Rochdale Borough Council

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

and

Review of the effectiveness of the local safeguarding children board[1]

Inspection date: 30 September 2014 – 22 October 2014

Report published: 5 December 2014

The overall judgement is that children's services require improvement		
The authority is not yet delivering good protection and help and care for children, young people and families. It is Ofsted's expectation that, as a minimum, all children and young people receive good help, care and protection.		
The judgements on areas of the service that contribute to overall effectiveness are:		
1. Children who need help and protection		**Requires Improvement**
2. Children looked after and achieving permanence		**Requires Improvement**
	2.1 Adoption performance	**Requires Improvement**
	2.2 Experiences and progress of care leavers	**Inadequate**
3. Leadership, management and governance		**Requires Improvement**

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

Contents

The local authority

Summary of findings

Children's services in Rochdale require improvement because:

Effectiveness of corporate parenting

- The local authority is not in contact with seven care leavers over the age of 19 years and therefore cannot be sure that these young people are safe.
- Timescales for adoption have not improved significantly, and permanency is achieved too slowly for some looked after children.
- The local authority does not demonstrate sufficient ambition for the children in its care or care leavers and does not afford them the opportunities to achieve their full potential.
- The educational progress of looked after children in secondary schools is unsatisfactory and too many looked after children in secondary and special schools are subject to temporary exclusions, disrupting their education.

Missing children

- Not all children who go missing have an opportunity to speak to an independent person on their return and information from return interviews is not used well enough to analyse patterns and trends.

Quality of intervention

- Partners apply thresholds for early help inconsistently. Too many children do not receive the early help they should from the agencies involved with them and too many are referred inappropriately to children's social care.
- Frequent changes of social worker have impeded some children and parents from building relationships with workers, which has delayed the progress of plans.
- Case recording of contact with children in need of help and protection is often too brief, insufficiently analytical and unclear.
- Assessments, plans and reviews do not strongly reflect what life is like for children, their wishes or feelings. Most assessments are not routinely updated and planning is not informed by a holistic analysis of children's needs.
- Plans for children do not prioritise key areas of risk and actions are not clearly linked to outcomes, making it difficult to measure progress.

Management oversight

- Some performance information is not consistently accurate or accessible. This leads to an incomplete understanding of the quality of practice.
- Managerial oversight does not focus on the difference that interventions make to children.
- Supervision for some social workers does not take place regularly and does not support the development of reflective practice.

What does the local authority need to improve?

Priority and immediate action

Corporate parenting

1. Re-establish contact with the high proportion of 20- and 21-year-olds not in contact with the service to ensure that they are not at risk.

2. Improve the quality and choice of accommodation for care leavers, and enable more young people to remain with their foster carers beyond the age of 18.

3. Ensure that all children and young people looked after and care leavers are aware of, and receive, their full entitlements.

4. Ensure that the improvement plans for the Care Leaver services and Rochdale's Care Leaver offer are sharply focused on making care leavers' lives better.

5. Ensure that the Corporate Parenting Board robustly and regularly monitors the actions taken to improve practice for care leavers.

6. Improve timescales for achieving permanency for children.

Missing children

7. Ensure that all children who go missing from home and care have a return interview, and that information is collated and analysed to identify patterns and trends so that children get the support they need.

Performance management, scrutiny and challenge

8. Improve the quality of performance data collection and analysis so that trends can be accurately assessed and information used to improve services.

9. Ensure that all staff have regular and properly documented supervision and performance reviews to guide their professional development.

Early help and thresholds

10. Ensure, with partners, that early help is coordinated and targeted effectively so that children receive help when their needs are first identified.

11. Ensure that partner agencies understand the thresholds to children's social care in order to reduce the number of inappropriate referrals.

Quality of intervention

12. Ensure that children and young people cared for long term have up-to-date assessments of their needs to reflect their changing circumstances.

13. Ensure that all cared for children[2] receive a timely annual health assessment.

Areas for improvement

Care leavers

14. Establish systems to understand patterns of offending behaviour by cared for children and care leavers so that appropriate support can be offered to tackle the underlying causes.

15. Increase the number of apprenticeships available to care leavers through effective partnerships between senior officers in local authority departments, partner agencies and the private sector.

Education of looked after children

16. Develop a management information system so that the virtual headteacher has access to data about the progress, attendance and temporary exclusions of all cared for children and so challenges, supports and intervenes as soon as concerns arise.

17. Take robust action with secondary and special schools to reduce the number of temporary exclusions of cared for children.

18. Improve the quality of personal education plans for cared for children by ensuring they have specific measurable actions linked to educational targets.

[2] Looked after children in Rochdale are known locally as cared for children, following a consultation with them. Where possible, we have used that term in this report.

Timeliness of intervention

19. Ensure that reviews of child protection plans are consistently robust in identifying drift and delay, and that authoritative action is taken when parents fail to engage with plans.

20. Further improve the timeliness of care proceedings to reduce delay and uncertainty for children and young people.

Quality of practice

21. Improve the quality of planning for children, prioritising key risks. Ensure that intended outcomes and timescales are clear, and that parents, carers and children understand what needs to change to improve children's well-being and safety.

22. Ensure that the child's voice and daily experience are represented in all assessments and that assessments are sharply focused on the analysis of risk and need.

23. Ensure that children witnessing domestic abuse have access to appropriate services.

Scrutiny and challenge

24. Establish an outcome-focused approach to practice at all levels of management.

25. Strengthen the role of the Independent Reviewing Officer in improving the consistency of care planning and review and in challenging wider corporate parenting issues.

26. Continue to monitor the use of special guardianship orders to ensure that this remains one of the permanence options for children and that it is supported beyond financial payments.

Voice of the child

27. Strengthen the contribution of children and young people to their plans, reviews and throughout the care planning process.

28. Take action to improve the take-up of advocacy services by children involved in child protection meetings.

The local authority's strengths

29. The local authority is a learning organisation. It actively seeks out opportunities for external scrutiny and challenge through the commissioning of independent audits and peer reviews. It uses the knowledge gained to improve services.

30. The calibre of the senior leadership team, combined with strong partnership working through the Local Safeguarding Children Board (LSCB), has driven improvements across children's services from a very low starting point.

31. The local authority has improved its strategic work with partner agencies to tackle child sexual exploitation (CSE) and this is resulting in increased awareness of and earlier identification and intervention for young people at risk. The Sunrise team completes robust and sensitive assessments of children at risk of CSE and offers a wide range of effective support to young people and their families.

32. The newly established Multi-Agency Safeguarding Service (MASS), co-located with the Sunrise team, is resulting in timely decision-making to reduce risks for children, including those at risk of CSE.

33. Good information sharing by partners, including the police, health and schools, leads to effective strategy meetings which contribute to reducing risk.

34. There have been no adoption breakdowns in the last 12 months: the quality of adoption support has been good.

35. The training offered to staff at all levels is relevant and effective. The Assessed and Supported Year in Employment (ASYE) programme has been successful in retaining newly qualified social workers within the authority.

36. The local authority is successfully narrowing the attainment gap between cared for children in primary schools and all Rochdale pupils.

37. Learning from complaints is used to improve practice.

Progress since the last inspection

38. Ofsted's last inspection of Rochdale's services for looked after children in July 2010 judged the services to be adequate. Ofsted's last inspection of the arrangements for the protection of children was in November 2012, when they were judged to be inadequate. This followed findings from a learning lessons review which detailed widespread failings in the local authority's response to young people who had been sexually exploited. The Secretary of State issued an Improvement Notice in April 2013, which also included a requirement to improve adoption performance.

39. A further Improvement Notice was issued in April 2014 to address weaknesses identified by the local authority's self-assessment and a Local Government Association peer review completed in September 2013. The peer review, while noting some progress made by the interim senior management team, highlighted further significant failings in the infrastructure to support social workers. The lack of a permanent stable workforce was a key risk to the pace and sustainability of improvement.

40. The pace of improvement has accelerated since the appointments of a permanent Director of Children's Services (DCS) and a permanent Assistant Director for Children's Social Care in the autumn of 2013. With the support of an effective Improvement Board, the local authority has made significant progress.

41. The local authority and partner agencies have transformed their approach to child sexual exploitation. They have implemented a whole-system approach that includes awareness raising, prevention and early identification through outreach work, combined with effective disruption and prosecution initiatives. Effective arrangements within the multi-agency screening service (MASS) are resulting in timely information sharing on contacts and referrals. Informed decision-making contributes to children being kept safe and their needs being met. The co-location of the Sunrise team with the MASS supports the early identification of risk in respect of child sexual exploitation.

