Oldham 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: 22 May 2015 – 18 June 2015

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Children's services in Oldham require improvement to be good
There are no widespread or serious failures that create or leave children being harmed or at risk of harm. However, the authority is not yet delivering good protection and help for children, young people and families. The authority is not yet delivering good care for children and young people looked after. Leadership, management and governance require improvement when any widespread or serious failures have been identified by the local authority and they are being effectively addressed, but the characteristics of good leadership are not in place. It is Ofsted's expectation that all children and young people receive the level of help, care and protection that will ensure their safety and help prepare them for adult life.

1. Children who need help and protection		Requires improvement
2. Children looked after and achieving permanence		Requires improvement
	2.1 Adoption performance	Good

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

	2.2 Experiences and progress of care leavers	Requires improvement
3. Leadership, management and governance		Requires improvement

Contents

The local authority

Information about this local authority area[2]

Previous Ofsted inspections

- The local authority operates four children's homes. All four were judged to be good or outstanding in their most recent Ofsted inspection.
- The previous inspection of Oldham's safeguarding arrangements was in February 2012. The local authority was judged to be good.
- The previous inspection of Oldham's services for looked after children was in February 2012. The local authority was judged to be good.

Local leadership

- The Director of Children's Services (DCS) has been in post since January 2015. She is also the Director of Adult Social Care Services.
- The chair of the Local Safeguarding Children Board (LSCB) has been in post since July 2014.
- The local authority has delegated its youth offending services to a local voluntary organisation, Positive Steps.

Children living in this area

- Approximately 57,168 children and young people under the age of 18 years live in Oldham. This is 25% of the total population in the area.[3]
- Approximately 27% of the local authority's children are living in poverty.[4]
- The proportion of children entitled to free school meals:[5]
  - in primary schools is 23% (the national average is 17%)
  - in secondary schools is 22% (the national average is 15%).
- Children and young people from minority ethnic groups account for 37% of all children living in the area compared with 22% in the country as a whole.[6]
- The largest minority ethnic groups of children and young people in the area are Asian or Asian British.[7]

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[2] The local authority was given the opportunity to review this section of the report and has updated it with local unvalidated data where this was available.
[3] ONS Mid Year 2013.
[4] HMRC Snapshot as at 31 August 2010.
[5] DfE Schools, pupils and their characteristics.
[6] ONS 2011 census.

- The proportion of children and young people with English as an additional language:[8]
  - in primary schools is 35% (the national average is 19%)
  - in secondary schools is 27% (the national average is 14%).

Child protection in this area

- As at May 2015, 1,732 children had been identified through assessment as being formally in need of a specialist children's service. This is an increase from 1,680 at 31 March 2014.[9]
- As at May 2015, 329 children and young people were the subject of a child protection plan. This is an increase from 277 at 31 March 2014.[10]
- As at May 2015, three children were living in a privately arranged fostering placement. This is a reduction from nine at 31 March 2014.[11]
- Since the last inspection, 12 serious incident notifications have been submitted to Ofsted and six serious case reviews have been completed or were ongoing at the time of the inspection.

Children looked after in this area

- As at May 2015, 392 children were being looked after by the local authority (a rate of 69 per 10,000 children). This is a very small reduction from 395 (69 per 10,000 children) at 31 March 2014.[12]
- Of this number 140 (or 36%) were living outside the local authority area:
  - 22 in residential children's homes, of whom 9% were living out of the authority area
  - two in residential special schools out of the authority area
  - 275 with foster families, of whom 36% were living out of the authority area
  - 53 with parents, of whom 30% were living out of the authority area
  - one child is an unaccompanied asylum seeker.
- In the last 12 months there have been:
  - 31 adoptions

[7] ONS 2011 census.
[8] DfE Schools, pupils and their characteristics.
[9] DfE Characteristics of children in need in England.
[10] DfE Characteristics of children in need in England.
[11] DfE Notifications of private fostering arrangements in England.
[12] DfE Children looked after in England including adoption.

- 13 children who became subject of special guardianship orders
- 165 children who have ceased to be looked after, of whom 7% subsequently returned to be looked after
- 21 children and young people who have ceased to be looked after and moved on to independent living
- nine children and young people who have ceased to be looked after and are now living in houses of multiple occupation, such as supported accommodation.

