

Cornwall Council

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

and

Review of the effectiveness of the Local Safeguarding Children Board¹

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Children's services in Cornwall are good	
1. Children who need help and protection	Requires improvement
2. Children looked after and achieving permanence	Good
2.1 Adoption performance	Good
2.2 Experiences and progress of care leavers	Good
3. Leadership, management and governance	Good

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.

Executive summary

Children's services in Cornwall are good. A stable and dedicated senior management team, led by an experienced director of children's services (DCS), has worked steadily and purposefully to implement systemic change to services for children and young people in Cornwall. In doing so, they have created a culture of learning, support and challenge in a professional environment that has enabled social work to flourish. The senior management team demonstrates a good understanding of services, is committed to continual improvement and responds swiftly to meet the changing needs and demands for services.

Children's services in Cornwall were subject to a period of intervention from the Department of Education between 2009 and 2013. Almost all areas for improvement identified during this period have been tackled and, as a result, services for children and young people have continued to improve and are in a much stronger position. Improvements achieved since the previous inspection of child protection services in 2013, and safeguarding and looked after children's services in 2011, have included a well-coordinated approach to services that provide targeted and specialist help at an early stage and reduced social work caseloads.

Continued investment in high quality training and support has resulted in a stable and skilled workforce. Social workers use a range of effective interventions to improve the lives of children and families. Managers and staff are enthusiastic about improving outcomes for children and young people. Children are visited regularly and social work practice is child centred. Direct work with children is an area of strength with creative methods used to assess and understand the individual needs, wishes and feelings of children. Children and young people in need of help and protection receive an effective and prompt response from the multi-agency referral unit (MARU). The MARU handles all new referrals to children's social care. Thresholds for services are clear and applied effectively. All decisions are clearly recorded and, in most cases, the rationale is clearly evident. A new early help hub (EHH) has further strengthened the arrangements that already existed. Consequently, children and families receive swift access to the most relevant services that result in positive and sustainable change for them.

Assessments are timely, comprehensive and analytical. They explicitly consider the voice of the child and the 'child's lived experience' and are routinely informed by research. When child protection referrals lead to strategy discussions, they are mainly timely with appropriate outcomes. However, for a very small number of children's cases open to the children in need teams, there had been delays in holding strategy discussions when their risks had increased. As a result, some children remained in situations where their risk had not been fully assessed. Child protection conferences effectively analyse and respond to the risks affecting children. Reviews of plans and core group meetings are regular and are attended by a range of agencies, which ensure that plans progress well and in the child's timescale.

The local authority has ensured that there are strong arrangements for children who

are on the edge of care. Gweres Tus Yowynk (GTY) provides an intensive response to support young people to stay at home. Decisions to take children into care are appropriate. The local authority Public Law Outline (PLO) and court work is an area of particular strength, with proceedings concluding well within national timescales. As a result, children move into a permanent home with carers or return to their families more quickly.

Children looked after in Cornwall receive a consistently good service, with some very strong work seen by inspectors. However, despite continued effort, a small minority of children still have too many placement moves and the gap in educational outcomes between children looked after and other children in the south west and nationally, although narrowing, is still too wide. Adoption services are good and children are placed in a timely way with well-matched and well-supported adoptive parents. Placements of brothers and sisters are not consistently informed by together or apart assessments and child permanence reports do not always explore the lifelong impact of all issues. The timeliness of stage one of adopter assessments requires improvement. Services for care leavers are good, with care leavers feeling well supported into adulthood, making good progress in their studies, receiving effective support and living in suitable accommodation.

The practice of only the youngest or most vulnerable child within a group of brothers and sisters having a named social worker has resulted in the individual needs of some children not always being given sufficient consideration. This practice was identified as an area for improvement in the Ofsted inspection in 2013 and remains an area which requires further work. Senior managers accepted this finding and took swift action during the inspection to clarify their policy in relation to child in need assessments.

Services for children vulnerable to sexual exploitation are at an early stage of development. Data and intelligence are not sufficiently aligned, collated or analysed to inform service development. The timeliness of return home interviews and the quality of safety plans to minimise risk for children who go missing from home and care, and children who are vulnerable to child sexual exploitation, vary in quality. The local authority and partner agencies had already recognised the majority of the areas for improvement identified during the inspection through a peer review and their own recent audits. Action is being taken to address the work required.

Young people aged 16 and 17 at risk of being homeless are well supported by targeted youth workers and a homeless housing officer. At the time of the inspection, no young people were living in bed and breakfast accommodation. However, over the past six months a small group of closely monitored and vetted bed and breakfast establishments have been used by the housing department for young people to live in while their needs are jointly assessed by social care and housing. This is not acceptable practice and leaves young people potentially vulnerable. Senior managers accept that this area needs to be addressed and plan to expand the 'Open Door' provision to meet the needs of this group and to extend the range of options available for supported living.

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The local authority

Information about this local authority area²

Previous Ofsted inspections

- The local authority operates five children's homes. Four were judged to be good or better in their most recent Ofsted inspection.
- The previous inspection of the local authority's arrangements for the protection of children was in February 2013. The local authority was judged to be adequate.
- The previous inspection of the local authority's services for children looked after was in January 2011. The local authority was judged to be adequate.

Local leadership

- The DCS has been in post since June 2010.
- The DCS is also responsible for adult and public health services.
- The chair of the local safeguarding children board (LSCB) has been in post since June 2014.
- The LSCB is shared with the Isles of Scilly local authority.

Children living in this area

- Approximately 117,102 children and young people under the age of 18 years live in Cornwall. This is 21.8% of the total population in the area.
- Approximately 18% of the local authority's children are living in poverty.
- The proportion of children entitled to free school meals:
 - in primary schools is 12.5% (the national average is 15.6%)
 - in secondary schools is 11.7% (the national average is 13.9%)
- Children and young people from minority ethnic groups account for 17.8% (including Cornish) of all children living in the area. Non-Cornish minority ethnic groups make up 2.9% of the children and young people population, compared with 21.5% in the country as a whole.
- The largest minority ethnic groups of children and young people in the area are Cornish (16,657 or 14.9%) and mixed/multiple ethnic group (2,068 or 1.8%).

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

- The proportion of children and young people with English as an additional language:
 - in primary schools is 2.3% (the national average is 19.4%).
 - in secondary schools is 1.8% (the national average is 15.0%).

Child protection in this area

- At 31 March 2016, 2915 children had been identified through assessment as being formally in need of a specialist children's service. This is a decrease from 3146 at 31 March 2015.
- At 31 March 2016, 413 children and young people were the subject of a child protection plan. This is an increase from 404 at 31 March 2015.
- At 31 March 2016, 20 children lived in a privately arranged fostering placement. This is a reduction from 25 at 31 March 2015.
- Since the previous inspection, two serious incident notifications have been submitted to Ofsted and two serious case reviews have been completed or were ongoing at the time of the inspection.

Children looked after in this area

- At 31 March 2016, 431 children are being looked after by the local authority (a rate of 38.6 per 10,000 children). This is a reduction from 440 (42 per 10,000 children) at 31 March 2015. Of this number:
 - 71 (or 16.5%) live outside the local authority area
 - 32 live in residential children's homes, of whom 66% live out of the authority area
 - 7 live in residential special schools³, of whom all live out of the authority area
 - 334 live with foster families, of whom 10% live out of the authority area
 - 24 live with parents, of whom 4% live out of the authority area
 - There are no unaccompanied asylum-seeking children.
- In the last 12 months:
 - 31 children have been adopted
 - 46 children became subject of special guardianship orders
 - 253 children ceased to be looked after, of whom 10% subsequently returned to be looked after

³ These are residential special schools that look after children for 295 days or less per year.

- 25 children and young people ceased to be looked after and moved on to independent living
 - no children or young people ceased to be looked after and are living in houses of multiple occupation.
- Social work model
- The local authority uses Signs of Safety as its social work model for child intervention work.

