through regular drop-in sessions at their site and their whereabouts are known.

67. There is good awareness of children whose families choose to educate them at home. Where it is judged that children are not receiving a suitable education, they are appropriately returned to school.

68. In the cases sampled by inspectors, the tracking and monitoring of children missing education were mostly good. The intervention of staff successfully improved outcomes for children in all but two cases seen, and children were returned to school in a timely fashion. In two more complex cases, where young people had a long history of non-attendance and non-engagement, interventions were not effective in returning them to school or engaging them in any alternative education.

69. A range of services commissioned by the local authority and delivered by voluntary agencies are available to children and adult victims of domestic abuse. Children's centres deliver 12-week programmes for survivors of domestic abuse. These services are making a difference for children and their parents, with some good examples of direct work available for children provided by local authority child and family workers. There are no perpetrator programmes other than through probation following conviction, with long waiting lists in some parts of the authority. This results in some children and parents waiting too long for help, including those subject to child in need and child protection plans.

70. Domestic abuse has only recently been a strategic priority for the local authority and this is a concern given the high volume of notifications and referrals. The Multi Agency Risk Assessment Conference (MARAC) is established in each of the three districts across the county, is well attended by a range of agencies and results in appropriate sharing of information, assessment of risk and provision of services.

71. Data are collated on the numbers of children on child protection and child in need plans where domestic abuse, drug or alcohol use or mental health is a feature.[5] This information is not routinely used to inform service provision. Evidence of effective work from domestic abuse and substance misuse services, in many cases, shows that it is making a positive difference for children. In contrast, there is very little evidence of multi-agency work between children's and adult services when parents are experiencing mental health difficulties. This means that in these cases a holistic view of risk to children was not always well informed by the concerns about adult mental health.

72. The local authority designated officer (LADO) role is well established and records show appropriate and timely responses to concerns, with appropriate oversight by relevant agencies. In addition to investigative work, the LADOs are also involved in offering advice and training to agencies through the LSCB. Since the appointment of a new manager in September 2014, the role of the LADO has become more high profile, resulting in better and more accurate recording of referrals, information and the management of LADO.

73. The local authority has seen an increase in homeless young people aged 16 and 17 years-old presenting for housing support services, from 174 in 2012–13 to 223 in 2013–14. Cumbria has revised its homelessness protocol to comply with legislation, but this is not yet rolled out across all areas of the county, so not all young people receive a consistent service. In cases seen, assessments result in support being provided, but do not always evidence consideration of the benefits for young people of becoming looked after, nor do they always result in robust children in need plans.

74. Despite work by the LSCB to raise awareness, the number of private fostering notifications remains low. Children are visited and assessments completed within the timescales required under private fostering arrangements. Plans are in place to ensure that children's safety and needs are addressed. The views of parents are not always clearly recorded and queries about financial arrangements for carers have not always been dealt with in a timely manner in all cases.

[5]At 31 January 2015, 146 child protection plans and a further 340 child in need plans identify domestic abuse as a feature; 69 child protection plans and 181 child in need plans identify parental drug misuse; 67 child protection plans and 44 child in need plans identify parental alcohol misuse and 119 child protection plans and 348 child in need plans feature parental mental health issues.

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

Summary

The looked after children service has suffered because of ineffective practice by some staff and managers. Too many looked after children experience drift and delay in their care plans. This is exacerbated by too many changes in social worker and insufficient management oversight and supervision of staff.

Too many looked after children continue to experience a disjointed and ineffective service. Seven out of the 14 cases tracked by inspectors were inadequate.

Decisions for too many children are unclear. For some children, deficits in care planning lead to delays in them being considered for adoption. When there are plans for adoption, they are not progressed swiftly enough.

The IRO service has been insufficiently robust in championing children's plans and tackling poor practice. Reviews are not timely and poor performance has been long-standing.

The lack of up-to-date chronologies, care plans, and other recording on children's case files means that workers who take over responsibility for a looked after child cannot be clear about what actions are required to support the child and drive forward their plans.

Not all decisions are based on up-to-date risk assessments, nor are effective plans always in place to progress permanency swiftly for children.

Currently, only 52% of looked after children have a health assessment within 28 days of becoming looked after. There are insufficient emotional and mental health services for looked after children, with no 'fast track' arrangements for children whose behaviour or emotional well-being indicates that a prompt service would be beneficial.

There are insufficient foster carers to meet demand and this means that too many young people are placed outside the local authority area. Almost all looked after children living outside of Cumbria are placed in good or better placements.

Very few children know about the local authority's 'pledge' for looked after children.

The attainment gap between looked after children and their peers is not consistently reducing. It has widened for those in the Early Years Foundation Stage and at Key Stage 4.

Care leavers wait too long to access suitable housing options and not enough is done to prevent tenancy disruptions. They do not yet receive the recommended £2,000 setting up home grant.

75. Too many looked after children do not receive the support they require. Fourteen looked after children and young people's cases were tracked for this inspection (12 of which were audited by the local authority); of these, seven are judged to be inadequate. This is an unacceptably high proportion of young people who are not receiving a good enough service from their corporate parent.

76. Poor practice is evident in a range of areas, including management oversight; drift and delay in progressing plans for children; outstanding actions identified from previous audits not being completed; poor case recording, with recent significant and past events not being on the child's file; absent or poor chronologies; absent or out-of-date risk assessments that do not consider new information; and children and young people's history not being taken into account sufficiently well in planning for their futures. For some looked after children and young people, a lack of proactive and sensitive planning has led to a continuous cycle of instability which is not being sufficiently well addressed. A lack of emphasis on permanency planning means that some children and young people continue to experience unacceptable drift and delay.

77. The local authority's own audit of looked after children's cases from November 2014 found similar significant concerns to those found on this inspection. This led to the commissioning of a full audit of all looked after children's cases. At the present time, 30% of the 409 cases audited so far are judged to be inadequate. Although this means that 70% are judged to be better, it remains the case that the service received by 124 children has not met their needs or promoted their welfare. Findings also confirm the marked differences between teams across the local authority, ranging from 4% to 54% of cases judged as inadequate. The poorest performing teams have the most looked after children.

78. Audits undertaken by the local authority found that although children are now in adoptive placements, there was drift and delay previously and adoption should have been progressed sooner. The pattern of drift, delay, legal advice and subsequent actions not being followed robustly, and reviews that do not challenge sufficiently is seen in too many cases and has had a lasting negative impact on permanency planning for some children.

79. Overall, too many looked after children and young people do not have up-to-date assessments or care plans on their files. Many looked after children's files lack accurate or up-to-date chronologies. Without a clear record of the child's life, it is difficult for new social workers to understand the child's history and take this into account in meeting their current and future needs. This exacerbates the issues of drift and delay.

80. Despite frequent changes of social worker, 96% of looked after children do see a social worker routinely and within timescales. This enables social workers to help children to understand their circumstances.

81. Even in cases which demonstrate good social work practice and knowledge of the children, shortfalls remain due to a lack of resources such as CAMHS, permanent long-term foster carers and insufficient resources to enable young people to remain with independent foster carers.

82. The local authority's performance indicators suggest that shortfalls were known to exist in the services for looked after children as early as December 2013. In addition, the annual report of the IRO service in May 2014 noted that the number of statutory looked after children reviews held in timescales had reduced from 62% in 2012–13 to 59% in 2013–14. Performance for the timeliness of reviews for looked after children is still only 60% as recently as 19 March 2015 and well below the local authority target of 85%. The management action to respond to these shortfalls was not sufficiently timely or robust and therefore has contributed to drift and delay for some children.