42. The local authority has increased its establishment by 42 social worker posts and 12 frontline managers. This increased capacity is reducing reliance on agency workers. Caseloads are now reported to be more manageable, and standards of accommodation for and administrative support to social workers are good.

43. A concentrated focus on the expected standards of performance, supported by a comprehensive programme of case audit and review, is helping to drive up practice standards.

Summary for children and young people

- Services for children who need help and protection in Rochdale were found to be inadequate in November 2012. Since that time, council leaders and managers have worked hard to improve services and have made a lot of progress, but services are not yet good.
- Improvements to the way that staff in the council respond when people report a serious concern about a child now mean that children and young people are helped more quickly to be safe.
- The Sunrise team, which works to help young people at risk of sexual exploitation, has improved over the last year and is successful in helping to support children at risk. Young people, parents and teachers have been involved in training to make sure everyone knows what to do if they have concerns.
- The Council knows that much more needs to be done before services are good, especially improvements in services for cared for children and care leavers. Although some of the care leavers who spoke to inspectors were happy with some of the support they receive, overall inspectors found the service to care leavers to be poor. The local authority is not in touch with enough older care leavers who might still need help and not enough care leavers are able to remain with their foster carers after the age of 18 if they wish to. There are far too few opportunities for these young people to take up an apprenticeship.
- Social workers work hard to find adoptive families for children who need them, and sometimes it takes too long.
- Not enough services across Rochdale are working together well to help families when they are just beginning to have difficulties. This means that problems get worse, and then too many children have to be referred to children's services.
- Social workers spoken to by inspectors knew the children they were working with very well and spent a lot of time trying to make their lives better. Plans for children and care leavers do not always show this. Too often they are just a list of actions that do not explain well enough what needs to change.
- Managers in children's services do not always check that the things staff are doing are making a difference to the lives of the children they are working with.
- Cared for children do well at primary school and attend regularly. The ones in secondary schools do not all do as well as other pupils in Rochdale, and too many of them are temporarily excluded from school.

Information about this local authority area[3]

Children living in this area

- Approximately 50,800 children and young people under the age of 18 years live in Rochdale. This is 24% of the total population in the area. Approximately 27% of the local authority's children are living in poverty.
- The proportion of children entitled to free school meals:
  - in primary schools is 22% (the national average is 18%)
  - in secondary schools is 25% (the national average is 15%)
- Children and young people from minority ethnic groups account for 29% of all children living in the area, compared with 22% in the country as a whole.
- The largest minority ethnic groups of children and young people in the Rochdale area are the Asian and mixed groups.
- The proportion of children and young people speaking English as an additional language:
  - in primary schools is 27% (the national average is 18%)
  - in secondary schools is 23% (the national average is 14%).
- Rochdale has a very ethnically diverse population. The 2011 census identified over 150 different ethnicities in the borough. The percentage of the all-age population that comes from minority ethnic groups is 21.4%, with the Asian/Asian British/Pakistani group (10.5%) being the largest. In total, groups of South Asian origin account for 13.1% of the borough's population. Rochdale also has the second largest Kashmiri population (1,658) in England and Wales.

Child protection in this area

- At 31 March 2014, 2,216 children had been identified through assessment as being formally in need of a specialist children's service. This is a reduction from 2,284 at 31 March 2013. At 31 March 2014, 316 children and young people were the subject of a child protection plan. This is an increase from 230 at 31 March 2013. At 31 March 2014, four children lived in a privately arranged fostering placement. This is an increase from two at 31 March 2013.
- Since the last inspection, three serious incident notifications have been submitted to Ofsted and two serious case reviews have been completed or were on-going at the time of the inspection.

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

Children looked after in this area

- At 31 March 2014, 533 children were being looked after by the local authority (a rate of 105 per 10,000 children). This is an increase from 507 (100 per 10,000 children) at 31 March 2013. Of this number:
  - 196 (or 37%) live outside the local authority area, of whom 12% are placed over 20 miles away
  - 40 live in residential children's homes, of whom 65% live out of the authority area
  - two live in residential special schools, and both live out of the authority area
  - 394 live with foster families, of whom 31% live out of the authority area
  - 42 live with parents, of whom 12% live out of the authority area.
  - There are no unaccompanied asylum-seeking children.
- In the last 12 months:
  - there have been 28 adoptions
  - 11 children became subjects of special guardianship orders
  - 160 children have ceased to be looked after, of whom 10% subsequently returned to be looked after
  - 33 children and young people have ceased to be looked after and moved on to independent living
  - 11 children and young people have ceased to be looked after and are now living in houses of multiple occupation.

Other Ofsted inspections

- The local authority operates four children's homes. Ofsted judged three of them to be good or outstanding in their most recent inspection. The previous inspection of Rochdale's arrangements for the protection of children was in 2012. The local authority was judged to be inadequate. The previous inspection of Rochdale's services for looked after children was in August 2010. The local authority was judged to be adequate.

Other information about this area

- The Director of Children's Services has been in post since October 2013.
- The Chair of the LSCB has been in post since January 2013.

Inspection judgements about the local authority

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

Summary

Early help is not yet sufficiently well coordinated in Rochdale. Not all agencies are fully engaged in providing early help, which means that some children's needs are not being met soon enough.

High levels of inappropriate contacts and referrals are made to children's social care. More work is required to improve the quality of referral information and to ensure that agencies understand and apply appropriate thresholds for referral.

Not all assessments include a focused analysis of risk or fully represent the views of the child.

Planning is too variable, and too many plans lack clear outcomes to help parents and carers understand what needs to change and why. Reviews of plans are regular, but do not consistently identify and ensure action to address drift and delay.

Services available for children who witness domestic abuse are insufficient.

Not all children who go missing from home receive a return interview, and steps taken to consider potential links between missing from home, care and education are very recent.

The newly established MASS is resulting in effective information sharing and decision-making. Strategy meetings and child protection enquiries are mostly well managed and result in safer outcomes for children.

Responses to CSE are strong. Awareness of this complex area of work is good. Preventative work with children's agencies and the wider community is leading to increased recognition and earlier referral of children who may need help. Skilled, direct work with young people and their families is reducing risk.

44. The Early Help Strategy was launched in 2013, under the leadership of the Children and Young People's Partnership. Progress has been slow. An evaluation of the effectiveness of services is not complete and the locality teams are not yet operational. Early help services are not sufficiently well targeted to meet need. Together with the lack of full engagement by all partner agencies, this means that children do not always get the right help and support at the right time.

45. The local authority provides a range of services for children and families who are in need of early help, including help out of hours and targeted youth services. Some older children and families receive good support from Stronger Families (Troubled Families). The most recent data provided by the local authority show that, out of a cohort of 675 families, 78% had shown improvement in outcomes.

46. Children's centres provide a wide range of services, including parenting programmes and family support. Feedback from parents and carers using these services has been positive. Many schools are making a positive contribution to providing effective early help. A primary headteacher has been seconded very recently to work with schools that have been less engaged, but it is too early to evaluate the outcome of this.

47. The number of early help assessments over the last two years has increased significantly from 212 in 2012–13 to 933 recorded in September 2014. Children's centres and schools complete 90% of the early help assessments.

48. Too many children are referred to children's social care by other agencies without the benefit of an earlier assessment of their needs, or the provision of early help support.

49. Step-down arrangements from child in need to early help are mostly timely and generally effectively managed. However, sometimes communication between social workers and early help managers is poor and this weakens the effectiveness of transition for children and families.

50. Co-location of police, health, early help and children's social care services, with access to electronic recording systems for the youth service and adult services, is resulting in timely information-sharing on contacts and referrals in the newly established MASS.

51. A wide range of agency checks is undertaken, with parental consent where needed. The co-location of the Sunrise team with the MASS ensures early identification of risk in respect of Child Sexual Exploitation (CSE), and good information sharing. When CSE is identified, it is clearly treated as a child protection issue. The Sunrise team is currently working with 50 young people at risk of CSE. Effective information sharing supports decision-making. It is timely and well informed to ensure that children are safe and their needs are met.

52. All decisions within the MASS are taken by an experienced, qualified social work manager and are appropriately recorded. Records are clear, specific, based on analysis of risk and include directions for social workers. In the majority of cases seen, management decision-making was appropriate.