Recommendations

1. Improve the arrangements to reduce the risk to children of sexual exploitation and episodes of missing from home and care by:
 - improving information sharing and ensuring that the missing and child sexual exploitation meeting (MACSE) identifies and monitors substantive intervention plans to ensure that risks are reduced
 - ensuring risk assessments are of a consistently good standard supported by good analysis of risks and protective factors
 - developing suitable arrangements to share and analyse information from child sexual exploitation risk assessments and return interviews to reduce future risks for individual children and young people, and to inform partnership prevention and disruption activity.
2. Ensure that homeless young people aged 16 and 17 are aware of their rights and entitlements to section 20 accommodation, assessment of risks are completed and adequate accommodation is available to meet their needs.
3. Ensure that strategy discussions are promptly considered and, where appropriate, held for all children when risks increase.
4. Ensure that, at the point of referral, all children in a household are considered and are subject to a referral and that they have an individual assessment of need that informs an individual plan.
5. Improve planning and work to support children who return home from care.
6. Improve educational attainment for all children looked after at all key stages, particularly at key stage 4.
7. Improve the quality of child permanence reports so that they provide a comprehensive understanding of the impact on the child of their history.
8. Ensure that all permanence decisions for brothers or sisters are informed by a formal together or apart assessment.

Summary for children and young people

- Inspectors found that services for children and young people in Cornwall are working well and some areas are good, but more work needs to be done to make sure that children at risk of sexual exploitation and homelessness are kept safe, particularly services for children who need help and protection.
- Social workers are good at finding out what needs to happen to help families make changes to keep children safe.
- Social workers meet children regularly and listen to them, but not all children have their own assessments and plans.
- Families, children and young people who need extra help are able to get the support they need when they are having difficulties.
- Social workers are good at helping children and young people to feel safe and supported and use lots of different ways to help children say what is worrying them and what they would like to happen.
- Managers are improving children's and young people's lives and making sure that there is sufficient money for services.
- When children cannot live at home, their social workers make the right decisions and they are looked after by people who take good care of them and support them in their education and hobbies.
- Senior managers and councillors take their role as corporate parents very seriously. They regularly meet with children and young people and take an interest in their lives. They understand what children need to lead healthy and successful lives.
- Social workers help children and young people to keep in contact with the people who are important to them.
- More needs to be done to help children do as well as they can in school.
- When children need to be adopted, this happens quickly and they are helped to understand their life stories.
- Most young people leaving care feel well supported by their personal advisers and feel safe where they live.
- The Children in Care Council, known as Voice4Us, is dynamic and their work helps make positive changes for all children looked after.

The experiences and progress of children who need help and protection

Requires improvement

Summary

Senior managers acknowledge that they need to improve and develop services for children at potential or actual risk of child sexual exploitation. This includes strengthening assessments of risk, safety planning and increasing the rigour and scrutiny of cases presented to missing and child sexual exploitation meetings. Nevertheless, the vast majority of children and young people who are in need of help and protection are identified, and prompt action is taken to ensure that they are safe.

Children and young people benefit from effective early help and specialist services. The coordination of these services through the new early help hub is increasingly effective in identifying need and supporting children and families at an early stage. The MARU is the entry point for all new referrals from the public and partners. Experienced social workers take account of the risks identified at the point of referral, incorporate historical information thoroughly and make prompt decisions about levels of intervention.

The practice of only allocating a named social worker to the youngest or most vulnerable child within a group of brothers and sisters has resulted in the individual needs of some children not always being given sufficient consideration. When child protection referrals lead to strategy discussions, they are mainly timely with appropriate outcomes. However, for a very small number of children's cases open to the children in need teams, there had been delays in holding strategy discussions when their risks had increased. As a result, some children remained in situations where their risk had not been fully assessed.

Assessments, including early help assessments, are comprehensive and make good use of research to inform practice. Social workers are knowledgeable about the children they are working with and use a wide range of effective direct work to understand their 'lived experiences'. Child protection and review conferences are timely and are attended by an appropriate range of agencies. These meetings analyse risk well.

The arrangements for responding to the needs of children and young people who go missing require improvement to ensure that children receive timely return home interviews, and rigorous safety plans to reduce risk. A small group of closely monitored and vetted bed and breakfast establishments have been used by housing for young people aged 16 and 17 at risk of homelessness to live in while their needs are jointly assessed by social care and housing. The local authority has acknowledged the urgent need to address the shortage of supported provision and while there are plans, it is too early to see any impact on the supply of supported provision.

Inspection findings

9. A wide range of coordinated early help provision supports children and young people in Cornwall. Early help services are now an integral part of the area's early help and protection services. Family support workers and targeted youth workers based in the early help locality teams work closely with partner agencies. A comprehensive range of evidence-based parenting programmes is available to parents and carers. As a result, some children's circumstances improve and others are quickly stepped up to targeted or specialist help.
10. The health and social care integrated early help hub, set up in October 2015 and located within the MARU, provides an accessible first point of contact for children, families and professionals. This ensures that children and young people who have identified needs but do not meet the threshold for a statutory service are signposted to the appropriate level of service within early help. Partner agencies have a good understanding and apply thresholds consistently.
11. In Cornwall, the 'Troubled Families' programme is being delivered through a range of direct delivery and commissioned services to support people with complex needs, including drug and alcohol misuse, domestic violence, unemployment and antisocial behaviour. Cornwall successfully met the target for phase one with 1270 families. Phase two has been launched with 711 families (689 target) identified in 2015–16.
12. Skilled multidisciplinary staff in the early help locality teams to produce detailed and analytical assessments that inform their work with families. Common assessment framework assessments completed by partners are more descriptive than analytical but contain sufficient information to ensure that children receive the right service. The number of children receiving early help in Cornwall has risen significantly, from a low base of 200 in 2011–12 to 2700 in 2015–16. Practitioners describe a culture change in the last few years and early help is now seen as everyone's business. Parents who spoke to inspectors highly value the help they receive, saying it was 'amazing' and 'brilliant'. They described real improvements in their children's lives as a result of the help they had received.
13. The MARU is the entry point for all new referrals from the public and agencies. Experienced social workers take good account of the risks identified at the point of referral, and incorporate historical information thoroughly. An experienced manager rigorously oversees all work. When the threshold for statutory intervention is met, cases transfer swiftly to children in need teams for further assessment. Nevertheless, the practice of opening only a referral on one child (usually the youngest), when brothers and sisters have the same or similar presenting need, means that not all children have an assessment based on their individual circumstances. This is likely to lead to under-reporting of re-referral rates and social workers' caseloads. Senior managers took swift action and issued renewed guidelines to managers in a response to learning from inspectors' findings (Recommendation).

14. When children are at risk of significant harm, in the large majority of cases, strategy discussions or meetings are timely. However, for a very small number of children's cases open to the children in need teams, there had been delays in holding strategy discussions when their risks had increased. As a result, some children remained in situations where risks had not been fully assessed. The quality of strategy meetings is variable with the majority comprehensively considering information and identifying clear actions. In weaker cases, they lacked clarity relating to actions, timescales and outcomes to inform effective planning (Recommendation).
15. Managers effectively oversee child protection enquiries which are prompt and thoroughly completed, and clearly outline risk and protective factors. Initial children protection conferences (ICPC) are timely: 83.8% in 2014–15 compared to statistical neighbours at 81% and the national level at 74.7%. The vast majority of plans are reviewed on time: 95.4% in 2014–15 compared with statistical neighbours at 97.8% and the national level at 94%. Multi-agency attendance and information sharing is good which contributes to effective decision-making and planning. Child protection conference chairs provide effective scrutiny and challenge to ensure alternative actions where planning is not securing the required change. Social work reports are comprehensive and include danger statements. Children and young people are encouraged to participate in child protection conferences. Advocacy arrangements are strong, with a presumption that advocacy will occur through an 'opt out' policy rather than 'opt in'. As a result, advocates have represented 418 children at ICPCs and review conferences in the last 12 months. This figure represents almost 80% of conferences at which the children's voice was heard.
16. The proportion of children in Cornwall subject to a child protection plan for a second or subsequent time in 2014–15 was 19%, slightly above statistical neighbours (18%) and England (17%). The local authority has a good understanding of the factors leading to children needing protection. At the time of the inspection, 413 were subject to child protection plans. Neglect featured in 54%, emotional abuse in 27%, physical abuse in 11% and sexual abuse in 8%. The number of children subject to a child protection plan under the category of sexual abuse has substantially increased from 31 March 2015 when 3% of children were subject to plans under this category. The local authority reports that this is due to awareness-raising of issues of sexual abuse and child sexual exploitation with social workers and partners.
17. Social workers demonstrate good awareness of the impact on children of domestic abuse, and have access to a range of specialist advice and services to support children and families. A domestic abuse and sexual violence needs assessment and work plan is in place. Progress to date has included independent domestic violence advisers based at the Royal Cornwall hospital, access to a specialist domestic violence perpetrator programme, and direct work with children and young people who have experienced domestic abuse. A specialist children and young person's violence adviser has successfully engaged with 84% of young people referred. There are six area-based multi-

agency risk assessment conferences (MARAC) held monthly across Cornwall that consider children living in households where domestic abuse is a risk. However, the levels of analysis, and consequently the quality of safety planning and following up of actions recorded by MARAC, are variable and require improvement. In 2015–16, 817 referrals (930 children in households) were made to MARAC, of which 38% (306) were re-referrals, which is above the national average of 25%.