Executive summary

Services for children, young people and their families were judged good at the last inspection in 2012. Since then services for children in need of help and protection, children looked after and care leavers have not made the progress expected. Some improvements have been made, such as the timeliness of adoption placements, and the overall standard of adoption services now is very good. The quality of personal education plans and the educational attainment and progress of children looked after and care leavers is not yet good enough. While the vast majority of children in Oldham receive services appropriate to their needs, the overall standard of social work practice is too variable. Some children receive very good quality assessment, support and services. A small minority of children do not have their full needs sufficiently well identified to enable effective services to be provided and for their outcomes to improve.

Children and their families generally experience a timely response to their needs, with a good offer of early help and statutory support being provided where necessary. For those children who need a statutory service, many receive a good standard with thorough assessments, plans and effective interventions. Others receive less thorough assessments, although the standard of the majority seen were at least requiring improvement. Some assessments lack detail, do not take the child's history into account well enough, and do not result in clear, measurable and time-bound plans. Children looked after and care leavers receive good support from their corporate parents in terms of the quality and stability of where they live and access to health and leisure services. However, too many are not in education, training or employment.

The variability in recording, supervision and management oversight is a theme across children's social care and requires attention to raise the standard to consistently good. The quality of services for children and families is mixed across children's social care. Some work is very good and thorough while other practice is less so. The council's restructuring in 2014 shared the responsibility for different aspects of children's services across different directorates; matrix management arrangements ensure that the DCS and chief executive have oversight of all aspects of children's services. There has been an appropriate focus on identified areas of weakness such as the timeliness of initial child protection conferences and the need for independent reviewing officers to speak privately with children before their meetings, but improvements are slow. The variable quality of assessments, supervision and management oversight within children's social care is increasingly well understood by the senior leadership team since the DCS took up post in January 2015. Some measures are in place to raise standards, but there is more to do to drive progress quickly enough. The DCS is also responsible for adult social care and is promoting good links between both aspects of social care services although it is early days in terms of impact.

The leader of the council, the lead member for children, the chief executive and the DCS all report good and appropriate relationships between political leaders and

senior officers. The priority given to children's safeguarding and welfare is exemplified in continuing efforts to protect children's services from budgetary reductions. Regular meetings are held that demonstrate scrutiny and challenge, and political leaders are knowledgeable about the wider issues facing children's services. There are well-established arrangements in place between partnerships such as the Community Safety Partnership, Local Safeguarding Children Board (LSCB), Local Adult Safeguarding Board (LASB) and the Health and Wellbeing Board. All execute their functions appropriately. Some communication arrangements between these partnerships has been formalised and some senior officers are represented on more than one board, which assists the flow of information. There is a need to clarify and formalise accountability, reporting and challenge arrangements so that areas of common concern, for example children living with domestic abuse, have appropriate services to meet their needs.

Good commissioning arrangements are in place to use third sector services appropriately, such as undertaking return interviews for children who have gone missing. However shortfalls in services have not been addressed swiftly enough, for example return interviews were not completed to the expected standard in 2014–15. This has had a detrimental impact on tackling children going missing, as the intelligence gathered through return interviews has not been informing a strategic approach.

The challenge of recruiting and retaining social workers is well understood within children's social care and good efforts are made to attract new staff. However, the workforce strategy does not take sufficient account of current and future pressures to inform contingency and forward planning arrangements. Although social workers report that they feel supported and valued in Oldham and have manageable caseloads, staff turnover has resulted in newly qualified social workers accounting for over 40% of all social workers responsible for safeguarding. Within children's social care, there is a need to improve the quality of supervision and management oversight of social work practice across the service; it is currently variable and too much is not yet good.

The senior leadership team recognises the need to improve the quality of performance information and good efforts are underway to achieve this. Current performance data does not consolidate and highlight all trends and provide explanatory narratives. Routine auditing of children's files is robust and identifies strengths and weaknesses. Shortfalls are not always fully addressed and recommendations made are not always followed through.

There is a good strategic response to major criminal activity such as child sexual exploitation, human trafficking and drug distribution. Effective working across partner agencies means that the links between these criminal activities are becoming increasingly well understood. This in turn is enabling partners to protect children and young people more effectively.