83. Until very recently the IRO service has not had sufficient capacity to provide a good enough service for looked after children. Their caseloads were too high, often double the good practice guidance of 50 to 70 recommended in the IRO handbook. This prevented them from building quality relationships with too many looked after children. The local authority has recently responded by increasing the number of IROs, which has reduced caseloads. At the time of the inspection, the Principal Social Worker was managing the service in the absence of a team manager, however a team manager appointment was made during the inspection period.

84. Reports from social workers are not routinely available prior to looked after children's reviews. Delay between the review being held and the minutes being uploaded to the child's record and distributed to all parties negatively impacts on the quality of planning and review. IROs make some use of the 'dispute resolution process' (DRP), but they agree that there is too much variability in its use by them and more consistency is needed if children are to benefit from this process.

85. The January 2015 performance report shows a declining participation rate by children and young people at their looked after reviews. At the end of quarter three, this was 80% against a target of 85%.The figures for 2013–2014 show reduced attendance by children and young people from 58% to 46% and participation declining from 90% to 79% from 2012-2013.

86. Young people spoken to during the inspection expressed mixed opinions about their reviews, though inspectors did see that children and young people's views are routinely considered and they are supported to attend where appropriate.

87. There is an established Children in Care Council (CICC) structure which engages well with looked after young people and has good support from participation and engagement staff. The groups have relatively small numbers attending regularly and the reach to all looked after children is under-developed. The CICC has developed some good materials to encourage children to express their views at reviews, but these are yet to be launched. Young people do not know about the local authority's Pledge (The Promise); staff agreed that this was little known and needs to be refreshed and re-launched.

88. Young people spoken to from the CICC voiced mixed opinions about it; for some it provides excellent opportunities for personal and social development, while others felt that it is too focused on a younger age range. The recently developed care leavers' forum has the potential to better meet the needs of older young people, but it is too early to see the impact of this as it has only recently been set up. Young people spoken to were able to articulate well the support they have with their education.

89. The local authority has a strategy in place to reduce the number of looked after children, as there is a higher rate in Cumbria than in comparable authorities. Inspectors did not see any children taken into care who did not meet the threshold for becoming looked after and a number of children should have become looked after earlier. Therefore, it is not clear how the ambitions of this strategy will be realised.

90. A very high proportion of looked after children (45%) live more than 20 miles from their home, with 19% living outside Cumbria which is much higher than comparable authorities (26%). This is, in part, a reflection of the sparsely populated nature of the area. However, almost all of these children are placed in good or better placements. Often communication between these children and their social workers is less frequent and social workers do not attend the range of meetings they attend when children live closer to home. In addition, some young people report they are not engaged with the work of the CICC. Many of these children and young people placed outside Cumbria experience poorer service than those placed in county.

91. There are insufficient local authority foster carers to meet the demand for placements. Within the fostering service, 25 households providing up to 36 placements have been approved in the first nine months of 2014–15. This is an improvement from 12 approvals in the same period in 2013–14 and reflects the recent success of the refreshed recruitment campaign and improved initial screening of enquiries. There has been some improvement in retention of carers, with fewer resignations and no terminations of approval. There has been a positive reduction in the use of exemptions to place too many children with the same foster carer from eight in 2013–14 to one in 2014–15.

92. The placement stability (three or more moves in the last 12 months) for looked after children remains positive at 7% and below comparable authorities (10%) and the national average (11%) during 2013-14. This has continued unchanged in 2014-15. At the time of the inspection, 27 children and young people required a long-term placement and this had not yet been identified. As a result, some children are waiting too long for permanent arrangements to be secured. This causes increased pressure on short-term carers who continue to care for children whose future is uncertain.

93. The fostering service benefits from careful, prompt and child-friendly decision-making by the Agency Decision Maker (ADM), who has a good overview of quality of practice. This is supported by regular meetings with service managers and a suitably skilled and experienced panel chair.

94. The foster carer files reviewed during this inspection were compliant with key aspects of regulations. Regular monthly supervision visits are well recorded overall. Unannounced visits take place and more frequent visits are carried out where there are concerns or additional support is required. All had annual reviews on file which are well recorded and detailed, and provide evidence of training attended.

95. Generally foster carers spoken to were positive about the support they receive from their Fostering Support Workers (FSWs), frequency of visits, access to training, local support groups and annual reviews. Foster carers described high variability in the quality of social workers assigned to the children they look after. The greatest concern expressed was about too many changes of social worker for children, which impacts negatively on the ability of the child to benefit from a trusting relationship and slows down the progress of plans. High numbers of approved foster carers, including family and friends carers, meet the nationally set 'Training, Support and Development Standards'

96. Kinship care arrangements, including placements with friends and family are not sufficiently robust. The local authority acknowledges inconsistent practice in the quality of viability assessments across the county. There have been delays in the completion of Regulation 24 assessments, resulting in too many requests for extensions, which leads to extended court timescales and delayed care planning.

97. While the number of Special Guardianship Orders (SGOs) is increasing, some foster carers say they are reluctant to apply for SGOs for children they are caring for because of the lack of clarity about future support, including financial arrangements. National regulations determine the arrangements for financial support, and the he local authority is currently exploring options to provide clearer arrangements for their future support needs.

98. Only 52% of newly looked after children have a health assessment within 28 days and this is poor. There has been an improvement in the proportion of looked after children with up-to-date review health assessments, which now stands at 87% compared with 78% in March 2014. During 2013–14, 79% of looked after children visited a dentist, which is below the national average of 84%. A very small number of looked after children were not up to date with immunisations, although this was achieved for 86% of those that required it.

99. There is no 'fast track' CAMHS service for looked after children and inspectors have seen cases where children require rapid assessment and support from CAMHS but have not received it. Overall there is a significant shortfall in services at Tiers 2 and 3 that can respond sufficiently quickly to the emotional and mental health needs of looked after children.

100. The local authority has put in place clearer management oversight of the arrangements to support the Public Law Outline (PLO) process once it identified that too much variance was leading to inconsistent decision-making. Legal actions are agreed at the Legal and Gateway panel. However, some decisions made at these meetings are not always followed and, in a small number of cases, decisions were reversed without the panel's knowledge. This contributed to avoidable drift and delay. In addition, some children had been left in neglectful situations too long before decisive action was taken.

101. The designated family judge described some recent improvements in the quality of social worker's reports to the court, although practice is not yet consistent. Cafcass also reported improved relationships with the local authority. However, concerns remain about some children not being brought before the court at an early enough stage, with children who are now in care having been left in neglectful situations for too long, although the picture is slowly improving. Proceedings have taken too long to be finalised and the local authority's legal services acknowledge that they have contributed to this at least in part, with insufficient administrative resources and poor locum solicitors. The local authority has invested in the child care legal team, with the recruitment of additional child care solicitors, legal assistants and bundling clerks, and the creation of in-house advocate posts. An improvement plan has also been implemented. In quarter four of 2012–13 the average length of care proceedings was 46 weeks, with too many adjournments attributable to the local authority. Timeliness is improving, although it remains outside the national standard of 26 weeks. Performance at the end of quarter three 2014–15 is reported as an average length of 30 weeks.