18. The vast majority of assessments and plans are of good quality. They are explicitly informed by up-to-date research, explore all presenting and historical concerns, address areas of risk and need and clearly reflect the 'lived experiences' of children. Step-up and step-down processes are effective. When change has been effective, cases are appropriately stepped down using the 'team around the family' process. This ensures that there is continuity of support for children and their families and smooth transfer to early help locality team workers. In a small number of assessments, absent fathers and significant male adults are not always involved in the assessment process.
19. Social workers visit children frequently and develop strong relationships with them. Case recording is mainly up to date and clearly demonstrates the voice of the child. A particular strength of social work practice is the comprehensive individual work with children using a variety of creative tools to enable them to express their views and to inform assessments and plans. Diversity is considered in the vast majority of cases, including the Cornish identity, sexual orientation and faith, but more analysis could be undertaken to consider the impact in assessments.
20. A specialist multidisciplinary team works with children and young people with disabilities. Inspectors saw thorough and sensitive work with children and their families. Risks are identified and appropriately assessed and children are protected. Transition arrangements between children and adult services for children and young people are timely. A recent peer review (January 2016) identified positive areas of practice in work undertaken with children with disabilities, including child protection, court work and for children looked after, and good multidisciplinary working helped by co-location.
21. The local authority is effective in making sure that support is offered to prevent children coming into care, particularly teenagers, if this is possible. The innovative specialist edge of care service, Gweres Tus Yownyk, provides a dedicated multidisciplinary intervention support for teenagers. An independent evaluation in January 2016 found that 90% of the young people were able to remain at home. Of the 10% who came into care, more was understood about their needs due to the intensive assessment and therapeutic work undertaken. The evaluation also showed positive impact through improved communication within the family, improved emotional well-being and a reduction in offending, substance misuse, missing and child sexual exploitation.

22. The arrangements for responding to the needs of children and young people who go missing require improvement. The local authority's own audit, completed in December 2015, raised concerns about the consistency of approach and the quality of practice. A number of children and young people who go missing do not receive a return interview or do not receive it within 72 hours of their return. The local authority's data shows that out of the 63 missing episodes involving 50 children between January 2016 and March 2016, a number did not have a completed return home interview. As a result, important information is not available to inform future safety planning to reduce risk (Recommendation).
23. Multi-agency arrangements for delivery of services in response to child sexual exploitation have been too slow to develop. Awareness-raising sessions and training have taken place with a wide range of professionals, which have increased the number of risk assessments and referrals to MACSE. However, awareness-raising sessions and training have not occurred with transport providers, hoteliers or licenced premises around the warning signs to look out for with children and young people. Between 1 January and 31 March 2016, 116 child sexual exploitation risk assessments were completed. The quality of analysis and information gathering within these assessments is variable. Some good quality assessments were seen, but not all are sufficiently rigorous in identifying all risks posed. As a result, plans are often weak and do not routinely identify named individuals to complete particular actions, or do not incorporate timescales. The local authority is developing this work and has improved identification of children at risk of sexual exploitation but it is too early to demonstrate any measurable difference (Recommendation).
24. MACSE meetings are held monthly in venues across the county. MACSE considered 137 children in 2015–16, but the level of risk to these children is unknown as the information presented lacks detail, such as the level of risk and the age of the child. As a result, the local authority and partners do not hold an accurate picture of the prevalence of child sexual exploitation in Cornwall. Actions from MACSE are often incomplete and the level of scrutiny and challenge is not good enough. Safety plans lack specificity: they are not clear about who is taking action and by when and they do not prioritise the changes needed to reduce risks. Actions from a recent multi-agency review of child sexual exploitation have included the use of a disruption toolkit and a police detective inspector chairing the three area MACSE meetings to bring consistency and greater rigour to the quality of actions (Recommendation).
25. The local authority has effective processes in place for identifying and tracking children missing education and elective home education, and maintains up-to-date records. Tracking is thorough following clear procedural guidelines, with regular reporting to the senior management team. A wide range of registered education provision is effectively integrating children back into mainstream placements.

26. Children missing education are carefully monitored and tracked. Of the 384 children who had been missing from education during the last academic year, only 32 were missing at the time of the inspection, 24 were known to have left the country and six had been referred to other local authorities. A dedicated officer coordinates a well-resourced team that follows up on the circumstances of these children. The children missing education officer is part of the MACSE, ensuring that children missing education are fully considered and ensures that there is effective information sharing with schools.
27. A high number of children (529) are electively home educated in Cornwall. The local authority is aware of parents' reasons for choosing this option and the virtual headteacher maintains a close overview through effective analysis of information from home visits. Where additional needs are identified, appropriate liaison with other agencies is carried out. Outcome data is not yet collected for children electively home educated. Consequently, the local authority does not know the numbers who progress into post-16 education provision or become not in education, employment or training.
28. At the time of the inspection, the local authority reported that no young people were living in bed and breakfast establishments. Nevertheless, arrangements for the provision of services to 16- and 17-year-old homeless young people are underdeveloped. Young people are not routinely informed of their rights to be accommodated under section 20 of the Children Act 1989. A joint protocol agreed with housing is comprehensive, but there remains a shortage of supported housing provision to offer young people, particularly in certain parts of Cornwall. A small number of quality assured bed and breakfast establishments have been used. While this is not appropriate, substantive assessments of young people's needs were undertaken and significant levels of support provided to ensure that young people were safe. The local authority has acknowledged the urgent need to address the shortage of supported provision, and while there are plans it is too early to see any impact (Recommendation).
29. Significant awareness-raising and the development of clear policies have enabled the local authority and its partners to respond effectively to issues of female genital mutilation and radicalisation. There is good communication with the MARU when referrals are made and the 'Prevent' team has been proactive in giving advice in situations where potential concerns have been identified.
30. Management by the designated officer of allegations about professionals is thorough and the arrangements that support the work are sound. The work of the designated officer is clearly recorded and enquiries responded to appropriately and promptly. Cases seen by inspectors demonstrated a good response, with prompt and appropriate steps taken to protect children, and active follow-up to ensure that children are protected.
31. The service for children, young people and their families who need support and intervention out of hours is sound. Staffing is provided by daytime social

workers and family support workers who work additional hours to cover the shifts required in the out of hours service. The majority of referrals relate to open cases. In cases seen by inspectors, comprehensive support was effective in resolving difficulties for children and was appropriately passed to daytime services. Three children have been detained in police custody overnight between January 2016 and April 2016. The local authority is undertaking work with the police to understand the reasons for this. It is intended that learning from this work will inform future practice.

<p>The experiences and progress of children looked after and achieving permanence</p>	<p>Good</p>
<p>Summary</p> <p>Children looked after in Cornwall receive a consistently good service resulting in good outcomes with some very effective work seen by inspectors. The quality and timeliness of court work is particularly strong. The highest consideration is given to children’s stability and emotional well-being and co-working, inclusion and participation with the Children in Care Council. There is a strong collective ownership and understanding of corporate parenting and a high profile and commitment to young people looked after placed outside of Cornwall.</p> <p>Children looked after have regular effective reviews, clear permanence plans, comprehensive health assessments, a good range of leisure activities, strong direct work and quick access to extensive and skilled clinical in-house psychology services. Children looked after are fully supported by a skilled and committed group of social workers who know them well, visit them frequently and ensure that their needs are understood and that their voices are heard. The Children in Care Council is well organised, inclusive and reflective, and is highly effective as a result.</p> <p>Placement choice is provided through a group of well-trained and well-supported foster carers with continued emphasis to expand both in-house and external local provision. Short-term placement stability has had a high profile and the local authority continues to maintain a tight management oversight on placement moves for children. Despite continued effort, a small minority of children still have too many placement moves.</p> <p>Thresholds for children coming into care are understood well and children do not come into care unnecessarily. When possible, they are placed within their families or return home. A small minority of children return home without the full circumstances being understood or appropriate support. Risks for children looked after are understood well but there is too much variability of response to children experiencing sexual exploitation or who go missing from care.</p> <p>Adoption services for children are good and children are placed in a timely way with well-matched and well-supported adoptive parents. Care leavers are well supported into adulthood, making good progress in their studies, receiving effective support and living in suitable accommodation. Pathway plans are helpful but overly long and care leavers require better access to careers advice.</p>	