Recommendations

1. Auditing of children's cases should ensure that all shortfalls in practice are identified, addressed and checked to ensure compliance (paragraphs 33, 154).

2. Ensure that all social workers benefit from good management oversight and supervision that provides direction, is well recorded, improves the quality of work with children and young people and is consistently of good quality (paragraphs 33, 34, 35, 138, 152, 153).

3. Performance management systems must enable staff and managers, in particular those with responsibility for care leavers' services, to understand the strengths and weaknesses of their service so remedial action can be taken promptly (paragraphs 139, 147).

4. Ensure children and young people have good quality assessments and plans which are up to date, take account of historical information, prioritise tasks and ascribe actions within clear timescales (paragraphs 25, 27, 43, 54, 56, 58, 75, 120, 152).

5. Ensure that strategy meetings include staff who are responsible for any subsequent child protection investigations (paragraph 24).

6. Children and young people on child protection plans must receive statutory visits in line with the local authority's expectations (paragraph 30).

7. Make sure core groups and child protection conferences are recorded in sufficient detail to show the progress made and reflect the views of participants. Children's contribution to child protection conferences should be strengthened (paragraphs 27, 36).

8. Ensure that independent reviewing officers (IROs) robustly challenge plans for children where there is drift and gather the views of children and young people before statutory meetings (paragraphs 28, 92, 155).

9. Track all children's cases through legal proceedings from the pre-proceedings stage to the making of final orders to ensure that drift and delay are avoided (paragraphs 62, 148).

10. Strengthen transition planning for disabled care leavers and other young people with complex needs so that they receive all the services they are entitled to, including support from the aftercare service (paragraph 122).

11. Ensure that all care leavers have full information about the entitlements they can expect from their corporate parents in addition to the more generic guidance currently available (paragraph 136).

12. Record return interviews with children who have been missing on their electronic records so that this information is clear and accessible and can fully influence planning (paragraphs 44, 59).

13. Ensure there is equal consideration and evaluation of the risks to young men who go missing as for young females who go missing (paragraph 45).

14. Ensure that the pupil premium is used to best effect by schools to enhance children's and young people's learning and ensure that schools inside and outside the borough monitor its impact (paragraph 77).

15. Actions taken in relation to concerns about adults who work with children must be fully recorded so respective responsibilities and tasks are clear (paragraph 52).

Summary for children and young people

- Council bosses and senior managers want to make sure all children and young people in Oldham get good services that meet their needs and give them best start in life. Inspectors spoke to staff and managers in the council, carers, children and young people, and looked at a lot of children's and young people's files. This helped us understand what is working well now and also how the council can improve the help it provides.
- Most services for children and young people in Oldham have been judged to require improvement because they are not all good. The adoption service is very good. Staff work hard to make sure that if adoption is the best plan for a child, they are found a family as quickly as possible.
- The Children in Care Council (CiCC) has a big impact on how children and young people are looked after and given support in Oldham. The local politicians and council managers listen to and act on what the CiCC says. The CiCC has helped to design things like leaflets that will really help other children and young people in the future.
- Oldham works hard to recruit enough social workers and there are not many vacancies. This means that all children and young people who need a social worker have one. Children and young people do not like having to change social workers and some have had lots of different ones. Social workers, particularly those that are newly qualified, need better supervision and guidance from their manager so that they are helped to support children and young people better.
- Children, young people and their families who need help get assessments, social work support and other services. Children and young people benefit from this support. Some assessments need to be better at taking everything into account, such as what has happened to children and young people in the past. Plans need to be clearer about what everyone is expected to do to improve things for children and young people.
- Children and young people only become looked after when they need to. There are enough foster places for all looked after children to be able to live in Oldham or nearby with a family that is right for them. The council needs to improve the information it gives to care leavers about what they are entitled to, and increase the choice of accommodation so care leavers have the right support for as long as they need it, and can learn to live independently and cope on their own.
- Oldham needs to do more to help looked after young people do better in education so they get more qualifications, get the chance to go on training courses and get jobs. Too many young people are not doing any of these things at the moment.