102. Educational achievement of looked after children is variable, despite being well supported during their education by the virtual school team, designated teachers and their schools. Children aged two and three are well supported to take up their entitlement to free nursery provision and a good number do so. Despite an increasing proportion of children under five years old achieving a good level of development, not enough do so. The low starting points of many children when they start school are reflected in the low proportion who achieve well at Key Stage 1.

103. The attainment of looked after children at Key Stage 2 in reading, writing, mathematics and grammar, punctuation and spelling has improved well over the last two years. They achieve particularly well in mathematics where 82% achieved level 4 in 2013/14. They make good progress from their low starting points.

104. At Key Stage 4 attainment varies year on year, and in 2013–14 those achieving 5 GCSEs, at grades A*-C, including English and mathematics declined from the previous year to below the England average for all looked after children. This decline is attributed to just a few young people missing a good grade in their English and mathematics exams. Between the ages of 11 and 16 too few young people make the expected level of progress in English and mathematics. Close tracking and good support by the virtual school, leaving care team and partners in year 11 ensure that nearly all looked after children make a successful transition to year 12.

105. The attainment gap between looked after children and their peers is not consistently reducing. At Key Stage 2, from 2012-2013 to 2013-14 the gap narrowed to 9%. However, in the same period, the gap widened for those in the Early Years Foundation Stage from 38% to 42.6%. Similarly at Key stage 4, the gap between looked after children and their peers widened from 40% to 50.4% and is bigger than the gap nationally.

106. Looked after children attend school regularly. This is closely monitored and effective action is taken by schools and the virtual school team should attendance fall. The virtual school is routinely informed of children at risk of exclusion and of those where there are attendance concerns. Action plans are put in place that help the vast majority of looked after children to attend school regularly. In the last academic year the attendance of looked after children and the proportion receiving a fixed term exclusion was better than their peers in the county. No looked after child has been permanently excluded from school since 2008.

107. All but two looked after children out of a cohort of over 400 access 25 hours or more education and the majority attend well. The virtual school has excellent knowledge of the whereabouts and progress of looked after children and is fully involved in progressing plans for the two young people not currently accessing educational provision. Those without a school place are supported to access education quickly.

108. A high proportion of children have an up-to-date, good quality personal education plan (PEP). PEPs for young children are of particularly good quality. Their views are well represented and the use of photographs and drawings by them personalises their plans to good effect and ensures that their views are recorded.

109. The pupil premium is used well to target support that helps looked after children in their academic studies and personal and social development. It is closely monitored so that the virtual school is well placed to be able to judge its impact over the academic year.

110. The 'edge of care' service has had a very positive impact in reducing the likelihood and need for young people to become looked after. The evaluation in March 2014 showed its positive impact on young people's outcomes and the local authority has taken the decision to invest in edge of care and expand the service. The progress of individual young people during their involvement with the service is carefully measured and regularly reviewed. Risk assessments, including assessments of young people at risk of child sexual exploitation, are good and kept up to date. The cornerstone to the edge of care service success is the support provided to families by a local authority children's home which has been rated as outstanding by Ofsted in its last inspection. Some examples have been seen where young people have gone home with thoughtful preparation including risk assessments, and this has enabled their return home to succeed.

111. When children go missing from care the police are promptly notified. Effective strategies are deployed to locate young people and return them to their placements. Independent return interviews are conducted by the recently commissioned provider, though not all staff are fully aware of these arrangements, which contributes to delays in the young people being offered a return interview. Missing episodes are considered by managers in the majority of cases, although this does not always result in effective action to reduce their incidence.

112. Inspectors have seen some good work by social workers and team managers with looked after children and young people. For example, in cases featuring child sexual exploitation inspectors found that all young people's needs were risk-assessed and regularly reviewed to monitor progress on a multi-agency basis. Direct interventions were put in place to help young people understand the risks and ways that they could be exploited. Case supervision on these cases is good. Some examples have also been seen of good direct work with children and young people to explore their feelings about key issues such as traumatic events in their past, feelings about their families and preparation for the future. Life story work is good, although some young people who should have this do not. Good account is taken of children's diverse needs in the majority of cases seen.

The graded judgement for adoption performance is that it requires improvement

113. Practice and decision-making processes to ensure that adoption is considered at an early stage, in cases where children are unlikely to safely return to the care of their parents or extended family, are inconsistent across the county and result in delays for some children. This variability in practice means that the local authority cannot be certain that adoption is always considered for all children when it may be appropriate.

114. The quality of care plans presented to the court does not consistently provide sufficiently compelling evidence about why adoption is the right plan. This adds to drift and delay for some children, as care proceedings can then be extended unnecessarily. The local authority has begun to use the learning from cases where this has happened, but this is not yet fully embedded in practice.

115. The adoption service manager has a good understanding and oversight of all the children waiting for adoption when this is identified as a potential plan. Effective monthly monitoring of plans means that there is a comprehensive picture of the progress to achieving permanence for children. For some children plans are not progressed sufficiently swiftly and robust action has not been taken to challenge this delay. The adoption service recognises the need to escalate cases to managers more robustly when timescales are not met.

116. Therapeutic support to help children address the impact of their pre-care experiences, such as attachment difficulties and behavioural issues, is not always available as looked after children are not prioritised by CAMHS. For some children, this has delayed plans for them to be placed with adopters.

117. The local authority shows some urgency through its effective use of fostering to adopt placements. This is discussed with all applicants in order to extend this option for children. Thirteen such placements have been approved so far in 2014–15. This enables children to be placed with potential adopters as they become looked after and means that they do not experience a move when legal orders are granted. To date, 11 children have benefited from such placements.

118. Placement orders have been granted for 97 children who are waiting to be placed with adopters. These include a number of brothers and sisters (33) where the plan is for them to be placed together, as well as older children and children with complex needs.

119. Family finding activity is comprehensive, persistent and successful for most children. It automatically includes consideration of adopters approved in-house, voluntary agency contract arrangements, and through established links with regional local authorities. The use of adoption activity days and exchange days is particularly successful for sibling groups and older children. As a result, 46 children were adopted last year; this is nearly double the performance in 2013–14 of 25, which is an achievement. In 2014–15 to date, 45 children have been placed with adopters, including six sibling groups. At the time of this inspection, 22 matches were under consideration, including a number of brothers and sisters together, with 18 matches likely to proceed to panel.

120. The local authority's performance against the most recently published (2011–14) Department for Education (DfE) adoption scorecard is inconsistent and shows a downward trajectory. Children in Cumbria wait on average 525 days between becoming looked after and being placed with their adoptive family, which is inside the DfE target of 547 days. This is better than comparable authorities and national averages. However, analysis of the data year-on-year shows that it is taking longer each year to place children and this is not helpful to children who are waiting to be adopted. The local authority's own data for 2014–15 confirms that children continue to wait longer. Children wait on average 164 days between placement order and matching which is outside the DfE target of 152 days. This is better than comparable authorities and national averages of 217 days.

121. The local authority has a good understanding of its performance and can articulate confidently the reasons for it. It has maintained a strong commitment and persistence in achieving adoption for children despite the negative impact that it knows some cases will have on the scorecard. It is able to evidence the reasons why some children, in particular siblings and children with complex health and other particular needs, took much longer to place; the authority is successful in achieving adoption for these children. Social workers are reluctant to 'give up' on the search, but managers are clear about the importance of their oversight and monitoring of progress of family finding. Realistic timescales are set, regularly monitored and reviewed and appropriate decisions have been taken to change the plan away from adoption for 15 children. In all of these cases there was a contingency plan for them to have permanency with their current foster carers.