Inspection findings

32. Significant improvements have been achieved in services for children looked after in Cornwall since the previous inspection in 2011, when they were found to be adequate. These improvements reflect the continued thought, effort and resources invested in services for children looked after to achieve the good outcomes seen in this inspection. The local authority demonstrates persistent commitment to improving services, with a high profile given to improving emotional well-being and offering secure permanent placements for children looked after.
33. As at 31 March 2016, there were 431 children looked after in Cornwall and this figure has remained constant. The vast majority of these children are over the age of 11 (approximately 68%) and only 14% are aged under four years. The local authority has appropriately targeted its plans and services to meet the needs of these older children while maintaining good outcomes for younger children.
34. Decisions to look after children are appropriate and children are not taken into care unless it is necessary. Decisions are informed by clear analytical assessments with a good understanding of history and risk. The work of the Teylu family and pre-birth parenting assessment team is particularly strong. This team enables parents in higher risk circumstances to have a well-supported assessment of their parenting in a highly specialised parent and child foster placement. Appropriate management oversight was seen in the majority of cases, including thoughtful consideration on contact with birth families.
35. Pre-proceedings work and the use of the Public Law Outline (PLO) are consistently strong and supported by a skilled legal service. Separate PLO and care proceedings tracking systems, overseen by senior managers, are effective in avoiding drift and delay. The legal planning process is effective, supported by a legal planning checklist and a helpful 'Parents Guide to Public Law' which is written in straightforward language.
36. Court work is exceptionally strong with all the components in place for timely, analytical work. With an average of 18 weeks for care proceedings (compared to a national standard of 26 weeks), Cornwall is one of the top performers nationally for timeliness. This is underpinned by minimal use of expert assessments and analytical, well-evidenced social work assessments. The quality of work seen was consistently good and praised by the designated judge.
37. If children are able to return home, purposeful work is undertaken to ensure that this happens in a safe and timely way. This work includes good cooperative relationships with parents, good partnership working and thoughtful and creative direct work with children, including looking at timelines of family history. In a small minority of cases, the planning process was insufficient with the home environment not fully explored and no formal meeting to plan the

move and support plan. For some, the support for the family lost momentum once the child had returned home (Recommendation).

38. Children looked after have stable relationships with social workers who know them well and ensure that their needs, including their emotional needs, are met well. Clear processes are in place for children looked after to make a complaint. The recent introduction of a self-advocacy application for mobile phones, Mind of My Own (Momo), has 64 young people signed up. This was seen in practice for a young person to raise a concern. Nine young people are matched with independent visitors who offer enduring support for children, with one child having had the same independent visitor for ten years.
39. Risks associated with child sexual exploitation and missing are known for individual children looked after. Strategy discussions are held and secure accommodation is used or considered for those at highest risk. In cases seen during the inspection, risk assessments and action taken were too variable. For example, some children receive a return home interview on the day of return and others not at all. More consistency in response, and analysis of push and pull factors is required to ensure that every child's individual needs are met. Findings from an audit completed by the local authority in September 2015 and a sector-led peer review identified many of the deficits seen in this inspection (Recommendation).
40. A well-resourced team of skilled nurse practitioners, psychologists and therapists, funded by the local authority in partnership with the children's community health provider, meet the health needs of children looked after effectively. These practitioners balance physical health needs with a clear understanding of history, trauma and attachment. The team regularly reports on performance data and the qualitative experience for children through a 'rate my health assessment' form. Team members are strong advocates for children looked after, including those placed outside of Cornwall. As a result, in 2015, 85% of initial health assessments were completed within 28 days and 99% by 42 days. Annual health assessment performance stood at 98% of children under the age of five and 90% of over fives. The local authority reports that the figures for 2016 are close to these, at 95% and 88% respectively, but have not yet been adjusted for the end of year.
41. Educational needs for children looked after are generally met well by the local authority, with 75% of pupils in good or outstanding schools. Risk assessments are undertaken for those in schools judged to require improvement. Outcomes for children looked after in early years show that their expected levels of development are just below what might be expected of them for their age. Cohort sizes, however, are small and are subject to fluctuation. Outcomes in reading, writing and mathematics are improving at key stages 1 and 2 but they are still, overall, below national rates of all pupils.
42. At key stage 4, the percentage of those gaining 5 A*-C including English and mathematics is above the national average for children looked after, but below

the national average for all pupils, and is still too low. The local authority has analysed this, understands where the difficulties are and has put in place measures to improve the progress of pupils (Recommendation).

43. The children in care education support services (CiCESS) and the virtual head closely monitor the educational achievements of children looked after and report through fixed updates to senior managers and the directorate management team.
44. The CiCESS effectively monitor absences of children through termly meetings with schools. They provide additional funding when needed and support to enable pupils to make a successful return to school. The average attendance of children looked after is above the national and the south west rate and is evidence of the effective working and strong partnership between the schools, CiCESS and foster carers. There have been no permanent exclusions of children looked after during the academic year (2014/15). However, fixed term exclusions have risen from previous years, to 132 in 2014/15.
45. The Personal Education Plan (PEP) coordinator is having a positive impact on monitoring the completion of PEPs. As a result, the quality of PEPs has improved, along with timeliness and numbers in place, moving from 87% in the summer term of 2015 to 95% in the spring term of 2016. The virtual head quality-assures PEPs, which has effectively improved the quality. However, there is no formal recording of learning from PEPs and further work is required to ensure that there is greater involvement and understanding of the PEPs more widely among staff in schools. A regular review of PEPs is one mechanism for monitoring and tracking, along with regular pupil progress meetings held. CiCESS teachers and higher-level teaching assistants support individual children who have had problems with attendance and with transitions from the primary to secondary phase of their education.
46. The CiCESS provide good support to schools to help children improve their confidence and study skills as well as using the pupil premium for a range of appropriate activities. The virtual head and the CiCESS have undertaken effective training with school governors, school staff, independent reviewing officers' (IROs), foster carers and some parents on use of the pupil premium and the use of the personal educational allowance.
47. Children looked after live in safe, well-supported placements. Placement moves for the majority of children are appropriate and well planned. An audit undertaken by the local authority in October 2015 showed that nearly 60% of moves were planned for positive reasons. It also identified further work to be undertaken to meet the placement needs of adolescents, including the matching at the time of placement and a shortage of foster carers for this group.
48. Improving short-term placement stability for adolescents continues to be a priority. The local authority has invested significantly to broaden services,

including expanding the GTY service and a plan to train all staff undertaking direct work with adolescents. The local authority is not yet achieving its target of less than 14% of children having three or more placement moves. An audit in October 2015 showed decisions about placement moves relating to younger children are appropriate. However, the experience for all children is not yet consistently good and more work needs to be done.

49. The local authority has recognised these placement issues and has clear actions and processes in place. These include monthly senior management monitoring, a clear placement recruitment strategy and good working relationships with providers to offer local residential and fostering placements. Creative and flexible commissioning has assisted in 17 new residential placements being available, six in Cornwall and 11 just 20 miles outside the local authority boundary.
50. Planning for children looked after is effective, resulting in clear plans, timely actions and agreed outcomes. Reviews take place on time, with the local authority consistently exceeding the target of 95% of reviews taking place on time. Care plans are clear, analytical and outline what needs to happen, by whom and by when. The effectiveness of permanency planning is supported further by having review meetings every three months for all children under the age of eight. Consequently, young children have permanence planning independently overseen frequently and this reduces the possibility of delay or drift for younger children.
51. The IROs' practice is strong. IROs provide added value by offering helpful analysis and the balancing of options through the review process. Permanency is appropriately considered at all second reviews. Inspectors saw clear and coherent evidence of strong permanence planning underpinned by a helpful permanence policy to guide practice. The IROs challenge practice when necessary. However, the management of this service needs to monitor this formally.
52. Effective permanence planning over the last 12 months has resulted in 31 adoption orders, 46 special guardianship orders and 24 agreed permanent fostering matches, representing a significant proportion of permanent arrangements for children and a sense of legal and emotional belonging. Children are prepared well for permanence and are routinely invited to attend the fostering panel. As part of an agreed protocol with adult services, up to 10 carers have changed status and become part of the 'Shared Lives' scheme to continue to offer young people a family experience into adulthood.
53. In cases seen by inspectors, decisions that children should live out of the county were appropriate. Senior managers only make these decisions when a highly specialised resource is required to meet their needs, which is not available within Cornwall. At the time of the inspection, 71 children (16.5%) lived outside the local authority area. The experience of these children is well understood and is given a high priority. Social workers visit them regularly and

their progress is closely monitored. They are included in celebration events and the corporate parenting board fully considers their experience.