The experiences and progress of children who need help and protection	Requires improvement

Summary

Agencies work together well to address the needs of those vulnerable children and young people in Oldham who need help at a lower level than statutory social work support. The multi-agency safeguarding hub (MASH) responds promptly to contacts and concerns. Strategy meetings are well attended by partner agencies and chaired by a social work manager but do not always include the social worker who will undertake the subsequent intervention. There is effective information-sharing in relation to children who go missing, those who may be at risk of child sexual exploitation and those at risk of domestic abuse, but the risk of sexual exploitation is not considered by practitioners in relation to boys and young men well enough. The newly commissioned service that undertakes return home interviews is showing improved performance but the records of interviews are not always added to the child's file, and this hampers risk assessment and planning for them.

The quality of management and supervision of social workers is mixed. This variability is evident across the full spectrum of children's safeguarding services. Management oversight is recorded too briefly in both supervision files and on children's files, although social workers report good access to managers and advice. There is a lack of evidence of reflective supervision supporting good quality social work practice.

Auditing of children's case files is effective in identifying both strengths and weaknesses in practice. Audits correctly identified shortfalls in practice, resulting in most of these being promptly addressed. However, some deficiencies have not been rectified and the lack of robust follow up by auditors or managers means that learning from auditing is limited in driving up practice standards.

Most children and young people experience timely assessments and interventions, resulting in improved safety and better outcomes. The quality of assessments is variable – from requiring improvement to good. The better ones take account of less explicit risk factors and historical information. Plans also vary in quality and there is a need to prioritise actions so that the most urgent are clear. Initial child protection conferences are thorough and well recorded. Review conferences and core groups are timely and well attended but records of these are too focused on future actions and lack detail about progress since the last meeting and the views of attendees. Children's views are not always considered at conferences and advocates are under-used. Good efforts are made to see children on child protection plans in their family home but insufficient consideration is given to what action is needed when social workers are unable to gain access to children on a child protection plan.

The local authority designated officer's (LADO) records are poor and do not always demonstrate all actions taken and decisions agreed.

Inspection findings

16. Early help and preventative services are increasingly effective. A wholesale re-organisation of preventative services, launched in April 2015, has improved access to appropriate early help for families. The early help service framework has a strong emphasis on coordination and learning lessons from the effective Troubled Families programme. At October 2014 680 families were in receipt of targeted support from this programme, with 80% showing improvement in some aspect of their lives, for example better school attendance by children. Service improvements arising from the re-organisation includes a single point of contact and clear routes for agencies and the public to receive advice, make referrals and be signposted to appropriate services. Inspectors saw very good multi-agency coordinated responses being offered to families according to their needs.

17. Families identified as needing additional support are allocated a worker who undertakes an early help assessment and secures appropriate services from a range of commissioned providers. Although the re-design of early help services is relatively recent, from cases seen it appears to be effective with staff using agreed tools to assess need and help families access the right services. In October 2014 there were 305 assessments but by April 2015 this had risen to 1,377. Managers continue to monitor early help pathways and services closely and this is effective in maintaining a swift and appropriate response to needs and risks.

18. The interface between early help services and children's social care is good. Partner agencies are positive about the support and guidance they are able to access, for example in relation to early help, safeguarding, radicalisation and child sexual exploitation. The 'threshold and continuum of need' document is clear and valued by partner agencies. As a result, thresholds for children's social care services are better understood.

19. Contacts from other agencies are dealt with swiftly by the MASH and allocated to either early help or children's social care as appropriate. The volume of contacts has increased from 351 per 10,000 in April 2014 to 380 in April 2015, attributed to an increased understanding and positive impact of the MASH. The number of children in need of statutory social work support has also risen in that time period from 1,374 to 1,450. Although re-referrals within 12 months increased in successive quarters in 2014–15, the rate of 14% for quarter 4 is still comparatively low but is being closely scrutinised by managers to ensure it does not rise to a point which might indicate the initial response was insufficient to meet need. The most recent nationally published data for 2013–14 showed a re-referral rate of 18%, lower than statistical neighbours (20%) and the England level (23%).