53. The MASS is beginning to have an impact on reducing the number of contacts to children's social care, which have decreased by 32% since the MASS was established in February 2014. However, contacts remain high compared to statistical neighbours and national averages. The quality of referral information is too variable: some referrals do not include relevant information such as details of the family and address, or clearly outline the areas of concern. More work is required to improve the quality of referral information and ensure that agencies understand and apply appropriate thresholds. This high level of contacts and referrals is resulting in additional and, in some cases, unnecessary work for the MASS.

54. Referrals progress to the First Response teams or Sunrise teams within 24 hours or earlier if required. Cases are allocated promptly and, at the time of the inspection, no cases were unallocated.

55. Strategy meetings are timely and the majority are very well attended by a range of partner agencies. Strategy meetings are recorded by a dedicated minute taker. Minutes seen by inspectors were very detailed, with evidence that relevant information is shared and analysed to inform decision-making about appropriate action to ensure that children are safe and their needs are met.

56. The number of child protection enquiries in 2013–14 has increased. The high level of child protection activity is partly due to a legacy of poor practice and previous lack of recognition of risk to some children. Appropriate action is now being taken to address identified risks and need, and targeted work has been undertaken to address neglect. This is resulting in a high volume of work, which is putting pressure on frontline services.

57. Child protection enquiries are conducted by suitably qualified and experienced social workers. Findings about significant harm are clear and appropriate action is taken to safeguard children. Management oversight of child protection enquiries is mostly clear and directive.

58. The quality of assessments of children in need of help and protection is too variable. Assessments that require improvement are too long and lack clear focus. Some assessments are too descriptive and do not analyse information sufficiently and draw together key themes and risks to children. Poorer assessments do not focus on the roles of fathers or significant males. Assessments involve partner agencies, and an overview of history to inform the analysis of risk. Only a small number of assessments have used research to inform decision-making.

59. The quality of assessments in the Sunrise team is good. Consideration of young people's identity is sensitive, and analysis of the range of risks and vulnerabilities they experience is effective in informing planning. Assessments within this team are resulting in a direct offer of a wide range of services to meet the specific needs of children. In many cases, the team is successful in engaging children and their families to work towards reducing risk.

60. The recording of child protection enquiries includes evidence that children have been seen and spoken to alone where appropriate, but the child's voice is not always sufficiently well recorded. Children's views, wishes and feelings are not recorded in many case records and assessments across all teams. However, assessments that are more recent represent the voice of the child more effectively. In some cases, frequent changes of social worker have affected their ability to build relationships with children and parents. In a small number of cases, this has hindered the progress of plans.

61. It is evident that most social workers know the children they work with well, although there is limited evidence of social workers undertaking direct work with children to inform assessments and influence decisions about next steps.

62. The quality of planning is too variable. Too many child protection plans lack timescales and clear outcomes. This does not support parents to understand risks and concerns fully. Better plans have timescales, clear actions for parents and agencies, and clarity as to what needs to change and why. Children's individual needs are not always represented in plans. Child in need plans do not always translate the findings from assessment into actions and clear intended outcomes.

63. Agencies work well together in providing services to support children who have a child protection plan. This includes family support, drug and alcohol services for parents and the Early Breaks project (drug and alcohol services for young people), as well as a range of parenting programmes and group work for women experiencing domestic abuse. The graded care profile, a tool for assessing the quality of care children receive, is used to support the assessment of the impact of neglect on children.

64. Data are collated on the numbers of children on child protection plans where domestic abuse, drug or alcohol use or mental health is a feature. Currently, 111 feature domestic abuse, 73 parental drug use, 66 parental alcohol use and 86 feature parental mental health issues. However, data are not routinely used to inform service provision. For example, few services are available for children who have experienced domestic abuse. This is a significant shortfall, given the high number of children who have a child protection plan for this reason.

65. Home visits are mostly regular and in accordance with plans. In a small number of cases, however, children were not seen alone.

66. The majority of child protection plans are reviewed regularly. Multi-agency attendance at case conferences and core groups is good, including by adult services, such as drug and alcohol agencies, and probation. This helps to ensure that appropriate information is shared to support decisions.

67. In most cases, agencies are challenged when actions in plans have not been completed and there is evidence of effective authoritative action when change is not secured and risks to children remain or intensify. However, in a small number of cases, parents have not engaged with plans and this had not been challenged by child protection chairs and core groups; this had led to drift and delay in children's needs being met. In all cases, this has recently been recognised and addressed.

68. Child protection chairs have very high caseloads of 90 to 100 cases. This limits their ability to track and monitor cases between reviews. Cases that give most concern are tracked. A system to monitor the escalation of cases where concerns are identified has recently been implemented. This is leading to a more robust response so that children's needs are met, and drift and delay are prevented.

69. Where children have received early help, effective escalation from early help up to child in need, and from child in need to child protection has been evident. There is evidence of good outcomes in some cases because of thresholds being applied and cases stepped up.

70. Effective screening of domestic abuse notifications by a dedicated police officer in the MASS, together with a daily multi-agency screening meeting, ensures timely information-sharing and effective responses in cases where children have witnessed domestic abuse. A large proportion (40%) of domestic abuse referrals result in no further action for children's social care, and data on the outcome of closed referrals are not currently available to assess how many children receive an alternative service, including early help. The local authority and police are aware that more needs to be done to meet the needs of children who are in families where domestic abuse is assessed as low risk, and a new post of domestic abuse advisor has recently been established to promote this work.

71. Partners including housing, adult social care, health, community psychiatrist, women's refuge, drug and alcohol services, Independent Domestic Violence Advisor, victim support, midwifery and education are fully engaged with Multi-Agency Risk Assessment Conferences. Risks to victims and children are appropriately assessed, and this informs decisions about actions needed to ensure their safety.

72. Strong partnership working with schools, police, local and national agencies, alongside detailed regular tracking systems, have improved the identification of children missing from education. The number of children on the missing from education register has reduced by 36 percentage points between September 2013 and September 2014. In September 2014 there were 37 cases. There have been clear improvements in determining where young people are when they go missing due to effective partnership working with police and other agencies. The names of children missing from education remain on the register until they are located or they reach statutory school age ensuring their circumstances continue to be considered. However, three children have been on the missing children register for one year and three for two years.

73. No cared for children are currently missing from education and all are in full-time or alternative provision. The welfare of children who are home educated is monitored by visits at least twice yearly.

74. In September 2014, nine cared for children had recently gone missing from their placement; all of them returned and received return interviews. Twelve children who were subject to children in need and child protection plans had been missing in September 2014; all returned home. All missing children are reported to the MASS and Sunrise teams. A recently established weekly missing panel, attended by a range of agencies, including education and the Sunrise team, reviews all police reports of children missing, including those missing for a few hours. This panel shares timely information on children missing from home, care and education and informs decision-making. This is good practice.

75. Not all children who have been missing from home are able to reflect upon their missing episode with an independent person. Those who are cared for receive a return visit from an independent person, but children subject to children in need and child protection planning will receive a visit from their social worker. The recording of these visits is not consistent, so findings from return interviews cannot be collated and analysed to identify patterns and trends. The local authority and partner agencies accept that more needs to be done to build a fully effective system for gathering intelligence about children missing from home and education. Inspectors did not see any examples of young people going missing who were being left at immediate risk.

76. Effective arrangements for the joint assessment of 16- and 17-year-olds who present as homeless to housing services or the MASS result in these young people being offered the support they need. In cases sampled, all young people were given the option of becoming looked after and offered appropriate placements based on their level of need, including foster care and supported accommodation.

77. Awareness-raising activity about private fostering during the past 12 months has not led to a significant increase in the number of notifications, which continues to be low. This raises concerns that there are more children whose circumstances are not known, and therefore potentially vulnerable. For those who are known, assessments and visiting are in accordance with statutory guidance.

78. The monitoring arrangements for the management of allegations by the Local Authority Designated Officer (LADO) have improved since April 2014. However, quarterly data do not include detailed information in relation to the source of the allegation or the timeliness of completed investigations. In quarter one 2014-15 40% of cases did not meet locally agreed timescales for progressing referrals to strategy meetings, although children were not left at risk of harm.

79. There are some good examples of child protection services being responsive to the individual needs of parents and children, including out of hours. Effective communication between daytime and out of hours services ensures continuity of response.

80. The Sunrise team undertakes robust assessments which are effective in considering young people's identity and individual needs. In meetings observed, interpreters and support for parents and carers were used effectively, so that they were able to fully participate. There was also sensitive management and consideration of the impact of disability on children, leading to better outcomes. The diversity of individual children, young people and families is not always well recognised or reflected in plans or in recording assessments.