54. The local authority fostering and placement services are effective and are underpinned by a good strategic plan. Although more carers left than were recruited in 2015–16, the service has not lost any carers due to dissatisfaction and has a skilled, committed and well-trained group of carers. Delegated authority is in place and understood and used by foster carers. This ensures that they make day-to-day decisions to facilitate a wide range of leisure activities and interests for the children and young people they look after. Foster carers are trained in the use of the pupil premium and ensure that it is used effectively to meet children's and young people's needs.
55. The local authority effectively prioritises placing brothers and sisters together, where this is in their best interests. Where this is not the case, arrangements for contact are well considered to ensure that brothers and sisters retain appropriate and meaningful contact with each other. Good consideration is given to placing children with family and friends. The vast majority of viability assessments seen by inspectors were of a good quality. Special guardianship orders (SGOs) are used effectively as a way to ensure permanence and that carers continue to be well supported by the family plus team. The family plus team is actively supporting 82 families where children are subject to SGOs.
56. Cornwall's foster carers are well supported by the local authority to develop their skills in meeting the needs of the children they look after. Foster carers report that they feel fully included as part of the professional team responsible for children looked after, and they universally praised children's services for the high quality social work support for themselves and children.
57. Diversity is considered appropriately in the vast majority of cases, including the Cornish identity and the importance of placing children locally if possible. While more analysis could be undertaken to consider the impact, some exceptional work was seen in ensuring that individual children had their identity needs met and supported.

The graded judgement for adoption performance is that it is good

58. Adoption is considered appropriately as a permanent option for all children who cannot live with their birth family. The local authority makes timely decisions for children who need to be adopted. Although there was a small decrease in the number of decisions to place children for adoption during 2015–2016 (from 35 to 31), other permanence options increased, such as special guardianship orders (46) and child arrangement orders (7).
59. The adoption scorecard for 2012–2015 shows that children in Cornwall waited an average of 413 days between entering care and being placed for adoption. This compares to 593 days for England, 492 days for statistical neighbours and is 74 days shorter than the national threshold of 487 days. The average time it takes to place children with their adoptive family has increased to 464 days in 2015–2016. The average time that children with a placement order waited to be matched during 2012–2015 was 162 days. This is better than the England average at 223 days and statistical neighbours at 187. The number of harder to place children waiting for adoptive families in Cornwall, including brothers and sisters, older children and those with extremely complex health needs, has had a significant impact on this performance. Despite this, the local authority's performance remains strong and the local authority continues to meet thresholds set out in the adoption scorecard.
60. A dedicated team leads recruitment of prospective adopters. Advertising materials are of good quality and a range of creative marketing approaches are used to widen coverage. National and regional systems are used early to strengthen family finding activity. The recruitment team supports adopters through the initial enquiries stage, as well as undertaking stage one of the assessment process. Adopters who spoke to inspectors were positive about their initial contact with the local authority adoption agency. They spoke about information being clear, the training helpful and the assessment process thought provoking.
61. Recruitment has been revitalised to reflect the changing profile of children waiting, with an emphasis on seeking to recruit prospective adopters for older children, brothers and sisters and those with complex needs. The local authority is actively recruiting prospective adopters for 'fostering to adopt'. Although numbers of these remain relatively low (with three in place at the time of the inspection), those seen were providing an opportunity to avoid further changes should children not be able to return to their birth families.
62. Assessments of prospective adopters are of a good standard. Since the redesign of the service, independent social workers complete stage two assessments. Consequently, the timeliness with which assessments are completed has improved considerably. However, too few stage one

assessments are completed in the required timescales due, predominantly, to delays in adopters' medicals, or in progressing Disclosure and Barring Service checks. The local authority has taken action to address this by introducing a tracker system to identify and respond to delays. Despite this work, the timescales for stage one assessments remain above national targets, at 85 days at the end of 2015– 2016.

63. The local authority is tenacious in seeking to match children with prospective adopters, though this has taken considerable time for some children with very complex needs. As a result, there has been an overall decline in the average time it takes between the local authority receiving authorisation to place and deciding on a match, at 276 days. In all cases seen by inspectors where there had been such delays, these had been purposeful and work had progressed at the child's pace. Despite this, the overall time it takes between children becoming looked after and being placed for adoption is good. Once placed, adoption orders are progressed within appropriate timescales for the vast majority of children.
64. Weekly family finding meetings effectively track children's progress towards permanence. At the time of the inspection, 20 children were subject to a placement order, with six of these tentatively matched with prospective adopters. Twenty five prospective adopters had been approved and were waiting for a match.
65. Learning from two adoption disruptions over recent years has informed the approach to adopters' assessments. Assessments examine adopters' attachments using adult attachment interviews. Matching uses a range of approaches, including the use of timeline meetings (similar to life appreciation days), which map the child's experience. Adopters spoken to by inspectors said this approach had been invaluable in helping them to understand their children's early experiences.
66. The panel and agency decision-making process is effective. The adoption panel is appropriately constituted, meets regularly and rigorously scrutinises practice. The panel provides a rigorous quality assurance function for child permanence reports and prospective adopter reports. The quality of reports has improved since this process was established, but there is still further work to do to strengthen the quality of child permanence records. These do not consistently provide sufficient detail to enable a comprehensive understanding of the impact of the child's history on future placement decisions (Recommendation).
67. The agency decision maker is knowledgeable and scrutinises panel recommendations to ensure that decisions for adoption are in children's best interests and that children are matched to families that will meet their needs. Decision-making is timely and thoroughly explores wider issues including post adoption support and children's ongoing needs for contact. Together or apart assessments are not used consistently to inform decisions about whether brothers and sisters should remain together. Consequently, some children may

grow up without an understanding of the rationale for being placed apart from their brothers and sisters. (Recommendation)

68. Thoughtful and considered work takes place to support children who move from foster care to their adoptive families. The panel medical adviser provides excellent advice and consultation to prospective adopters when considering potential matches with children. A further strength is the support provided by the in-house psychology service, jointly provided with the local children's community health provider. Psychological interventions, recovery well-being plans and attachment workshops provide invaluable support, helping to improve children's emotional well-being and preparing them for adoption.
69. Sensitive and child-centred direct work is undertaken with children to prepare them for adoption. Life story books seen by inspectors were comprehensive and of good quality, but are not consistently completed early enough for all children. The local authority had recognised this shortfall prior to the inspection and was already in the process of recruiting to a post to carry out this function.
70. Adopted children and their adoptive families are well supported after placement, with 80 families in receipt of such support at the time of the inspection. Adoption support is provided swiftly in response to identified need and there are no adopters waiting to receive a service. Adoption support plans are thorough and provide sound analysis of children's and adopters' support needs. Multidisciplinary support is of a high quality, particularly psychological and paediatric input, which adopters value highly. This support is having a strong and positive impact for those families accessing the service, reducing the potential for disruptions in the future.

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

71. The local authority care leavers' team, 16-plus, provides effective support to 194 care leavers. Personal advisers know their young people well and are in contact with the vast majority (98%). Personal advisers have manageable caseloads, and they contact and visit young people regularly. Care leavers spoke positively to inspectors about the help and support they receive, particularly from their personal advisers.
72. At 16 years of age, a personal adviser works alongside the young person's social worker. This practice ensures a smooth transition to leaving care services and enables young people to build up a relationship with their personal adviser prior to case transfer at their 18th birthday. Transition planning for care leavers who require adult social care begins soon after their 16th birthday, thereby reducing uncertainty and anxiety for young people. A small number of foster carers have converted to 'Open Door' and 'Shared Lives' and provide long-term

care to young people with disabilities. A high proportion of care leavers stay with their foster carers beyond the age of 18, with the number increasing. For example, in 2015–2016, 43 care leavers 'stayed put' with carers after their 18th birthday, an increase from 31 in 2014–2015.