122. Ensuring that there are enough adopters to meet the needs of children waiting, including sibling groups, older children and children with complex needs and backgrounds, effectively informs the local authority's recruitment activity. Additional contracting arrangements are in place with other providers. The local authority has approved 22 adoptive households so far in 2014–15, which is lower than the previous full year, when 41 adoptive households were approved. Approvals reflect the priority given to finding adopters for sibling groups.

123. Stage one of the approval process training and preparation groups are effectively forward planned and shared with a voluntary adoption agency. Prospective adopters are able to attend preparation groups promptly. The quality of assessments seen is satisfactory, with some being good. Although there is some overall variability in the quality of assessments, effective processes are in place to support development and improve practice through the panel adviser.

124. Adopter approvals are not consistently completed within nationally recommended timescales. Since the appointment of a permanent team manager in September 2014, more robust tracking of applications and identification of barriers has been developed. This is beginning to have an impact as delays are identified and minimised.

125. Adopters are matched with children within an average of four months of their approval as adopters. Scrutiny by the adoption panel of matching proposals and plans is effective and makes a positive contribution to minimising the likelihood of disruption. A new matching process is beginning to improve quality and consistency of work and ensures that all necessary work is complete prior to panel. When matches do not proceed or placements disrupt, the authority is quick to arrange disruption meetings in order to extract the learning to benefit other children. Two adoption placements have disrupted during 2014–15.

126. There is an effective working relationship between the panel chair and the agency decision maker (ADM). The ADM ensures that her consideration of the panel's recommendation is thorough and prompt so that there are no delays. The quarterly meetings between the panel chair, the ADM and adoption and fostering managers are effective in dealing with issues.

127. The very recent service reconfiguration is now providing more continuity for adopters following their approval, as support continues up to the adoption order and post-adoption support. Adoption support plans are detailed and individually tailored to the child's and adopters' specific needs. The therapeutic social worker attached to the adoption support team provides advice and direct input to adopters pre- and post-placement. The local authority is aware that it does not always respond promptly to the need for therapeutic support and has made a bid for Adoption Reform Grant money to address this gap.

128. The post-adoption service, at December 2014, had 143 cases open. Of these, 51 pre- and post-adoption families were receiving a range of support. In total, 69 individuals have used the service to access birth records, including tracing and intermediary work and there has been a significant reduction in the number of people waiting for this. The 'affected by adoption' service is working with 13 birth parents. The letterbox service facilitates indirect contact in approximately 500 cases.

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

129. Care leavers spoken to reported mixed experiences of the support they receive, ranging from good to unreliable. Most young people, from the age of 15 years, receive long-term support into adulthood from a consistent worker who knows them very well. The local authority is in contact with 228 of 232 care leavers. For the remaining four young people, the service has an understanding of their circumstances and the reasons why the young people refuse contact. Advisers are creative in their attempts to continually monitor their well-being.

130. When risks are identified for care leavers, including child sexual exploitation, these are assessed and used to inform young people's plans. Where circumstances change, advisers routinely re-assess young people's needs in consultation with them and other agencies to update plans. Where risks escalate, multi-agency meetings are convened to target support more effectively.

131. Pathway assessments and pathway plans have begun to show improvement in the last three months, in response to concerns raised from the local authority's own auditing activity. Improvements are still required to ensure they are consistently thorough and actions set are meaningful and measurable for care leavers. Not all plans identify the progress young people are making towards independence. In a few plans, young people's educational needs were not explicit.

132. Transition planning for children with disabilities starts at an early stage, between 13 and 14 years old depending on the young person's needs. Joint working and communication is effective to support long-term planning towards leaving care for these young people. For young people with complex needs, and approaching 18 years old, timely referrals to adult services are considered as part of forward planning.

133. Care leavers are not routinely receiving their health passports and so are not suitably knowledgeable about their health histories. This does not prepare them to understand and meet their own health needs independently. Care leavers have access to a range of universal services to promote their health, and advisers actively support them to arrange and attend appointments where this is needed. Care leavers' health needs are reflected in plans. Of the plans sampled, all health needs were suitably identified and met. In the majority of cases, care leavers are accessing health services independently. For older care leavers in need of specific and targeted health interventions, adult services were leading on these, with close liaison with the leaving care team to promote care leavers' wider needs.

134. The majority of care leavers are well supported through a range of methods to support increasing independence, such as individual work with advisers and youth workers, preparation in semi-independent lodgings and structured programmes through housing providers. Young people receive training on how to manage a tenancy agreement. To date, a 2012–15 lottery-funded initiative has helped 200 care leavers to gain skills for their future adulthood.

135. For care leavers who become parents, good and intensive support is provided through the family nurse partnership to enable them to care for their baby. However, this is a limited resource and not available for all those who may need it.

136. The local authority has been slow to increase the setting up home grant for care leavers to the £2,000 expected within national guidance. The current offer of £1,450 has resulted in those who left care after October 2014, when guidance was issued, losing £550. There is no plan to address the inequity of this. From April 2015 all new care leavers will receive the full £2,000. The current leaving care guide does not inform care leavers about the setting up home grant, making it very difficult for them to know what to expect or to challenge what they receive.

137. As young people progress through their teenage years they increasingly disengage from education, training and employment (EET). Participation in education is high for those aged 16, with 96% attending in year 12. However, the proportion of young people who are in EET decreases for 16 to 18-year-olds to 78%. Just 39% of 19 to 21-year-olds participated in EET during 2013/14 which is lower than comparable authorities (48%) and national averages (45%).

138. The good work undertaken to support the transition of young people into post-16 education is not replicated with older young people. Strategies to engage those who drop-out of education, employment and training are not well developed and action is not urgent or effective enough to successfully re-engage them. Too few creative opportunities are provided for young people who have exhausted existing pathways and who have not been able to sustain a college or training place.

139. The local authority offers apprenticeship opportunities for young people, including six children's rights apprenticeship places. There have been 30 care leavers in local authority apprenticeships over the last three years and 10 new apprenticeships this year. Types of apprenticeship include teaching assistants, youth work, catering, children's rights and business administration. A voluntary sector partner, commissioned by the local authority, that supports care leavers has provided an increasing number of young people with work experience opportunities and some excellent opportunities to develop their career aspirations and build their self-esteem and confidence. However, these initiatives have been insufficient in helping enough care leavers move into sustainable further education, training or employment opportunities.

140. Young people are supported well to attend higher education, with good financial support packages in place. Over the last three years, 21 care leavers have attended university, studying a wide range of degree courses such as economics, geographical oceanography, social work and midwifery. In contrast, the financial incentives and entitlements for those wishing to undertake vocational training are not sufficiently well developed.

141. Currently, 25 young people are recorded as living in multi-occupancy homes. This includes a range of accommodation types, for example supported accommodation, specialist residential accommodation and university student accommodation. The arrangements for these young people are carefully monitored, risk assessed and are meeting their current needs. The use of bed and breakfast (B&B) accommodation still occurs in emergencies but is not common. There were no care leavers in B&B at the time of this inspection.

142. Care leavers are well supported to navigate their accommodation options and think carefully about their needs and what they are ready for. This is, however, complex and time consuming, and the criteria young people need to meet do not always sit realistically with the challenges that care leavers may experience in the transition to adulthood. The local authority has recognised this, alongside the need for more accommodation options, which are reflected in their action plan for care leavers.