81. Feedback from professionals and families who attend child protection conferences is collated periodically. Feedback from parents is mostly very positive. An advocacy service is available for children attending conferences, but take-up of this service is low.

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

Summary

The outcomes for cared for children are not yet good and the service needs to improve further to address a legacy of poor practice, insufficient managerial oversight and a lack of strategic priority for corporate parenting.

Re-modelling of the Cared for Children teams, revised strategies and strengthened management arrangements are new and have yet to demonstrate consistent and sustained impact for all children.

The Independent Reviewing Officer service is not yet fully addressing all aspects of quality in care planning, and care plans for cared for children are not sufficiently detailed and individual. The child's voice, ethnicity and individual needs are not explicit or consistent through care planning and reviews.

Children and young people looked after long-term do not have their needs assessed and updated to reflect their changing situations.

Not enough has been done to ensure that cared for students in secondary schools achieve well in their education. The gap between their achievement and other students in Rochdale is too wide. Too many of them in secondary and special schools are subject to temporary exclusions. Primary-aged pupils attend school regularly and make expected progress.

The Public Law Outline is used effectively, resulting in some parents making the positive changes needed. Where risks escalate and children cannot remain at home, decisive action is taken. The time children wait for the outcome of care proceedings has steadily reduced over the last year and is better than the national average.

Placement stability for children is good, enabling them to form consistent relationships with their carers and within the local community.

Children benefit from timely life-story work which helps them to understand their experiences and their family background.

Children who are placed out of area receive the same level of support for their health and education as cared for children who live nearby.

Cared for children who are at risk of sexual exploitation receive the same good level of support as children who live at home.

The local authority works with private providers to raise awareness of and reduce risk for all cared for children, including those placed in Rochdale by other local authorities.

Children who need permanence wait too long. Performance against the adoption scorecard is not improving quickly enough. Special guardianship applications in the local authority have fallen. However, adoption support is strong, resulting in no adoption breakdowns in the last 12 months, with 31 children being placed for

adoption since April 2014 – more than the number placed in the whole of the previous year.

Care leavers are not well informed about what they are entitled to as they prepare for independence and not enough of them are able to stay with their foster carers after the age of 18 if they wish. Seven care leavers aged 19-21 are no longer in touch with their corporate parent.

The proportion of care leavers able to take up apprenticeships is too low but the number of care leavers attending university has recently increased from one to nine.

The proportion of care leavers in custody is too high, going against the trend of an overall reduction in custodial sentences for young people in Rochdale. The local authority has not analysed the underlying reasons, and has therefore missed an opportunity to inform preventative work with cared for children at risk of offending.

82. Rochdale has experienced a significant increase in the number of cared for children. This has risen from 448 as of 31 March 2012 to 533 as of 31 March 2014. Decisions that children should become cared for are made at an appropriately senior level. Inspectors saw no cases where children had entered care inappropriately. The local authority has completed diagnostic reports of cared for children's services and the adoption service, with subsequent well-thought-through actions to address the legacy of poor care planning, monitoring and management oversight. This is beginning to have a positive impact across the service.

83. The Children in Care council the 'Listen Up' group meets fortnightly. Members of the group sit on the corporate parenting board which is improving the influence cared for children have on decision-making. The local authority acknowledges more needs to be done to ensure information from 'Listen Up' is consistently shared with all young people and membership of the group is not limited to those young people referred by their allocated worker.

84. The Public Law Outline (PLO) is used well to ensure that timely changes are made for children. Parents are suitably engaged through the effective use of a contract of expectations and regular reviews, resulting in some parents making the required changes. One parent told inspectors, 'I knew I was going to lose my child if I didn't change. It was a real wake-up call.' Regular Legal Gateway meetings monitor progress to prevent drift. When legal action is necessary, the timeliness of court proceedings is improving, having reduced from 49 weeks in 2012–2013 to 36 weeks in 2013–2014. The first quarter data of 2014–15 confirm that further improvement was achieved, with a reported average duration of 28 weeks; nationally, the average was 31 weeks. This does not meet the national requirement of 26 weeks, but is an improving picture.

85. A senior manager tracks children who may require permanence through adoption to ensure, if this is the care plan, that there are no unnecessary delays. Improvements in the quality of evidence and plans before the court are helping to reduce delay, and the majority of assessments include thorough analysis to support the conclusions. The use of family group conferences has increased in the last year and there are examples of positive engagement by the wider family to discuss the support they can offer. Where family members, potentially, can care for children, appropriate viability assessments consider these options, which mean that those children return to their families in a timely way.

86. Legal planning meetings are increasingly effective and permanence, including special guardianship orders s considered for children at the point of becoming cared for. Currently, 89 children are cared for under special guardianship orders, although the number of new applications has declined. In two cases seen, there had been extensive delays in providing appropriate levels of support to progress the applications; these remained unresolved at the time of the inspection. Work undertaken recently has not yet increased the number of children in long-term fostering whose permanence is secured through special guardianship with their carers.

87. Foster placements within the local authority's own resources are insufficient when children need accommodation. The authority makes good use of independent fostering agency (IFA) placements to ensure that brothers and sisters are placed together. Although 37% live out of area, a high proportion of children remain within 20 miles of their community. This means they are able to access local services and maintain family relationships. Twelve per cent of children are placed further away, which is in line with national figures. Such placements seen were based on meeting children's needs effectively and, in one case, were providing the child with their most stable period of public care. Senior managers routinely monitor these placements to ensure arrangements are suitable and continue to meet needs.

88. Eight per cent (47 children) of cared for children live with a parent. Some of these children have been placed at home for a number of years without consideration of whether a formal order was still required. This reflects historic poor planning and a lack of purposeful review. Targeted work to review the situations for these children is ongoing, but has yet to result in any applications for the discharge of an order.

89. Children who have been returned home more recently by the courts under a final care plan are monitored closely to ensure that the placement continues to meet the child's needs and that they do not remain subject to statutory orders unnecessarily. In these cases, good multi-agency support helps their parents to maintain and build on progress. Overall, a low proportion (10%) of children who return home after becoming cared for require further care. This indicates that the majority of children who return home receive sufficient support to prevent their re-entry to care.

90. The majority of children live in stable placements with few (9%) experiencing more than three moves in 12 months in 2013–14. This compares well with the latest national figure for 2012–13 of 11%. Stability for children in the same placement for more than two years is currently 73.5%, which compares favourably with the latest published England average of 67% in 2012–13. The number of children in residential care has reduced from 45 to 34 in 2012–13 as a result of reviewing children's needs across the service.

91. Foster carers are well trained and value the support around them to care for children. This minimises disruptions to children's placements. The child and adolescent mental health service (CAMHS) provides a range of direct and indirect interventions to support cared for children. This increases the strategies their foster carers and residential workers can use to support emotional resilience and to help children understand their family history.

92. Most statutory visits to children are now timely, which has improved as a result of the revised management structure. The quality of the visits has improved and records over the last six months show a clear representation of children's views and record how their welfare is being monitored.

93. Children are supported through life story work to gain an understanding of their identity and their family history, both for now and later in life.

94. All children have care plans but not all plans contain sufficient detail to outline children's specific needs or identify the intended outcomes clearly. Children's views are reflected in recent plans, but there is still work to do to reflect children's voices strongly in all aspects of care planning. Children's ethnicity and diversity are represented in plans, but the depth and quality of analysis vary.

95. The ethnic profile of foster carers does not reflect the profile of children in the local area. Not enough young people have the option of staying with their foster carers beyond the age of 18. Very few children are able to live with foster carers who are recruited to become adoptive parents if this becomes their plan. A defined strategy is targeting these specific areas but is not yet having an impact.

96. The Independent Reviewing Service (IRO) has improved since 2013 from a low starting point and has contributed to the improvement of practice compliance and recording within social care. The current timeliness of reviews is 91%, and those not held are adjourned to improve the quality of information available to the review. Inspectors saw some good examples of reviews, with IROs providing effective challenge and driving improvement. In a small number, the recommendations were not child-focused and insufficient progress was made between reviews. The challenge from IROs has raised practice compliance. However, their role in improving quality and consistency in care planning and advocating stronger corporate parenting requires further development. Children and young people cared for long term do not have their needs assessed to reflect their changing circumstances; in one case seen, the child's assessment had not been updated since 2011.