73. The vast majority (97%) of care leavers live in suitable accommodation. Bed and breakfast establishments have not been used in the past 12 months and are only ever used in an emergency for very short periods. A dedicated housing officer works with care leavers who have access to a range of housing options. The 'Open Door' project provides an appropriate range of suitable supported lodgings and similar accommodation for 50 care leavers, enabling a good match of need to accommodation. An effective media campaign has increased recruitment of suitable providers. Care leavers told inspectors that they felt safe where they were living and were positive about the genuine attempts to meet their preferences.
74. Young people are encouraged to keep in touch with support workers. For example, care leavers who are parents spoke positively about the help they received from the family nurse practitioner, personal advisers and with assistance to continue with their studies. One care leaver, in higher education, described their personal adviser as 'magic' for the swift and decisive way she managed to sort out financial help.
75. Regular and helpful outreach support is available in many places, and takes account of the geography and rural nature of Cornwall. Care leavers are able to drop into offices for help or advice if they wish. However, some of the buildings are not welcoming to care leavers, or are not conducive to providing 'on-the-spot' counselling or support to a young person needing help. Care leavers receive effective support in their journey towards independence, primarily from their personal advisers, especially in helping them to understand and manage their finances. Personal advisers use a well-designed independence toolkit to aid care leavers and accommodation providers to assess the levels of help needed. In 2015–16, 47 accommodation providers received specific training on independent skills support. Each young person in 'Open Door' accommodation, a service run by the 16-plus team, receives 12 hours targeted support a week to help them to build confidence and independence to adulthood.
76. Good attention is given to meeting the health needs of care leavers. The designated nurse for care leavers provides targeted help for young people when they need it. For example, by signposting to services for drug and alcohol services, sexual health and pregnancy support. A compact health passport, launched more than two years ago and designed by care leavers, is a useful document, which records all essential information in one place. One young person expresses its value as 'helpful and handy, all info in one place'. However, the accessibility of the child and adolescent mental health service (CAMHS) for care leavers remains an area for further improvement. The recent appointment of a dedicated psychologist is a positive move to increase the

availability of psychological and emotional support. The impact of this recent development is yet to be seen.

77. Care leavers receive good financial help. Young people are able to make an application for additional funds to the care leavers' council. This is a council where care leavers themselves make decisions based on agreed criteria, such as quantifying how this would make life better for the young person. Personal advisers help care leavers to manage their budgets and spend their money wisely. The vast majority of care leavers are aware of their entitlements. A leaving care booklet 'Leap', designed by care leavers in Cornwall, is a lively, informative guide which clearly and directly sets out legal entitlements such as financial support, how to complain and rights to health histories in a language and format that is user-friendly.
78. Support for care leavers to remain in education, employment or training is good. Partnerships with local providers and local colleges are effective. PEPs are in place to support the education of care leavers at key stage 4 and key stage 5. Young people are encouraged to attend taster days at local universities. Twenty five care leavers are studying at university. Young people who are harder to engage receive effective targeted support to enable them to re-engage in education, employment and training. In 2015, 185 (74.3%) of 16 to 21 year old care leavers were in education, employment or training. This is well above the national rate for care leavers. Personal advisers are in touch with 36 of the 37 care leavers who are not in education, employment or training and they know each of the reasons for this.
79. Pathway plans, although comprehensive and detailed, are too long. Care leavers find that there is often too much information to review and take in. The plans do not pay sufficient attention to how care leavers might improve their emotional and psychological well-being and needs. Additionally, the pathway plans do not give enough attention to the views of care leavers and are written for young people rather than written with them. Consequently, these limit their usefulness for care leavers in planning their journey towards adulthood. Managers acknowledge that this is an area for development (Recommendation).
80. The local authority employs only one care leaver as an apprentice. Although there are plans to take more care leavers as apprentices, the local authority has not previously done enough to increase the opportunities for care leavers to become apprentices.
81. A particular strength of the local authority is the involvement and consultation with care leavers. Two care leavers sit on the fostering panel and a care leaver is the vice-chair of the virtual school. An annual celebration of achievement is held every year during national care leavers' week and is attended by senior managers. Children in care and care leavers are part of a choir, which practises regularly and performs proudly in public.

Leadership, management and governance	Good
<p>Summary</p> <p>Leadership, management and governance are good. The DCS is a strong and confident leader, effectively supported by the chief executive and the senior management team. Together, they have worked successfully to continually develop services for children and young people and have effectively responded to areas for development identified in previous inspections. As a result, services for children looked after, children who are adopted and care leavers are much improved. For the vast majority of children and young people who need protection, action is immediate and risks are effectively reduced. However, more work is needed in some areas. For example, to strengthen the management and scrutiny of children and young people at risk of going missing and at risk of child sexual exploitation, to provide appropriate accommodation for vulnerable homeless 16 and 17 year olds, and to ensure that all children in need benefit from an assessment and plan that is tailored to their individual circumstances.</p> <p>The early help hub, commissioned jointly with children’s community health services, is effective in ensuring easy access to the right help from universal and targeted services. Social work teams are increasingly multidisciplinary, with significant contributions from educational psychologists.</p> <p>Significant investment in high quality training for social workers, other social care practitioners and partner agencies has ensured that there is a whole-system approach to improving outcomes for children. Social work staff have manageable caseloads across the services and this ensures that social workers spend time with children and young people. A particular strength of social work practice is the comprehensive individual work with children using a variety of creative tools to enable them to express their views and inform assessments and plans. Staff feel valued and respected and have access to effective managers who are experienced, approachable and are regularly accessible to staff. As a result, the workforce is stable.</p> <p>The lead member visits staff teams regularly and is well informed and respected for his energy, passion and advocacy for children and young people. The corporate parenting board effectively engages with children looked after and care leavers. Elected members are well aware of the issues affecting children and young people. Strong performance management systems provide detailed data and analysis for staff, leaders and partners to monitor and develop services effectively. Clear governance arrangements between a range of strategic boards, including the Local Safeguarding Children’s Board, the Children’s Trust, the Health and Well-being Board (H&WBB), Safer Cornwall Partnership and the Emotional and Mental Health Wellbeing Board (E&MHWB), ensures that there is clarity of the role for each board and avoids duplication.</p>	

Inspection findings

82. The local authority has made a sustained improvement to the quality of services to children and families since 2011, particularly since the previous Ofsted inspection in 2013. Social work caseloads have reduced and the workforce is increasingly stable and skilled. Early help services are well coordinated and provide good quality, targeted support at an early stage.
83. The vast majority of the recommendations for the inspection of child protection services in 2013, and safeguarding and looked after children's services in 2011, have been implemented successfully. More work is needed in some areas, such as ensuring that each child has an individual child in need assessment and plan.
84. Staff from a range of agencies are co-located in the MARU and EHH, which provides an effective front door to services. Early help support for families is strong and prevents problems re-emerging. Management oversight of practice in the majority of cases is clear and evident in casework. Staff receive regular supervision and report good support from managers.
85. Senior managers, leaders and elected members discharge their individual and collective responsibilities well. The DCS and the head of service have been in post since 2010 and 2011 respectively, and have overseen extensive changes in practice. As a result, services have been refocused and are now firmly established, and effectively support children and young people.
86. The lead member for children is visible and effective. He attends both the Children's Trust Board (CTB) and the LSCB and provides regular briefings to elected members. He routinely visits frontline teams and children and young people. Elected members take their role as corporate parents seriously. They ensure that sufficient funds are in place to support developments and improvements for children looked after. For example, funds raised from the selling of a children's home were used to fund the adolescent edge of care service (GTY) which is now core funded.
87. Appropriate arrangements for governance, leadership, scrutiny and challenge are in place. The role of the DCS has substantially expanded since 2014 and now includes responsibility for adult social care and public health. However, there has been no test of assurance. This means that the local authority cannot be sure that the DCS has sufficient capacity to effectively lead and manage the range of services for which he has responsibility.
88. Performance management and quality assurance arrangements are comprehensive and well established. Senior managers scrutinise and analyse performance, which is disseminated to managers effectively. Managers use performance information routinely to assess the quality of the work of their team. This enables shortfalls to be addressed and prompt action to be taken.