143. Care leavers have a range of different accommodation options delivered by a number of different providers. Almost all care leavers are reported as living in suitable accommodation, which is checked individually by advisers or as part of contractual arrangements. A very small number of young people are currently detained in Youth Offending Institutions. The majority of care leavers live in supported lodgings or in accommodation through packages with housing providers. Care leavers spoken with said they felt safe where they are living.

144. Some young people are waiting too long to secure suitable accommodation, particularly those with high levels of needs. The local authority is not tracking the number of young people waiting, or the timescales they wait.

145. Some young people with high needs experience frequent accommodation changes and disrupted tenancy agreements. This is reported as 11 young people in 2013–2014. Too often responses to breakdowns are reactive and not enough preventative strategies are used to avoid disruptions. For some young people, it can take too long to be re-considered as a suitable tenant by providers. The local authority is not proactive enough in these circumstances to ensure a second chance is promptly provided to young people. The availability of supported lodgings, from the Homestay scheme, has increased from seven places to 23. Homestay providers support young people living in their own accommodation or provide university holiday accommodation. Further increases are identified in the local authority's action plan for the care leaver service.

146. Currently 13 care leavers benefit from 'staying put' arrangements with their previous foster carers or family carers. This is a low number and is not increasing year-on-year. An insufficient number of young people, including those placed with foster carers in independent fostering agencies, are able to access this as an option into adulthood.

Achievements for some care leavers are recognised through an annual event for looked after children focusing on those who achieve academically. , The local authority acknowledge that not enough focus is given to recognising the personal and social achievements for the wider group of care leavers and is taking action to tackle this.

Key judgement	Judgement grade
Leadership, management and governance	Inadequate

Summary

Leaders have introduced a series of service developments that have led to improvements in the experience of some children and young people in Cumbria. However, the work undertaken to improve safeguarding has led management attention to be insufficiently focused on services for looked after children, which are judged to be inadequate. Looked after children experience too many delays and the quality of support in a high number of cases is poor.

Services to help and protect children have improved from a low base, but inspectors still saw some cases of poor practice and ineffective management oversight.

Leadership has not been effective in addressing the inconsistencies of practice across Cumbria. The local authority has been slow to respond to findings from the looked after children inspection in April 2012 and the poor management oversight currently affecting looked after children. The self-assessment fails to give sufficient consideration to the actual experience of looked after children.

The local authority's political leadership has prioritised and invested in children's services at a time of financial austerity. The Lead Member for children has not been strong enough in her scrutiny of services for looked after children.

There have been improvements in establishing much needed structures and processes since the appointments of the new Chief Executive, the Corporate Director, and Independent Chair of the LSCB. The new leadership has been effective in developing a more transparent and open culture within the organisation and with partners. Most recently there has been focused, multi-agency partnership work to develop the safeguarding hub and early help services. The quality of practice is not yet consistent. Leaders cannot be confident that all children in Cumbria are achieving good outcomes.

The Safeguarding Improvement Board has not given sufficient focus to the poor practice and management oversight of looked after children's services.

The improvements undertaken in relation to workforce development, including the authority-wide strengthening practice and leadership training, and the programme of audits and performance management, have enabled the local authority to improve help and protection services from a low baseline. Some good impact was seen, in particular in the quality of direct work with children and their families. Senior leaders have appropriately challenged poor performance in relation to safeguarding. The appointment of a Principal Social Worker is having an impact on raising social work standards.

147. Services for looked after children are inadequate and those for children who need help and protection require improvement.

148. The Corporate Director of Children's Services and independent Chair of the LSCB were both appointed in 2014. Since their appointments, there is evidence of increased pace in tackling known service deficits. They have worked hard to engage partners and there is now evidence of a change in culture within the wider children's services partnerships. They have welcomed external scrutiny and this has included inviting peer reviews by the Local Government Association. They have used the feedback from this scrutiny well to develop further the improvement plans. The Safeguarding Improvement Board reports that these key individuals have made a significant difference in a relatively short period of time, albeit with more to be done to improve consistency of practice.

149. The local authority's political leadership has prioritised and invested in children's services at a time of financial austerity. This has resulted in the creation of additional social worker posts, the early help team, the extension of the successful Edge of Care service model and the social work academy. Political leaders have also ensured that performance in relation to children's services is reviewed by the local authority Cabinet and scrutinised through member scrutiny arrangements.

150. The management focus on services for looked after children has been insufficient and these were judged to be inadequate during this inspection. Focused work by leaders in the local authority and partner organisations has improved safeguarding arrangements, including early help services, in Cumbria. The wider strategic partnerships including the Children's Trust, LSCB and the Safeguarding Improvement Board have been effective in driving forward these improvements but have failed to tackle the lack of progress for looked after children.

151. Leaders and managers have not been effective in prioritising, challenging and making improvements for looked after children. Performance information known to the leadership in December 2013 identified serious issues with the services for looked after children. However, it was not until November 2014, almost a year later, that the local authority commissioned an audit of looked after children's cases. While it is to the authority's credit that it did this, it had known about the significant issues for some time. The audit identified that there are some serious weaknesses in these services and that too many children continue to receive an inadequate service. Too many looked after children cases examined by inspectors were judged to be inadequate. The findings of the commissioned audit have been mirrored by the findings of this inspection.

152. As part of its preparation for this inspection, the local authority completed a self-assessment. This judged their looked after services to require improvement. While recognising the structural and strategic improvements made, this assessment failed to give sufficient weight to the actual experience of looked after children in Cumbria. Too much weight was given to reported improvements in the IRO service, which inspectors found continues to have serious weaknesses. While the service does not have a team manager, an appointment was made during the inspection period. The quality of its work has been inconsistent and in many cases poor. The very recent appointment of the Principal Social Worker has brought focus to the improvements required in this service. In addition, the appointment of seven agency workers to provide some additional capacity to the service and cover for sickness and absence within the team is positive progress. However, it is too early to demonstrate the impact of these changes for children.

153. Leaders have not ensured that looked after children receive a consistent service across Cumbria. Inspectors' findings and local authority performance information evidence that the quality of services for looked after children in some parts of the county is considerably weaker than in others. Several employees told inspectors of instability in the looked after children's service in one area due to lack of management oversight, sickness rates and high turnover of staff, including agency staff. The Local Authority recently increased management capacity to improve looked after children services. It is too early to see the impact of this.

154. Increased management oversight has led to some improvements in performance, although this is not a consistent picture, with some teams doing better than others across Cumbria. In particular at January 2015, recording in case records of basic details has risen to 98% and the voice of the child is evident in 78.4% of cases, an improvement from 68.2% from 2013-14. In the same period, the timely allocation of cases has improved from 77.7% to 83.6% but is not yet meeting the local authority's own target of 93%.

155. In other areas performance improvements are not as marked and some have deteriorated. For example, at January 2015, only 57.6% of plans meet the local authority's required standards, which is deterioration from 62.7% for 2013–14. According to the local authority's own figures the percentages of cases meeting its own performance standards for case management and management oversight have improved slightly from 2013-14 until January 2015 from 52.8% to 57.6% and 61% to 69.3% respectively. However, considerable further improvement is needed. In the same period, copies of social work reports for initial child protection conferences are shared with parents two days in advance in 64.9% of cases, which is a significant increase from 31.5% and exceeds the milestone target set by the local authority of 55%. The local authority judges this as good performance from a low base, though the target remains unambitious overall. In reality, 35% of parents are still not sufficiently well prepared and this requires improvement. Performance data do not provide sufficient focus on the experiences of looked after children and the quality of work done with them. For example, the quality of reports and updated assessments prepared by social workers for looked after children's reviews are absent.