97. The majority of children and young people's health needs are met through timely health assessments (84%), dental checks (86%) and immunisations (96%); however, this is not consistently good enough for all cared for children and young people. The quality of health assessments for children placed out of area are reviewed by the looked after health professional to ensure that other authorities are meeting the needs of these children.

98. CAMHS offers services to meet cared for children's needs through direct work, informal group work and weekly support to foster carers and residential workers. This support is valued. CAMHS provides intervention at times of need, although the waiting time for individual assessments is three to four weeks and for direct work 10 to 12 weeks. Currently, the cases of 89 cared for children are open CAMHS cases. Some of these are for direct CAMHS work; others are for work conducted under consultation by the social worker or foster carer. Currently, 18 cared for children are being treated for substance misuse, which is 3% of all cared for children.

99. Good partnership working between the local authority's school improvement staff, the virtual headteacher, designated teachers and school leaders is helping to ensure that primary-aged cared for children attend school regularly and make good progress against expected targets. Cared for children's attainment at the ages of 7 and 11 has been above that found nationally for similar pupils over the past three years and the gap between all Rochdale pupils and cared for pupils is narrower than that found nationally for similar groups.

100. The attainment and progress of cared for students in secondary schools are not good enough. Although 2013 saw strong improvement and the proportion of pupils (32%) achieving five good GCSEs including English and mathematics was well above that of similar pupils nationally; provisional results indicate this improvement has not been sustained in 2014, with only 16% achieving five good GSCEs including English and mathematics. The gap between cared for children's achievement and that of other pupils in Rochdale widened, even though results fell for all Rochdale pupils, as they did nationally.

101. No cared for children in primary schools have been subject to fixed term exclusions over the past year which is good. The local authority accepts that too many cared for children in secondary and special schools receive temporary exclusions. The most recently published information in the Annual Report on Educational Outcomes for Cared for Children indicates that 9.48% of cared for children overall have been subject to temporary exclusions in the past year compared to 4.37% for all children in Rochdale. This is too high. Three cared for children (0.67%) have been permanently excluded over the same period; this is above the rate found nationally and above that for all children in Rochdale (0.11%). The three excluded cared for children all attend full-time provision in a Pupil Referral Unit that was judged to be good at its most recent inspection. Reducing exclusions of cared for children is a current priority of the virtual headteacher.

102. All cared for children access their full entitlement to education. Recent, robust checking of schools' unregistered alternative provision and the whereabouts of cared for children in those schools has ensured that all are currently attending their education placements and none is in unregistered provision.

103. Management information systems do not enable the virtual headteacher to access timely data on pupils' progress and exclusions. This limits the ability to intervene, challenge or support schools early when issues start to emerge. Action to ensure that cared for children attend good or better schools is good. Currently, around 84% of these children are in such provision. This is above that found for all children in Rochdale (83%), and above the national average (81%). Risk assessments are completed on any provision where a recent inspection has judged it to be less than good. Designated teachers report that every effort is made to maintain continuity of school placement when home circumstances change. Young people placed out of the borough are able to access similar support to that of their peers in Rochdale. The virtual headteacher attends all reviews of personal education plans for children whose progress is of concern.

104. Personal education plans are of variable quality and usefulness and, overall, require improvement to be good. The local authority has identified this as an area for improvement and a new plan has been developed alongside both Early Years and Post-16 Plans. These changes have yet to be rolled out fully to all schools.

105. Pupils usually contribute to the review of their personal education plans before the review meeting through the 'All About Me' questionnaire, although not enough use is made of the array of information in their responses to inform their personal targets. Academic targets were often not specific about what children needed to do to achieve the next level. None of the plans reviewed provided evidence that the additional government funding for cared for pupils had been well used or described the impact of that funding on pupils' achievement. In relation to the plans seen, all young people had been present at the reviews.

106. Strategic oversight and support to ensure young people can access leisure, sports arts and cultural activities are under-developed. Personal education plans often capture information about a range of additional leisure, cultural, arts or sporting activities that cared for children take part in, but this is not considered at a strategic level to ensure equality of opportunity for all.

107. Offending by cared for children has returned to the proportion reported in 2011–2012 (3%) after a spike in 2012–2013 of 9%. The local authority has not analysed the reasons for that increase or the return to previous levels.

108. The Looked After Children Virtual Team is driving improvements to support the refreshed strategies for cared for children. This is beginning to show impact, for example in the improved completion of health assessments for this year.

The graded judgment for adoption performance is that it requires improvement

109. Adoption performance is not good because children do not achieve permanency quickly enough. The adoption scorecard reports 709 days as the time taken from the point at which children in Rochdale come into care until they are placed for adoption; this is 101 days away from the threshold for 2010 to 2013, which are the most recent published data.

110. The time taken to find permanent adoptive families is too long. This means that children do not achieve permanency in a timescale that meets their needs. Performance measured against the scorecard for 2010 to 2013 shows that the average time taken to find families is increasing. The local authority's unvalidated data and contextual information show extensive historical drift and delay for a very small number of children. This skews the average and has contributed to the authority's poor performance.

111. In April 2014 the adoption service was reconfigured to give a sharper focus in relation to children waiting to be adopted, including allocating an adoption worker for children at the point of permanency. Thirty-one children have been placed for adoption since April 2014, bringing the current total for 2014 to 44. This demonstrates recent improved performance. Family finding meetings are held fortnightly to track the progress of individual children and profiling now begins before the final order is issued. Prospective adopters are now linked with children much earlier. In two cases seen adopters were approved and matched to children at the same panel. This resulted in those children being placed with permanent carers in a timely way.

112. Rochdale's performance on placing children for adoption is above the national average. The scorecard average for 2010 to 2013 was 19%, compared with the national average of 13%. However, it takes too long for the local authority to match children with an adoptive family following authority from the court. The scorecard reported Rochdale's performance in 2010 to 2013 as 259 days, well above the national threshold of 182 days.

113. In 2013–14, 13 children had a plan for adoption changed. One child returned to live with their family and 12 remained with their foster carers, either as a result of no suitable adoptive family being found or because the children had developed a secure attachment to their foster carers and the change of plan reflected their views.

114. The proportion of ethnic minority children adopted, at 15%, is more than double the national average of 7%, demonstrating the good focus on the needs of this group.

115. The recruitment of carers for fostering to adopt is in the early stages, with only two children currently being placed through this route. The authority understands the reasons for these low numbers and continues to recruit for this purpose. Prospective adopters who met inspectors described how they are given good information about fostering to adopt and feel able to make an informed decision about whether it is suitable for them.

116. Arrangements for tracking and reviewing children who may need adoption ensure regular liaison between the family finding worker and the child's social worker. Practice managers now attend weekly Legal Gateway and Legal Care Planning Meetings.

117. Life story books and later life letters are sensitively written and provide the child with a record of their journey to finding a permanent family; in the cases sampled by inspectors, this work was timely.

118. A range of methods is used to find children an adoptive family, including activity days, the adoption register, exchange days and the children's profiles being sent out to the North West consortium, Adoption 22. Information evenings are also held to share DVD profiles of children. This is reducing delay in securing permanency for children and has contributed to a significant increase in the number of children placed with adoptive families. The local authority engages in a continuing programme of recruitment for adopters. This work is undertaken in partnership with two other local authorities. There are currently five approved adopters, 12 prospective adopters at stage one and 11 at stage two of the adoption process. Twenty-four children are waiting to be adopted. The authority recognises that more work is needed to recruit adopters for specific groups of children, including sibling groups, and adopters who live in the local area.

119. Inspectors met six prospective adopters who spoke highly of the support, advice and guidance they had received from the authority and about their experience of applying to adopt. They spoke positively of the swift responses they receive to their queries and concerns.

120. The adoption panel is properly constituted. The chair of the panel is experienced and independent of the local authority. She told inspectors that, in the last 12 months, the quality of reports going to panel had improved, which was having an impact on the timeliness of approval for adopters and adoption timescales for children. Child Permanence reports and Prospective Adopter's reports sampled by inspectors were all of good quality.

121. The annual adoption report does not provide a sufficiently analytical account of the work of the panel or report on the most up-to-date management information. This means the panel does not have a full view of the impact it is having on improving adoption performance.

122. Adoption support is a strength; as a result, there have been no adoption breakdowns in the last 12 months. Adoption support plans viewed by inspectors were of a good quality and ensured that children would receive appropriate support. The virtual headteacher's contribution to support plans ensures that children who are placed outside the authority attend a school that is suited to their needs. An adoption support worker attends the second cared for children review to provide support to adopters at an early stage. Currently, 87 adopted children and 34 adopted families are in receipt of financial support from the authority.