89. Managers regularly undertake case file audits and make good use of learning from both compliance and the quality of work with children and families to develop and improve practice. Senior managers require a follow up audit to identify and understand the reasons for any identified deficits and ensure that swift actions have been completed to resolve them. A quarterly conference uses a 'Turning the Curve' exercise with service groups to aid discussion about specific service areas of performance and agree action to improve practice. The LSCB chair has an open invitation to attend these conferences. Learning, from recent deep-dive audits on missing children and child exploitation and external peer reviews, has been used to address shortfalls systematically. For example, a renewed and clearer emphasis on child sexual exploitation and children missing, return home interview processes that trigger a child sexual exploitation risk assessment, and revised terms of reference for the MACSE meeting, including the attendance of a police analyst.
90. Children's services performance indicators are reviewed by the directorate and corporate leadership teams and by both the Children's Trust and LSCB. The lead member and the head of service meet monthly to review performance to improve understanding of the service. Good use has been made of findings from a number of peer reviews and internal audits to target areas for improvement. The local authority's self-assessment and service plan accurately reflect the majority of the findings from this inspection, such as data regarding children at risk of child sexual exploitation and information from return interviews not being collated and analysed sufficiently (Recommendation).
91. The chief executive, lead member and elected members have a sound understanding of the strengths and weaknesses of the service. Links are clear between the chief executive, the DCS and the LSCB chair, with regular meetings in place, roles are clearly defined and understood. As a result, the needs of children are effectively prioritised.
92. The corporate parenting board is well established, well attended and effective. Children and young people attend the corporate parenting board twice a year. The board has ensured that issues that are important to children and young people are addressed. These include an apprenticeship scheme for care leavers, work experience within the council for 15 to 16 year old children looked after and providing support to children and young people to get home safely from meetings and social activities. The corporate parenting strategy needs updating to ensure that priorities are appropriate for the future.
93. The CTB is the overarching governance body for children in Cornwall. The board has five delivery priorities, which are aligned with service improvement plans. Each priority has identified leads, plans and governance accountability. The CTB reports to the Health and Well-being Board (HWB). Children's services have been at the forefront of integration of social care, education and health in Cornwall and the governance arrangements have been pivotal in this progress. For example, the HWB used its position to support the DCS in the development of the early help hub to ensure that partners met their resource

commitments in a timely way and that the initiatives progressed as planned and on time.

94. Kernow Matters is the needs assessment of children and young people in Cornwall and complements the joint strategic needs assessment (JSNA). The local authority and partners have identified that the JSNA needs refreshing to reflect priorities for children, including child sexual exploitation and children missing.
95. The local authority has a range of both externally commissioned and in-house services for children and young people. Comprehensive monitoring of these arrangements is in place. Young people participate in the commissioning process for every commissioned piece of work. Recent management changes in the Clinical Commissioning Group (CCG) have affected the progress of an integrated commissioning strategy. Existing contracts with health providers for children and young people are in place and will continue until April 2018.
96. The local authority has a positive relationship with the Children and Family Court Advisory and Support Service and a good reputation in the local court. Cases are filed on time and social work statements are of high quality, reducing the need for 'expert' witnesses and delays for children.
97. Arrangements to deal with complaints are in place with learning effectively disseminated to staff. Staff work hard to resolve issues before they become complaints. A self-advocacy tool, Momo, and the high use of advocacy have made it easier to engage children and young people so that important issues can be dealt with at an early stage. As a result, no complaints have been received from children and young people during the period April 2015 to March 2016.
98. Social workers are well trained, have manageable caseloads and regular supervision. Supervision records seen by inspectors displayed a strong focus on the 'lived experience of children' with some demonstrating critical reflection in considering actions needed when insufficient progress is made. The local authority has invested significantly in a core curriculum for social workers, with a comprehensive career path for social workers through to team manager level. A trainee social work scheme has 18 social work trainees at any one time to establish a social work workforce for the future, and a further assessed and supported year in employment programme that aims to build up resilience. Since the schemes started in 2012, 33 of the social workers recruited are still working for Cornwall. This has reduced vacancy rates from 16.8% in September 2015 to 14% in February 2016. Reliance on agency staff has also reduced from 27 in September 2015 to 22 in February 2016.
99. A particular area of strength of the local authority is the involvement and consultation with young people who are looked after. Two care leavers sit on the fostering panel, a care leaver is the vice chair of the virtual school and the Children in Care Council co-hosted the annual social work conference. Young

people routinely take part in the training of foster carers and the recruitment of new staff members. The local authority acts upon issues raised by children and young people. For example, a survey completed by young people in the 16-plus team found young people required more support to increase friendship groups, so changes were made to the psychological support available to them and their carers to promote social relationships.

100. Short-term placement stability for children looked after is a challenge for the local authority and rightly has a high profile. The local authority continues to maintain a tight management oversight on placement moves for children. Despite continued effort, a small minority of children still have too many placement moves.
101. The Children in Care Council, known as Voice4Us, is vibrant, committed and dynamic. Supported through a contract with the voluntary sector, Voice4Us has a programme of recruiting and training peer mentors and peer befrienders to ensure that children looked after are supported by each other. Particularly on social isolation, emotional well-being and attachment.

The Local Safeguarding Children Board (LSCB)

The Local Safeguarding Children Board requires improvement

Executive summary

The LSCB is a joint board covering both Cornwall and the Isles of Scilly. The board requires improvement to be good, but is making substantial progress and is well positioned to enhance significantly the coordination and effectiveness of safeguarding arrangements for children and young people in the county. The LSCB is meeting its statutory responsibilities and has made significant progress in developing strategic partnerships and shared priorities over the last year. The board has narrowed its attention to five major priorities, providing a clearly defined pathway for measuring the performance of partner agencies. The board has addressed gaps in partner agencies' capacity to provide performance information and outcomes, illustrating how children's and young people's safeguarding is central to their provision of services. Quality assurance and scrutiny panels rigorously challenge all partner agencies. These processes are transforming partner agencies' ability to self-assess and improve their oversight of safeguarding children and young people, while simultaneously developing inter-agency knowledge and cooperation.

The board has only recently coordinated multi-agency arrangements for responding to young people at risk of sexual exploitation. This means that the board lacks an understanding of the prevalence and extent of child sexual exploitation in Cornwall and the capacity to disrupt and prosecute perpetrators. The board's child sexual exploitation and missing sub-group is unable to use intelligence from children and young people who go missing with risks of exposure to sexual exploitation to evaluate patterns and associations.

The board has not provided a comprehensive multi-agency auditing programme to test the quality of practice and services to inform improvements. This is being remedied, but the impact on multi-agency service development and improvement remains to be demonstrated. The board is not yet systematically evaluating the effectiveness of early help services.

The influence and participation of children and young people in understanding and informing board priorities, and providing ongoing feedback, is in its infancy. The board has a comprehensive multi-agency training programme, ensuring that lessons from serious case reviews (SCRs) are carefully promoted across partner agencies. The board has a strong interest in children looked after performance indicators. It has recently challenged a notable increase in short-term placement instability and monitors a considerable number of other performance indicators concerning this group of children and young people. The board's strategic relationship with the corporate parenting panel could be more precisely outlined to avoid duplication and confused accountability.

Recommendations

102. The board should develop, through recently reformed governance arrangements, a better strategic understanding and response to raising awareness of, and responding to, child sexual exploitation.
103. The board should ensure that multi-agency audits provide an effective overview of frontline practice and inter-agency cooperation to safeguard children. Audits should include frontline practitioners, managers and children to provide inclusive, comprehensive intelligence and be repeated, where indicated, to evaluate the rate of progress.
104. The board should ensure that children and young people have more influence in forming the board's priorities and that feedback from their experiences regarding multi-agency safeguarding arrangements is well-considered. This should include methods for an ongoing feedback loop with children and young people.
105. The board should evaluate the impact of early help services across the partnership.
106. The LSCB annual report should fully reflect the analysis and conclusions that the board has reached concerning the effectiveness of multi-agency safeguarding arrangements.
107. The board should determine lines of accountability with the corporate parenting panel, prioritising the safety and welfare of children and young people who are looked after outside Cornwall and who go missing.

Inspection findings – the Local Safeguarding Children Board

108. Following a self-assessment in September 2015, the LSCB is purposefully addressing all recommendations arising from it. The board's presence and impact in calling to account the children's safeguarding priorities of other boards is gaining momentum within the Children's Trust, the H&WBB, the Safer Cornwall Partnership and the E&MHWB. The impact of stronger partnerships is illustrated in an objective to improve the range, quality and access to emotional and mental health well-being services becoming one of the board's five priorities.
109. The board provides rigorous scrutiny of partners' performance. For example, the board regularly challenges the CCG and the E&MHWB on the pace and breadth of reforms, influencing the progress of the CAMHS transformation programme.