156. Current performance data identify that approximately 33% of cases closed by social work teams are re-referred within a year, which is significantly higher than the national average. Inspectors found, and the local authority's own audits confirm, that some cases are closed prematurely, without packages of support put in place to meet identified needs. The actions of senior leaders have been insufficient to ensure that robust plans are in place to tackle this known weakness in relation to early help and protection.

157. Across Cumbria, supervision of social workers is too variable. The quality ranges from inadequate to good. There is insufficient evidence of case direction or reflective supervision. Senior managers have not checked the quality of staff supervision, which is particularly concerning given a shortfall in management capacity recently. In the poorest performing team, workers have not had frequent enough supervision, though the quality and frequency of supervision in other teams is better.

158. All of the help and protection social workers met by inspectors reported positively about working for Cumbria. They reported that supervision supports them and they feel challenged by their managers. This was not always reflected in their supervision folders or on children's files.

159. The Lead Member has championed improved outcomes for all children in Cumbria and has provided political leadership in the development of partnership arrangements, and in service improvements such as Edge of Care and the safeguarding hub. However, corporate parenting by elected members is under-developed. Elected members, including the Lead Member for children, are committed and enthusiastic about promoting best outcomes for looked after children and care leavers. However, their influence in terms of improving the service for looked after children has been limited, despite providing scrutiny of the performance of officers.

160. There has been a lack of consistency in strategic developments in relation to services for looked after children. While a number of plans are in place, an overarching strategic plan for looked after children, which should exist to drive improvements, monitor performance and the impact for children, is absent. This means that there is poor coordination and analysis of services for looked after children. This was identified as an area for improvement in the looked after children inspection in April 2012.

161. At the time of the inspection, the authority was not meeting its obligations in relation to giving care leavers the full amount of the leaving care grant indicated in statutory guidance. Arrangements are in place for this to be paid from April 2015. The Corporate Director of Children's Services is not meeting his statutory obligation to authorise the placement of children out of the county. Inspectors were assured that this would be immediately addressed by the local authority.

162. Strategic planning by the local authority in response to child sexual exploitation is in the early stages of development and behind that of many other authorities. The local authority contribution to driving forward the multi-agency action plan, at pace, has been weak. The local authority, with its partners, is not yet sufficiently focused on disruption activity and ensuring that all children vulnerable to child sexual exploitation are identified early. When identified, plans to reduce risk from sexual exploitation are in place and are having impact for most young people.

163. Understanding the effectiveness of domestic abuse services has not been a priority for the local authority. This is a concern given the high number of incidents of domestic abuse affecting children in the county.

164. Children's Services are well supported by the central commissioning team. The Commissioning Strategy 2014–2018 makes good links to the local authority priorities and service plans. A mixed economy of in-house provision and commissioning takes into account the demographics of the area. Good support is available to enable smaller providers to build up third sector infrastructure. For example, a thorough consultation exercise over the last two years on targeted early help led to the construction of an 'outcomes focused' model. This measures the success of commissioned services in meeting set objectives for those most in need.

165. There is a Joint Strategic Needs Analysis (JSNA) which is currently under review and does not yet provide collated and analysed information on the current needs of children in the county.

166. The annual complaints report appropriately identifies the profile and trends of complaints and compliments about Children's Services in 2013–14. A log of learning arising from complaints is routinely shared with senior managers. Actions are tracked to their conclusion and inform wider service development. There continue to be significant issues in responding to complaints within national timescales. When complaints are made, young people are routinely offered support from a commissioned advocacy service, with evidence of high take-up. Clear decisions about whether or not the complaint is upheld are recorded, along with any actions taken as a result.

167. The local authority has a good knowledge of its own performance, specifically in its child protection and child in need services, through an established programme of audits. As a result of these audits, work has been identified to improve practice and this includes further training, coaching, one-to-one sessions, workshops, promotion of research, the use of new templates and enhancing supervision for individuals. The performance information used by Children's Services is accurate and the analysis of it detailed, although more work should be undertaken to use the feedback from service users to improve the quality of practice and to ensure greater focus on the outcomes for children and young people. The same scrutiny for looked after children's services has been absent until November 2014. Performance information is not sufficiently wide-ranging to have enabled the deterioration in services for looked after children and care leavers to be identified at an early stage.

168. The local authority is training its staff through the Strengthening Practice programme. Managers have also been supported and challenged through a parallel Strengthening Leadership programme. Despite this investment, action is not yet resulting in sufficient consistency on many aspects of practice or in improved management oversight. Following decisive action to remove some staff, not all incoming agency staff and newly appointed workers have received this training, which is contributing to inconsistency of practice. Further programmes are in place for 2015–2016. Social workers speak highly of this programme and inspectors noted that it has had considerable impact on the quality of direct work with children by social workers.

169. The Children's Trust Board meets twice a year, once to set priorities and once to receive an update on progress. This is underpinned by sub-groups, including child poverty and emotional health and well-being. The emotional health and wellbeing group is chaired by an Executive Head, has a budget and has supported the piloting and roll out of the HeadStart initiative. This is a good example of partnership work, with 28 HeadStart schools and a range of commissioned projects set to launch in April 2015.

170. There are clear linkages between the various strategic bodies, including the Health and Wellbeing Board and the Safer Cumbria Partnership. Despite these arrangements, action has not resulted in improved timeliness of initial health assessments when children become looked after. This necessitated an extra-ordinary meeting between senior leaders across the partnership in January 2015 to tackle the issue. It is too early to identify whether this will lead to improvements of this longstanding issue.

171. The leaders in children's services benefit from cross party political support. The local authority has set the budget and this has elements to continue to develop services, and also to fund the significant overspend caused by the high cost of the number of looked after children. The 2015–16 budget is focused on improving early help services and reducing the number of looked after children from 649 to 520 during the year. It has been a target for some years to reduce the number of looked after children, yet this has repeatedly not been achieved. Consequently, it is unclear how this ambitious target will be met and how the identified budget reductions will be made.

172. There has been considerable focus on work to improve the number of permanent staff in children's services. Since January 2014, there have been 27 new social workers recruited and a drop in agency staff from 14.2% to 9.5%, although the distribution of temporary staff continues to affect teams unevenly across the county. Some creative initiatives are helping to attract workers to Cumbria and the 'grow your own' initiative is a slow but important response to a significant problem. Following investment by the local authority, the newly developed Social Work Academy is due to commence in the autumn of 2015. To further assist with turning around the considerable practice issues within children's services, the local authority funds 26 additional staff over the 235 posts funded in the base budget, and this is positive.

173. The newly appointed Principal Social Worker is having an impact in promoting and improving professional practice within the authority. For example she was instrumental in organising the 'Championing Social Work' conference in 2014, which had been initiated by the Lead Member and Corporate Director. This was attended by over 100 social workers as well as the Chief Executive and the Corporate Director of Children's Services. Following this, both the Corporate Director and the Principal Social Worker have held three roadshows in each of the districts to hold 'conversations' with groups of social workers and child and family workers. These have focused on affirming the expected standards for social work practice, including an emphasis on the child's voice and how it needs to be driving planning and interventions.