123. Good-quality generic and tailored intervention includes individual support for adopted children in school Safe Base training, for adoptive parents to understand and manage children's behaviour resulting from past experiences; access to a weekly CAMHS drop-in centre; and monthly support groups for adopted children and adopters. This is providing adoptive families with timely advice and is helping them to understand what their children may have experienced in the past.

124. In the last year, 55 adopted adults have received a service either directly from the authority or a commissioned service from Caritas. This means that adopted adults who choose to view their adoption files or attempt to trace their birth families do not have to wait for support and advice.

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

125. Seven 19- to 21-year-olds are not in contact with the care leavers' service. Not enough is being done to re-establish contact with this vulnerable group to ensure that they are safe.

126. Seven care leavers are currently serving custodial sentences. This is a high number, particularly when taking into account the reduction in custodial rates in the general youth population in Rochdale. Little analysis has been undertaken to understand this trend and to ensure that appropriate support is available to address the behaviours that led to their offending.

127. Care leavers reported that they did not have access to their health histories and did not understand that they are entitled to this information. The local authority accepts that only four young people currently have their health passports. Work is taking place with health partners to increase this proportion, but the pace of change is too slow. Care leavers report positively about the support provided by personal advisers and the designated nurse, and access to CAMHS in times of great need. Some had only been allocated a personal adviser when they were approaching 18 years of age; this is not in line with the local authority's Care Leaver Offer.

128. Pathway Plans vary too much in their quality, usefulness and impact. The pathway plan proforma is cumbersome, with no facility to delete early or redundant information. Information in the plans is too brief to provide a clear understanding of the specific actions needed to improve outcomes. Young people report that they know they have a pathway plan but are not sure of its purpose. The local authority is developing a new plan, with training currently being rolled out, but it is too soon to see the impact of any changes.

129. Not enough young people over the age of 18 have been able to remain living with their foster carers, and this is limiting their choices about when they are ready to live independently. Case studies of the six young people now 'staying put' with their carers showed the positive impact this option can have on the young people's security, confidence and emotional well-being.

130. The number of care leavers in suitable accommodation has decreased in 2014 by 8 percentage points and is currently 86%, a reduction on previously good performance. The range of accommodation options for young people is not extensive enough and the local authority is exploring alternatives to improve this. Two flats are available to help care leavers prepare for living independently. A range of supported lodgings provides a stepping-stone into independence but this commissioned service does not have provision within Rochdale, so those who use it have to live outside their local communities. Those in independent living arrangements felt the quality to be good. No young people are placed in bed and breakfast accommodation.

131. The small group of care leavers who spoke to inspectors reported positively on the support they received to help them into the accommodation of their choice. They felt safe where they lived and were informed about risks to their personal safety, including online. Support from agencies such as Early Break, the drugs and alcohol counselling service, are reported by care leavers to be timely and accessible. The risk of CSE to care leavers is assessed and appropriately addressed, with specialist support from the Sunrise team where necessary.

132. Until very recently, no care leavers were in apprenticeships. The Council's apprenticeship strategy has only very recently been amended to ensure that care leavers are a specific target group. The proportion of 16- to 19-year-old care leavers in education, training or employment was 66% in 2013–14. Although this is slightly above that found nationally for similar young people, current tracking shows the proportion has fallen further to 61%, which is not good enough.

133. Programmes such as the 'Chances' programme with Huddersfield and Bolton Universities, and work with personal assistants, foster carers and secondary schools to raise aspirations and encourage more young people to go to university, are beginning to make their mark. The number of young people moving on to university has improved from one in 2013 to nine currently, which is similar to care leavers nationally.

134. The local authority has been too slow in implementing its 'Care Leavers Offer', developed in January 2014 and closely aligned to the government's expectations for care leavers. Young people spoken to had very limited understanding about their legal entitlements. Information has not yet been systematically shared with care leavers.

135. The action plan to tackle issues identified in the review of Care Leaver Services in September 2014 is too new to show impact and it is insufficiently outcome-focused. This makes it difficult for the Corporate Parenting Board and senior officers to identify the extent to which actions have been successful in making a positive difference to the achievements and life chances of care leavers. Although the monitoring of services for care leavers is regular, it focuses too much on what is being done and not enough on the difference that the actions are making.

Key judgement	Judgement grade
Leadership, management and governance	Requires improvement

Summary

Although the authority has taken assertive action following the recognition of deficits in the provision of services to vulnerable children in Rochdale in 2012, all services require further improvement to be good and services for care leavers are inadequate.

Corporate parenting is not sufficiently developed to understand and respond to the needs of all the children in the care of the local authority.

The local authority struggled to give accurate and accessible performance management data to inspectors during the inspection and not all performance data were properly validated. This limits the extent to which managers and elected members can analyse trends in what is otherwise a developing culture of performance management.

While senior leaders in the local authority have robustly challenged partners' lack of involvement in early help, this has not yet led to improvements.

Formal supervision of staff is not consistently regular and does not offer enough opportunity for reflection or a focus on personal development.

The new, permanent senior management team has increased the pace of change from a very low baseline. The local authority's strategic and operational work with partners within the Sunrise team is a strength. The authority works actively with private children's homes to increase their awareness of risk to children who go missing or who are subject to CSE. It successfully challenges planning applications from providers who wish to open homes in unsuitable areas. As a result of this work, the risk to all cared for children, including those placed by other local authorities, has reduced.

The investment of the authority in increasing the number of social workers and the training available, combined with restructuring of social work teams, have reduced caseloads and greatly improved the infrastructure that supports staff. This is beginning to show some positive impact, particularly in frontline child protection services.

136. Following an inspection judgement in 2012 that child protection arrangements were inadequate and the findings of high-profile serious case reviews highlighting deficits in services, the authority acted immediately to improve services. An interim team of experienced senior managers was appointed to implement an Improvement Notice from the Secretary of State for Education with robust oversight from an independently chaired Improvement Board.

137. A permanent senior management team, appointed in autumn 2013, has significantly increased the pace of improvement. Team members provide clear visible leadership of and vision for the future of the service. They have the confidence of the local authority, partners and staff. The discrete role of the Director of Children's Services within the authority effectively ensures that there is proper focus on the considerable improvements that are still needed. The restructuring of social work teams is being managed well but has resulted in staff changes. These have led to disruption for some children. From a very low baseline, services to vulnerable children and young people are beginning to show some improvement in most areas. Although services for children are not yet good, the progress made has been considerable.

138. Strategic plans within the authority and the partnership are properly aligned, with clear links between the Joint Strategic Needs Assessment for vulnerable children and the Children and Young People's Strategic Plan. A number of plans that underpin the strategies are new, such as the placement strategy for cared for children, and some, including the Early Help Strategy, are not properly embedded. As a result, strategic planning has yet to show a consistent impact on improving outcomes for children.

139. A comprehensive joint commissioning strategy and work to establish a joint commissioning unit by March 2015 is yet to result in commissioning that is sufficiently coordinated to fully meet local need. The local authority and partner agencies collect prevalence information which helps to inform commissioning activity. This is not always sufficiently detailed or current enough to be fully effective. For example, data are collected in relation to drugs and alcohol users in treatment who are living with children, but these data do not show the ages and numbers of these children or whether the children have caring responsibilities. Some effective jointly commissioned services have already been successfully created to meet local need, such as the establishment of the multi-agency Sunrise team.

140. Clear lines of accountability between senior officers and elected members ensure that progress is monitored through regular reporting at all levels of the local authority. The lead member for children's services is knowledgeable in her role and uses her knowledge effectively to promote the service and provide appropriate challenge. Cross-party support has helped to implement improvements in children's services. For example, following a recognised shortage, additional resources have been made available to increase the number of social worker posts by 42, as well as an additional 12 frontline managers.

141. Effective working relationships between the Director of Children's Services, the Acting Chief Executive and the chair of the local safeguarding board have led to significant improvements in some of the work of the local authority, for example in taking an authority-wide approach to child sexual exploitation. The Acting Chief Executive has challenged partner agencies where there have been shortfalls in performance, such as in relation to early help. As yet, this has not led to sufficient positive change.

142. Managers at all levels are visible and approachable. Senior managers chair a number of panels, so that they are in direct contact with frontline staff, and undertake regular audits of cases with social workers. As a result, they understand the operational issues of the service. Staff who spoke to inspectors understood the need to improve services. Most workers had caseloads in excess of the authority's target of 20 cases.