110. Earlier frustrations experienced by the LSCB in monitoring the effectiveness of local multi-agency safeguarding arrangements have been assertively addressed. This has been achieved through setting up scrutiny panels in which all board partners have to demonstrate and evidence the rigour and effectiveness of their operational safeguarding arrangements. Partners are questioned on six common core safeguarding themes, including child sexual exploitation and missing children, the quality of their single agency audits, and how children and young people are involved in their decision-making. A further set of questions are tailored to the service priorities of each partner agency. Partner agencies are required to provide quantifiable evidence in support of their self-assessments.
111. The board has identified, through its scrutiny panels, considerable gaps and shortfalls in partner agencies' capacity to respond consistently well to indicators of children's safeguarding. By contrast, children's social care standards are of a higher quality. The majority of agencies scrutinised are found to be needing improvements with a minority of good practice and services highlighted. This level of scrutiny has strengthened the culture of multi-agency cooperation and accountability through peer challenge and public oversight. Recommendations are closely tracked and scrutiny reports published on the LSCB website. Partners are expected to make timely progress towards better outcomes. The board's understanding of the quality of multi-agency safeguarding, while rapidly developing, is not yet complete.
112. The LSCB has engaged productively with the Safer Cornwall Partnership, building awareness and strategic and operational responses to issues such as modern slavery, radicalisation and female genital mutilation. The board continues to develop its influence in holding other strategic boards to account. It has, for example, successfully influenced and increased the content for young people in the H&WBB 'Preventing Suicide Strategy' for Cornwall and the quality of safeguarding 'Together For Families' programme (Cornwall's 'Troubled Families' initiative).
113. The board has not yet introduced a comprehensive programme of multi-agency audits to inform its understanding of the quality of frontline practice and management oversight. An independent multi-agency case audit, linked to board priorities, was commencing at the point of the inspection. This is the first audit where a significant volume of cases will be reviewed. The frequency and quality of single agency audits were identified as weaknesses in the scrutiny panels, typically confined to testing the quality of referrals to the multi-agency referral unit. The quality and value of single agency auditing in children's social care is more established. Repeat audits will be undertaken where progress against recommendations is judged too slow and this, in due course, will add to the board's understanding of frontline multi-agency safeguarding practice.
114. The board has not given sufficient attention to include the views of children and young people in deciding its priorities, nor sought their contributions to the evaluation of multi-agency safeguarding. Partner agencies are asked to self-

assess the inclusion of children's views in their scrutiny panel presentations to the board, but the impact of consultation with children and young people is yet to be demonstrated. The LSCB website is not an attractive or interactive platform for children or the wider public to engage with the board. Plans to modernise this should be implemented as soon as possible. This will help in the board's aspiration to achieve an ongoing exchange with children, helping to understand how safe children feel in their schools and communities.

115. A multi-agency strategic and operational response to child sexual exploitation and missing children is in place but is yet to be fully tested in reducing the effectiveness of frontline practice. Efforts to tackle this shortfall have been delayed across key partner agencies and the board has only recently addressed this concern with sufficient energy. The board's recent changes to the governance arrangements have strengthened its ability to improve. In particular, the amalgamation of the child sexual exploitation and missing sub-group, along with the appointment of a police superintendent to chair it, supported by senior managers from partner agencies, provides the seniority required to achieve improvements.
116. The board has purposefully led improvements to three multi-agency child sexual exploitation panels operating in Cornwall. Since April 2016, the panels have been chaired by a police detective inspector to bring consistency and greater rigour to the quality of chairing, information sharing and analysis of data and intelligence. The board has been active in improving both the quality and volume of returns of partner agencies' section 11 reports. The large majority of agencies submit returns and the board's increased engagement, particularly with schools, has resulted in almost all schools completing section 175 returns. The board has assessed the content of reports more closely than previously, returning them for further work when required, and conducting monitoring visits to schools to evaluate compliance in on-site reviews. The board's scrutiny panel process is aligned with major section 11 themes, adding a further layer of checks and balances.
117. The board facilitates a varied and carefully targeted programme of training through the learning and development group and training contract monitoring group. A diverse pool of experienced trainers, many with extensive operational and practitioner backgrounds, deliver well-evaluated courses to practitioners, first line and senior managers. Careful training needs analyses and emerging themes from local learning and serious case reviews are considered, allowing course content to adapt to intelligence from multi-agency practice. Course capacities and allocations for optimising the attendance of agencies are carefully planned, and patterns of low attendance from some partner agencies, particularly adult agencies and the police, are challenged. Certificates validating professional development are issued three months after attendance, when both practitioners and managers have completed reflective learning feedback, demonstrating how learning has informed subsequent improved practice.

118. Serious incident notifications are thoroughly scrutinised by board partners through the SCR sub-group, with appropriate and timely recommendations reviewed and endorsed by the chair. Opportunities for learning from cases not progressed to a formal review are generated through local learning reviews. Learning from SCRs is well integrated with lessons concerning fabricated illness carefully disseminated across health and social care settings following publication of an SCR in 2014.
119. The board is innovative in considering different methods of distributing learning from a range of activities. The board is part of a Department for Education pilot, undertaking reflective analyses of live cases tested in 'real time' to assess the extent to which core groups are considering well-formed questions in implementing child protection plans concerning babies and infants. The group uses a wide range of methods to communicate key messages from SCRs and learning reviews, by providing well-attended annual multi-agency conferences, seminars and newsletters.
120. The board was involved in shaping the early help offer in Cornwall, particularly a well-regarded early help hub, and provides ongoing training of lead professionals. The board's published threshold document is a helpful matrix guide for frontline practitioners and managers, exploring and balancing levels of vulnerability with comprehensive guidance on securing parental consent. The board lacks data and analysis on the extent to which targeted early help interventions are reducing the level of demand on the statutory children's social work service and improving children's outcomes at an earlier stage of their difficulties.
121. The board has a strong interest in children looked after performance indicators. It has recently challenged a notable increase in short-term placement instability and monitors a considerable number of other performance indicators concerning this group of children and young people. The board's strategic relationship with the corporate parenting panel could be more precisely outlined to avoid duplication and confused accountability. For example, the board's attention should be primarily on holding the corporate parenting panel to account on its contribution to the safety and protection of children and young people who are looked after who live outside Cornwall. The board does not maintain a separate challenge log, but evidence was seen during the inspection of the board's tenacious challenge of partner agencies' shortfalls in safeguarding arrangements identified in the scrutiny panel programme. The chair corresponds with and visits senior managers to address delayed progress. These have been particularly prominent in the chair's pursuit of shortcomings and delays by the CCG and police to safeguarding deficits highlighted in their recent regulatory inspections.
122. The board's risk register has been reduced to two overriding risks: child sexual exploitation and missing children, and the quality and lack of timely access for children to emotional and mental health services. A large number of earlier risks have been effectively addressed. However, it is important, that the board

maintains a keen eye on some risks that sit outside its five core priorities. The board was not aware that the practice of only allocating a named social worker to subject children referred to children's social care, and omitting their siblings, might be a factor impinging on reduced re-referral rates which it regularly monitors. Similarly, the board was not actively scrutinising the Children's Trust concerning high numbers of young people, aged 16 and 17 years old, presenting as homeless who were housed in bed and breakfast accommodation.

123. The Cornwall LSCB Chair is the peninsula representative on the child death overview panel (CDOP) and actively communicates learning from child deaths to partners. Modifiable factors in children's deaths are considered on a peninsula-wide basis rather than at an individual local authority level. The most recent CDOP annual report identified that governance arrangements between the CDOP and CCGs needs to be strengthened and this is now being addressed. Scrutiny of the panel has also identified that the process for following through actions and outcomes between the CDOP, LSCBs and Children's Trusts should be improved. This work is in its infancy. There were 27 child deaths in Cornwall during the last reporting year, continuing a sharp downward trend reflecting national trends.
124. The forthcoming LSCB Annual Report for 2015–16 should more explicitly address how the board's improving oversight and scrutiny arrangements are contributing to improving outcomes for children and young people across partner agencies. The last annual report was comprehensive but its content largely described safeguarding arrangements rather than providing a cogent evaluation of them.

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.

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