The Local Safeguarding Children Board (LSCB)

The Local Safeguarding Children Board requires improvement
The arrangements in place to evaluate the effectiveness of what is done by the authority and board partners to safeguard and promote the welfare of children require improvement.

Summary of findings

The LSCB requires improvement because:

Scrutiny, awareness and challenge

- A review of the Board has contributed to a better understanding of roles and responsibilities of individual members to ensure that safeguarding is given priority in Cumbria. As a result, significant improvements in how the Board is organised and holds agencies to account are in place.
- The partnership has a shared understanding and ownership of early help; thresholds have been reviewed and re-launched, but are not yet consistently understood or applied by all agencies.
- Step down arrangements between the local authority and early help services are not consistently established across the partnership, which leaves some children's needs unmet.
- Arrangements for the Board to monitor the number of children subject to an early help assessment are in place, but do not include evaluation of the outcomes for children that receive this support.
- The Board does not have sufficient strategic oversight, influence or challenge of the partnership arrangements concerned with domestic abuse.
- The Board is not providing challenge to the lack of urgency afforded by key partner agencies to respond to child sexual exploitation.
- The services for looked after children and the welfare of looked after children have not received sufficient attention from the Board.
- Arrangements to consider serious case reviews have been appropriately refreshed by the LSCB Chair, with improved decision-making processes now in place.

Training and practice development

- The training delivered to staff by the Board does not fully reflect the its current priorities. It is not evaluated to measure its long-term impact on practice and on outcomes for children.

What does the LSCB need to improve?

Areas for improvement

Scrutiny, awareness and challenge

174.

175. Ensure that clear governance arrangements are in place so that the LSCB can evaluate the effectiveness of services provided to children who live in households where domestic abuse occurs.

176. Deliver the Child Sexual Exploitation Action Plan as developed from the LSCB self-assessment of child sexual exploitation. Develop robust measures to improve the Board's oversight of children and young people who go missing and who are vulnerable to child sexual exploitation.

177. Evaluate the outcomes for those children who receive early help services, including those who experience step-down arrangements when child protection or child in need plans end.

178. Monitor the effectiveness of all partners in promoting the welfare of looked after children.

179. Ensure that the annual report contains a rigorous and transparent assessment of the performance and effectiveness of local services, identifies areas of weakness and the causes of those weaknesses, and evaluates and where necessary challenges the action being taken.

Training and practice development

180. Develop a range of training opportunities which reflect the Board's current priorities, including children who are missing and vulnerable to child sexual exploitation, domestic abuse and early help practice. Evaluate the effectiveness of this training, including through feedback and audit activity.

181. Monitor and evaluate the consistent use of local multi-agency procedures by all agencies, including the application of thresholds.

Inspection judgement about the LSCB

182. The independent Chair has been in post since April 2014 and is clear about the core functions of the Board and its statutory responsibilities. She has improved the functioning of the Board so that members' responsibilities and accountability are clearer. The membership of the Board was robustly reviewed by the Chair and effective changes were made. Although the membership has reduced, the current Board has representation from all statutory partners. All relevant agencies are represented by officers of appropriate seniority and attendance is good. The Chair has conducted individual appraisal and development sessions with Board members. As a result, the clarity for individuals about their role and contribution to the Board has improved.

183. Governance arrangements and relationships between the different strategic boards, including the children's trust board, the Adult Safeguarding Board, the Safer Cumbria Partnership (SCP) and the Health and Wellbeing Board, are clearly set out in a jointly agreed memorandum of understanding. The LSCB Chair also has regular, separate meetings with the local authority's Chief Executive, the Director of Children's Services and the Chair of the Adults Safeguarding Board. The local authority has provided additional funding to the LSCB to contract a vice chair to provide extra capacity to the leadership of the LSCB. This has increased the effectiveness and visibility of the LSCB and the confidence of the partnership. LSCB members sit on each of the other boards, and there is a standing agenda item for every meeting of the respective boards where all members are updated about relevant issues from other boards, and have an opportunity to raise items of mutual concern or interest or to challenge each other. The different boards are therefore aware of and able to support each other's work.

184. The Board has a constructive relationship with the Safeguarding Improvement Board. The chair of the Safeguarding Improvement Board confirmed their confidence in the LSCB Chair and increasing confidence in the partnership to effectively monitor and evaluate services to children. The Board has a range of sub-groups, including one for missing children and child sexual exploitation. Sub-group chairs represent a comprehensive range of partner agencies. Chairs and sub-group membership have the expertise and influence to ensure that the decisions and agreed priorities of the Board are progressed. The statutory and regulatory responsibilities of the Board are suitably integrated into sub-group arrangements.

185. The business group includes the chairs of all of the Board's sub-groups and is chaired by the independent LSCB Chair and meets before each main LSCB meeting. It is becoming an effective mechanism for ensuring that all of the sub-groups are regularly held to account for progress against agreed plans.

186. The Board does not yet provide sufficient challenge or urgency in its oversight of arrangements for missing children and those vulnerable to child sexual exploitation. There is delay in obtaining the offender profile analysis from the police, which is overdue. The Board has failed to put local performance indicators in place to evaluate the effectiveness of the sexual exploitation strategy. Specific multi-agency training is planned but will not be available to staff until September 2015. Some examples of progress can be seen. For example, information on the prevalence of child sexual exploitation is available; a child sexual exploitation assessment tool has been developed; there are now designated child sexual exploitation 'champions' in social work teams, who are soon to be trained; there has been significant awareness-raising activity in schools including an event delivered to 7,000 young people; and since January 2015 there are arrangements in place for return interviews when children go missing. Child sexual exploitation is identified as a priority for the Board for the coming year and there is evidence of recent improvement. However, this is too little progress and the Board has not given this issue the urgency it requires.

187. Domestic abuse is a major area where the Board's strategic involvement and detailed knowledge are too recent and underdeveloped. Governance arrangements within the partnership mean that domestic abuse is the responsibility of the Safer Cumbria Partnership (SCP). Although the work of the SCP is reported to the LSCB, this provides insufficient direct evaluation of an issue which has a major impact on the safety and welfare of children in the area. This means that the LSCB's knowledge about the prevalence, nature and effects of domestic abuse is too limited to allow the Board to satisfy itself that partners are working effectively to safeguard children from the effects of abuse, and developing services to meet their needs. This is an identified priority for the LSCB business plan in 2015–16.

188. The Board's scrutiny and challenge to the effectiveness of child and adolescent mental health services has been on-going for a number of years as this has been a significant issue for the partnership for some time. Serious care reviews have repeatedly found a poor response to meeting children's needs by CAMHS. However, recent collaborative partnership working has seen the development of the HeadStart initiative to improve the emotional wellbeing of young people. A range of services has been commissioned and will be available from April 2015.

189. The Board has had limited awareness of the welfare of looked after children. This is an area of concern, but has not been a priority for the Board until very recently. The Board is not yet knowledgeable enough about the experiences of looked after children and young people in Cumbria to challenge partners about standards of practice and the welfare of this group of children.