143. The service has a clear supervision policy, which shows how managers can support workers to develop their practice. Staff reported that they were well supported by their managers and received good quality and timely supervision. However, in files seen by inspectors, the recording of supervision did not show sufficient evidence that workers were being challenged and supported to do their jobs effectively. In some cases, there were significant unexplained gaps in the supervision history of staff and not all staff had current performance plans. Training and development needs were not properly monitored.

144. The training offered to staff at all levels is comprehensive and has been used well to focus on areas for improvement. Regular 'lunch and learn' seminars highlight new or changing areas of practice. Training from Rochdale Borough Safeguarding Children Board (RBSCB) is well used.

145. The Assessed and Supported Year in Employment (ASYE) programme is a strength and has been particularly successful in retaining social workers within the authority. However, the authority recognises the need to attract and retain more experienced social workers. A recently implemented professional development framework sets out to provide a clear career path for social workers so that they remain in the authority.

146. The role of the corporate parent is not sufficiently established within the authority. Although this was an area for development in the Improvement Notice, the authority is still not sufficiently ambitious for all the children in its care. The Corporate Parenting Strategy 2013, for example, recognises the importance of offering apprenticeships and training opportunities, but these are still not embedded, and nor is sufficient consideration given as to whether the proposed offer meets the specific needs of the cared for population.

147. The Corporate Parenting Board is properly constituted with senior officers, elected members, and representatives of foster carers and young people in its care. Although members are individually committed to improving services, and are beginning to challenge both the authority and its partners, this commitment has yet to show a significant outcome in improving services. The Board meets infrequently and receives a limited dataset. While the Board focuses on key performance areas, it does not consider the trends in performance outside this dataset. For example, it did not review the significant increase in offending by cared for young people in 2013 and the factors that may have led to this.

148. There are a high number of private children's homes in the area. The local authority runs a monthly Private Providers Group which the lead member attends. Relevant training to promote good practice in relation to missing children and child sexual exploitation k is given. Vigorous opposition has been evident in relation to planning applications from providers wishing to open homes in areas of the town deemed unsafe. As a result risk is reduced to all cared for children in private homes including those placed in the area by other local authorities.

149. Performance management and quality assurance processes have recently improved through the implementation of a new strategy. Managers at all levels undertake regular audits and performance information is scrutinised to ensure that children, young people and their families receive timely services. The introduction of performance clinics each month, chaired by senior managers, offers challenge and scrutiny to individual service areas. As a result, frontline child protection services are beginning to show sustained improvement, but progress has been slower in services to children who are cared for and care leavers.

150. Despite this improved oversight, the authority has only recently become aware of the extent of deficits in the quality of services to care leavers. Although it produces a wide range of performance information, inspectors found that not all these data were properly validated. Scrutiny of data to understand trends is limited. Recent improving trends in the number of young people who attend university, for example, have not been analysed so that improvement can be understood, sustained and built on.

151. Throughout its journey to improve services, the authority has used opportunities to learn from external scrutiny of its services through peer audits. It has commissioned reviews of specific areas, including one to consider the effectiveness of the Health and Well-being Board.

152. Learning from complaints and feedback is well managed to ensure that lessons are learnt. Children and young people seen by inspectors were able to tell them that this had been used to improve practice.

153. The membership of the Corporate Parenting Board includes young people in care, allowing them to communicate the needs of young people directly to senior officers and members. This has resulted in some changes in policy within the authority, for example in improving the provision of laptops to cared for children.

154. The authority has improving relationships with Cafcass and partners within the family justice system, and this has reduced delay in care proceedings. Relationships with the health community are more mature and have contributed to the development of the joint commissioning strategy.

155. In order to provide a high quality and sustainable service for vulnerable children, the authority began a comprehensive and well-planned restructuring. Workforce issues that arose from these changes have been managed effectively, with support from elected members and other departments in the authority. The recruitment of additional social work posts has been managed well. Although the authority's current use of agency workers is high at 35% (50 posts), they are experienced social workers and the majority of them work in parts of the service where the work is more short-term, for example in the MASS. There is a plan to phase out the use of agency staff as permanent staff are appointed. Currently, 27 newly appointed social workers are waiting to start work and a further 22 posts will be advertised in the near future.

156. The local authority reports serious incidents appropriately and has notified Ofsted of three incidents in the last year. Decisions to undertake serious case reviews are undertaken in a timely way. One review is currently in preparation and a second is due for publication in the near future.

The Local Safeguarding Children Board (LSCB)

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

Summary of findings

The LSCB requires improvement because:

Scrutiny, assurance and challenge

- The oversight of allegations management has not yet resulted in effective or timely involvement of all agencies in the process.
- The coordination of multi-agency arrangements for responding to children who go missing from home is at an early stage and does not provide sufficient assurance.
- The RBSCB's challenge to some partner agencies about their engagement with early help has yet to have sufficient impact.
- The work of the RBSCB to improve understanding and application of thresholds by partners is not yet reflected consistently enough within practice.

Awareness-raising, learning and engagement

- The work to identify and raise awareness of privately fostered children has not been effective to date.
- The RBSCB's engagement with young people to drive improvement to safeguarding practice and effectiveness is at an early stage.
- The RBSCB chair is not sufficiently engaged with the Health and Well-being Board and is therefore not maximising opportunities to strengthen the coordination, focus and impact of the RBSCB within the health and well-being agenda.
- The work of the Child Death Overview Panel in identifying modifiable factors in respect of childhood death is not having sufficient impact on learning.

What does the LSCB need to improve?

Priority and immediate action

Management of allegations

157. Ensure that arrangements for the effective management of allegations against people who work with children are sufficiently robust, including the full engagement of partners with the Local Authority Designated Officer (LADO) and the capacity to respond to concerns or allegations in a timely manner.

Thresholds

158. Ensure that all partners have a good understanding of the Needs and Response Framework and are applying the thresholds consistently in their practice.

159. Ensure that all agencies are fully engaged in delivering the early help offer and applying the common assessment framework.

Areas for improvement

Scrutiny, assurance and challenge

160. Further review arrangements for inter-agency responses to children who go missing from home or care, including the provision of independent return home interviews and the collation of themes arising from these to inform service planning.

161. Ensure that managers and practitioners have a good understanding of how to access safeguarding policies and procedures and an up-to-date knowledge of their content.

162. Review current governance arrangements to ensure that the RBSCB is having sufficient influence and impact and that the Health and Well-being Board is focusing sufficiently on safeguarding children.

Awareness raising and engagement

163. Ensure that all partner agencies maximise opportunities to disseminate learning from serious case reviews, lessons learnt reviews and themed audits.

164. Ensure that opportunities to learn from the reviews of unexpected child deaths are maximised to inform safeguarding practices.

165. Strengthen its work in promoting safeguarding within the voluntary, community and faith sectors, with a particular focus on raising awareness of private fostering within communities.

Inspection judgement about the LSCB

166. The RBSCB has made significant progress during the last 18 months. It benefits from strong independent leadership, supported by effective business management. The Board now has a sub-structure, which is fit for purpose and effectively coordinated. Members are appropriately senior to enable the RBSCB to drive forward its key priorities and the wider safeguarding agenda. This rate of progress needs to continue.

167. The development and implementation of Rochdale's Early Help Strategy have been driven by the Children and Young People's Partnership. Fulfilling its responsibilities to monitor the effectiveness of early help remains a challenge for the RBSCB. Despite the launch of the strategy in April 2013, progress to embed an integrated early help offer across all partner agencies has been insufficient. The reluctance of some partners to initiate common assessments means that some children's needs deteriorate and then require statutory intervention. The Board's role in assuring partners' effectiveness, and challenging them where necessary, has yet to make sufficient impact.

168. The RBSCB has made a significant contribution to overseeing the development of the Multi-Agency Screening Service (MASS), including the screening of domestic abuse incidents involving children living within households. However, evidence indicates that partner agencies do not understand thresholds or apply them consistently. The proportion of referrals made to the MASS, which are accompanied by an appropriate assessment, is low. The combination of inconsistent thresholds and the reluctance of some partners to fully engage with the early help offer means that some children and families are not receiving the help they need early enough. The RBSCB is in the process of revising its threshold guidance to partners and there are plans for a series of workshops to support the consistent application of thresholds. A 'deep dive' audit of thresholds is also underway, but these developments are yet to have impact.