190. The Board is increasingly offering timely and robust challenge to all partners. Its challenge log records constructive challenge made to partners. Progress in respect of these challenges is managed through the business group. This is an effective system and partners report that the Board has experienced a significant, albeit recent, culture change which allows such challenges to be used as opportunities to develop and drive collaborative solutions. For example, the LSCB was appropriately provided with outcomes from the local authority-commissioned independent audit of children subject to child protection plans. The audit and quality assurance exercise concluded that thresholds had not been applied consistently and too many children were inappropriately subject to child protection plans. Partners were consulted about the review of these cases and, as a result, the numbers decreased rapidly. The Board and the Chair exercised appropriate and detailed oversight of this process. This included the Chair re-auditing cases to satisfy the Board that the local authority's own auditing and review of the cases had been safe and robust.

191. Partnership working has rightly prioritised the development of a safeguarding hub in recognition of past failures of triage arrangements to respond to contacts and referrals. A multi-agency programme board reports to the Safeguarding Improvement Board and the LSCB and has overseen the introduction of a safeguarding hub within six months. The hub has been subject to detailed monitoring, including external peer review, to support its development. The LSCB is the strategic driver of this work and has been instrumental in ensuring that significant and rapid improvements have been made.

192. The LSCB has revised, agreed and re-launched the local threshold document which is accessible and fit for purpose. This gives clear guidance on partners' responsibilities for helping families early when problems first emerge. The LSCB is monitoring the application of the threshold through its evaluation of the safeguarding hub, and recognises that thresholds are not understood consistently across the partnership. The LSCB actively monitors the prevalence and quality of early help assessments through audits and an external peer review. However, practice once the early help assessment is completed is not evaluated by the Board. It has not paid sufficient attention to the impact on outcomes that early help is having for children and families. In particular, the Board's awareness of the effectiveness of step-down arrangements between the local authority and early help services is limited and requires further work.

193. Board members are responsible for ensuring that information and involvement in the Board are shared throughout the county. The education sub-group now has a primary school head teacher as chair and a secondary head teacher as vice chair, both of whom also have a specific responsibility to ensure that the Board's decisions are shared with the locality and sector bodies for education within the authority. They are also responsible for ensuring that Section 175 audits are completed to an acceptable standard. Similarly, the health group is chaired by a general practitioner who links with the six locality groups for general practitioners in the county. These changes represent an improvement on the previous organisation, and provide a framework for addressing the Board's challenging work programme and priorities. However, they are too recent to show impact yet.

194. The Board is committed to developing arrangements for a robust performance management framework to drive quality and improvement. The performance management and quality assurance sub-group reports to the business group on the outcomes and learning from audits, and this information helps to inform the priorities and work plan of the Board. There has been significant audit activity, including thematic and multi-agency audits which report on standards of practice and have helped to inform the Board's training programme and partner agencies' service development.

195. Section 11 audits are effective and closely follow the standards set out in guidance. The Board achieved a 100% completion rate of section 11 audits and has used the findings to improve safeguarding practice and identify multi-agency training and development needs for individuals and organisations. The process was well managed, and included follow-up compliance visits to agencies from Board members and the identification of areas for development for the training and improvement sub-group.

196. The Board's practice and the Chair's management of the serious case review process have improved significantly. In the period up to the appointment of the current independent Chair, there were a number of serious case reviews which were delayed in their completion. In addition, decisions not to initiate serious case reviews in the last three years were also reviewed by the Chair. This resulted in four additional case reviews being undertaken and one serious case review being changed to a practice review. The Chair's reasoning in each of these cases was discussed and agreed by the Board and Ofsted was notified. As a result, the criteria for initiating serious case reviews and practice reviews are now well understood and applied consistently by the sub-group and the Board. The learning from these cases has been integrated into the business plan of the Board and its sub-groups and action plans are monitored effectively by the business group. All actions and recommendations from completed case reviews have either been implemented, included in other parts of the Board's planning or have realistic timescales for completion and are regularly reviewed.

197. The Board disseminates learning from serious case reviews and practice reviews widely through its website, newsletter and training and practice forums. Staff are aware of this activity and of the principle that learning from reviews informs training. However, few staff were able to identify specific improvements which were the result of local case reviews. This raises questions about the impact and quality of this training and the extent to which it is reinforced in practice, supervision and management oversight of cases.

198. The process for reviewing child deaths was too slow and has not been effective. The annual report was not completed on time. A new Chair was appointed for the Child Death Overview Panel (CDOP) during the year, and the panel has now produced a report as required by regulations, which provides relevant information and analysis of the small number of deaths considered. The improvements achieved during 2014–15 mean that the panel is in a position to ensure that future reports meet the standard expected by the Board.

199. During this inspection the LSCB provided timely notification to Ofsted of the death of a child who was known to partners and the local authority. Appropriate arrangements are progressing to inform decision-making about whether a serious case review is required.

200. The Board has held the local authority and partners to account for their performance over private fostering. Too few children are identified and referred to the local authority by partner agencies. The Board has increased its level of oversight in this area since the 2012 Ofsted inspection, when it was identified as an area of weakness. The local authority private fostering annual report to the LSCB shows that notifications have increased from 15 in 2012–13 to 20 in 2013–14. However, the Board has not received an update on progress in this area since the annual report was considered in May 2014 and cannot be assured that this continues to be a priority for partners.

201. The Board has a training strategy which is currently under review. Although the Board does provide some appropriate training, the range of this is limited. The Board does not have a dedicated training officer and there is a shortage of trained volunteer trainers from across the partnership in recent months. A number of courses have also been cancelled due to low take-up. The learning and improvement sub-group does not systematically collect information to allow it to evaluate the sustained impact of training on staff.

202. During the inspection the Board re-launched its suite of procedures manuals, which have been refreshed through a commissioning arrangement. These are now accessible to all partners via the internet. The procedures are clear and fit for purpose and the Board has ensured that the commissioning arrangement allows for the procedures to be reviewed and amended twice per year to reflect changes in legislation, regulations and local policy. This process has been overseen by the Board's policy and procedures sub-group, which will also monitor and review its implementation. It is not yet possible to measure the impact of these changes on practice as they have only just occurred.

203. The annual report requires improvement. It lacks breadth and provides too little analytical detail about the range of responsibilities the Board. It does not provide a rigorous and transparent assessment of the effectiveness of local services. This is acknowledged as an area for improvement by the Chair, who is constrained by the fact that the reporting period was prior to her appointment.

204. The funding of the Board is shared by key partners and is detailed in the annual report. The level of financial support is sufficient and includes additional leadership capacity to support the improvement and development needs identified by the Board during the current year.

What the inspection judgements mean

The local authority

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

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

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

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

The LSCB

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

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

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

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

Information about this inspection

Inspectors have looked closely at the experiences of children and young people who have needed or still need help and/or protection. This also includes children and young people who are looked after and young people who are leaving care and starting their lives as young adults.

Inspectors considered the quality of work and the difference adults make to the lives of children, young people and families. They read case files, watched how professional staff work with families and each other and discussed the effectiveness of help and care given to children and young people. Wherever possible, they talked to children, young people and their families. In addition the inspectors have tried to understand what the local authority knows about how well it is performing, how well it is doing and what difference it is making for the people who it is trying to help, protect and look after.

The inspection of the local authority was carried out under section 136 of the Education and Inspections Act 2006.

The review of the Local Safeguarding Children Board was carried out under section 15A of the Children Act 2004.

Ofsted produces this report of the inspection of local authority functions and the review of the local safeguarding children board under its power to combine reports in accordance with section 152 of the Education and Inspections Act 2006.

The inspection team consisted of six of Her Majesty's Inspectors (HMI) from Ofsted and two additional inspectors (AI).

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