169. Some areas of safeguarding performance have not been sufficiently scrutinised by the Board. For example, arrangements for managing allegations against people who work with children indicate that some sectors are not making sufficient referrals to the Local Authority Designated Officer (LADO), including health, police and the voluntary sector. The LADO quarterly report is available to the board but lacks detailed information on contacts made to the LADO. Data produced by the LADO for the first quarter of 2014–15 indicate that 40% of management strategy meetings about allegations took place outside the locally agreed timescale.

170. The number of children who are privately fostered has remained low for a prolonged period. At the time of the review, three children were privately fostered a reduction of one since March 2014. The action plan has yet to be effective in increasing the number of notifications to the local authority. The RBSCB has not evaluated the impact of this work to ensure that awareness raising is appropriately focused and targeted on communities where these arrangements may be more prevalent.

171. The Board's published safeguarding policies and procedures are good. They are suitably localised where the need for more tailored information for practitioners is required, for example, about local arrangements concerning young people at risk of sexual exploitation and the work of the Sunrise Team. However, a survey conducted by the Board in July 2014 indicated practitioners' low levels of awareness and use of these policies and procedures. The Board has taken action to promote awareness through its training programme and newsletters, and has commissioned a further survey of practitioners, but the impact of this has yet to be evaluated.

172. Attendance at the Board is mostly good. The sub-groups are chaired by RBSCB members all of whom are senior officers in their own agencies. Partners are increasingly confident about holding one another to account, and the chair maintains a record of challenge. These indicate an increasingly mature partnership.

173. Governance arrangements are clear and enable the RBSCB to fulfil its statutory responsibilities. A protocol between the RBSCB, the Children and Young People's Partnership (CYPP) and the Health and Well-being Board defines how these partnerships will work together and hold one another to account. The RBSCB chair is a member of the Children and Young People's Partnership and the Improvement Board, and attends the Health and Well-being Board a minimum of twice a year to present the RBSCB's annual report and a half-yearly update report. These arrangements are not maximising opportunities to strengthen the coordination, focus and impact of the RBSCB's influence within the health and well-being agenda.

174. Accountability arrangements are clear. The chair of the RBSCB has regular meetings with the Director of Children's Services and Acting Chief Executive of Rochdale Borough Council. There are also examples of strong collaboration involving the Lead Member for Children's Services to secure partner investment, such as for developing the MASS and responding to child sexual exploitation. This follows high-profile serious case reviews. The Board is developing collaborative approaches with Rochdale Borough Safeguarding Adults Board (RBSAB) and the Community Safety Partnership. For example, active engagement with Greater Manchester Police is designed to strengthen relationships with independent children's homes within Rochdale; a joint conference has taken place with the RBSAB to explore ways of working with children and families where there are problems with parental mental health, alcohol and substance misuse.

175. The Strategic Performance Management and Quality Assurance Framework informs the priorities set out in the Board's business plan. It is helping the RBSCB to improve its monitoring and evaluation of safeguarding practice. A quarterly performance scorecard highlights indicators that are of concern in terms of not meeting agreed targets, those that are changing significantly and those that are 'noteworthy of celebration'. There is evidence that the Performance, Quality Assurance and Improvement sub-group is using data effectively to analyse and evaluate specific areas of practice. While the dataset has evolved to include some partner activity, further work is required to ensure that it reflects the contribution that all partners make to safeguarding children, for example, services for adult mental health and substance misuse.

176. The RBSCB has a well-managed programme of multi-agency themed audits, enabling partners to identify good practice and areas for improvement. The programme is supported by a dedicated quality assurance post, deployed across both the children and adult safeguarding boards. The RBSCB has re-audited some areas of performance, for example around child protection plans due to neglect, to test whether improvements identified have been achieved. The re-audit demonstrated improvements in management oversight and supervision, and information sharing between partner agencies. The audit programme has also included sexual exploitation, missing from home, cared for children, domestic abuse and early intervention. An overarching action plan supports the Board to monitor the implementation of recommendations effectively and the actions agreed by partners. The findings from audits are widely disseminated across partner agencies to ensure a good understanding of their relevance to improving practice. However, not all social workers spoken to during the inspection could identify lessons learnt.

177. The Board operates an effective programme of Section 11 audits, involving the annual completion of an audit by all partners. The audit tool has been adapted for schools to use for their Section 175 responsibilities, although the impact of this has yet to be evaluated. In 2014–15, challenge panels have been piloted to provide additional support and scrutiny. This has enabled the Board to track progress in identified areas for improvement, and to test for assurance where partners have assessed themselves positively against the standards. The process provides an additional opportunity to seek assurance about agency recommendations that have come from serious case reviews. Plans to strengthen assurance through scrutinising key evidence to support self-assessment are appropriate.

178. The Board's Learning and Improvement Framework includes a rigorous process for screening for serious case reviews (SCRs) and for disseminating learning from SCRs and other case reviews. The learning from SCRs has significantly contributed to a number of strategic developments in safeguarding, such as inter-agency responses to child sexual exploitation, neglect and domestic abuse. Actions arising from SCRs are monitored effectively by the SCR sub-group and, where there is slippage, agencies are held to account for this. Learning is disseminated within multi-agency events. These include opportunities for practitioners to hear directly from the independent authors of the reports. Along with messages within the RBSCB newsletters, the Board places strong emphasis on partner agencies disseminating key messages within their organisations. The RBSCB does not currently collate evidence to assure itself that this is undertaken consistently across all partners. The Learning and Improvement Framework refers to learning from child death reviews; however, the effectiveness of learning from the Child Death Overview Panel has not been evaluated.

179. The Board's development and effective implementation of a CSE strategy has resulted in significant improvements to multi-agency responses to young people at risk of child sexual exploitation. Innovative work has been undertaken to raise awareness among young people and to engage with minority ethnic communities. For example, 'World Cafés' were established within communities to engage members of community groups to share and develop ideas about how to address child sexual exploitation in their localities. The Council of Mosques now has a dedicated trained safeguarding lead; 1,600 taxi drivers have completed training; work has been undertaken in respect of licensed premises; 1,395 secondary school pupils have benefited from seeing the play, 'Somebody's Sister, Somebody's Daughter'; and over 16,000 people have completed online CSE training. Face-to-face training has been delivered to 800 staff. Partners, including schools, are very positive about the impact of the work that has been undertaken; for example, headteachers have described the work in schools as 'highly regarded and powerful'.

180. Inter-agency responses to children who go missing are less rigorous. Not all children who go missing from home are offered an independent return home interview. This means that the Board does not currently have sufficient analysis of the reasons why young people go missing and therefore cannot sufficiently monitor the effectiveness of work to minimise or reduce such episodes. The Board is alert to issues of radicalisation and has appropriate procedures.

181. The RBSCB has a comprehensive and good-quality training programme, benefiting from a large pool of committed trainers from various partner agencies. Feedback from delegates is very positive, and the Board has secured good evaluations of the impact of safeguarding training on practice, with 96% of practitioners stating that they have changed or improved their practice because of it. Learning from serious case reviews is well embedded within safeguarding training. The take-up of training across the partners is mostly good. Representation tends to be weaker where agencies cover other local authority boundaries.

182. The RBSCB is focusing on improving the engagement of children, young people and families. For example, it has committed resources effectively to engage in the Crucial Crew initiative, which has led to delivering online safety messages to all Year 6 pupils in Rochdale. Parents and carers views have been included as part of the thematic audit programme and young people have been directly involved with the re-design of the Board's website. The RBSCB receives regular information in respect of parents' experience of child protection conferences. However, the Board's engagement and participation strategy has yet to demonstrate a consistent impact on improving safeguarding practice and outcomes for children.

183. The Annual Report provides a suitably robust analysis of performance and effectiveness and sets out a series of challenges for all partners. The Board has agreed four strategic objectives. These define how business is managed within meetings and provides an effective focus for partner agencies. A well-written young person's version of the report is to be disseminated shortly.

184. The RBSCB is committed to critical self-reflection. The Board commissioned another LSCB to undertake a follow-up peer review to the one undertaken in 2013. The report provides a helpful narrative of the step-by-step journey of improvement that the RBSCB has made, although it falls short of outlining recommendations for further action. While the RBSCB is judged to be not yet good, the Board has made significant progress in terms of its priorities and is now well placed to continue to drive improvements in the coordination and effectiveness of safeguarding arrangements for the children and young people of Rochdale.

What the inspection judgements mean

The local authority

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

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

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

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

The LSCB

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

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

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

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

Information about this inspection

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

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

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

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

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

The inspection team consisted of six of Her Majesty's Inspectors (HMI) and one associate inspector from Ofsted.

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