20. The MASH benefits from the physical co-location of a wide range of agency representatives, including early help, adult safeguarding, community safety, health safeguarding staff, police public protection staff and domestic violence

specialists. This supports prompt and effective information-sharing and joint planning. However, while these activities occur regularly, case recording does not always reflect the richness of discussions and decisions made. In a small number of cases seen, there was insufficient consideration by social workers of historical matters. This resulted in a few children being inappropriately signposted to early help services, which meant that they were re-referred for social work assessment once the level of need and risk had been enquired into more thoroughly. The robustness of these 'step up' arrangements ensures that children receive a service appropriate to their level of need and risks.

21. Children and families who are initially assessed as needing support but not at the level of statutory intervention, have their needs considered at weekly meetings. The meetings are well run, attended by a very wide range of agencies, consider the needs of families in detail and identify appropriate support services which are promptly put in place to help families.

22. The social care MASH team manager considers all children and young people who are reported as missing, at risk of child sexual exploitation and those at risk from domestic abuse. The manager's ability to access the police national computer system enhances her ability to carry out further checks if necessary. Children's social care staff participate fully in the police-led Operation Challenger, which tackles organised and serious crime. Weekly meetings, convened by the police, ensure information about organised crime is linked to emerging and known concerns about vulnerable adults and children to maximise opportunities to disrupt illegal activity, prevent harm and rescue those already experiencing harm. 'Silo' thinking is avoided and links between different types of criminal activity and their impact on vulnerable people is becoming increasingly well understood. Close liaison between the council and the police has raised awareness of radicalisation and provided guidance to partner agencies about what to do if they have concerns. The regular Channel panel considers all referrals in detail, ensuring they are assessed for engagement, capacity and intent and followed up as necessary. Strong support from a wide variety of council and other relevant agencies, such as the MASH, benefits agencies and housing providers, maximises the effectiveness of these arrangements and maintains a clear focus on the welfare of children who may be identified by either the Challenger or Channel forums.

23. The Oldham Emergency Duty Team (EDT) provides a good quality social work service for children and adults outside office hours, although records of social work activity are too brief in a minority of cases and of a lower standard than daytime services. Handover arrangements between EDT and daytime services are seamless, and outstanding tasks are followed through promptly. The MASH team manager provides good support to EDT staff.

24. Where there are concerns of a child protection nature, strategy discussions are held in the MASH before cases are passed to the children's assessment team (CAT). Strategy discussions are always chaired by a social work manager. However, social workers from the CAT are not always available to attend the

strategy meetings so do not hear at first-hand what the issues are and what other information is known; they rely on information and guidance from the social work manager and the written record of the strategy discussion. The quality of the recording of these meetings is variable. Some good examples were seen but others lack sufficient detail, including specific actions about how agencies will review the progress of the work.

25. All child protection cases are dealt with promptly by the CAT. At the time of the inspection, the CAT was not fully staffed, which means priority is given to child protection cases over those requiring assessment to determine level of need. This means some children experience some delay. The quality of the work in the team varies, with some good practice seen. Inspectors also saw poorer assessments that lacked a focus on key issues or were poorly recorded, although no children were left at risk as a result.

26. The timeliness of initial child protection conferences (ICPCs) has been poor. The local authority reports that this has been due to a misinterpretation of national guidance. Local processes have very recently been amended to rectify this. The local authority's figures for conferences held within 15 days are 57% in quarter 3 of 2014–15 and 61% in quarter 4. However, 25% of all conferences were held on the 16th day and this shows improving performance overall. Managers are closely monitoring the revised arrangements to improve timeliness but it is too soon to see any impact of this. ICPCs are well attended by relevant partner agencies and are very well recorded. Risks are considered well and children who require a child protection plan are identified appropriately.

27. Child protection plans set out the matters that need addressing clearly and are thorough. However, many contain large numbers of actions. These need prioritising to ensure that the most urgent or significant needs are highlighted and receive the most focus. In the majority of cases actions are set out but require more detail about who is responsible for each one and the timescales for expected completion. Most review child protection conferences (RCPCs) are timely. Social workers routinely update their assessments for RCPCs but the level of detail underpinning assessments varies. Some are very good but some require improvement. RCPCs are recorded by way of a chair's summary which includes a good level of detail in the decisions and actions agreed upon. However no other notes are formally made of the RCPCs so it is not clear what the 'distance travelled' by the family is, whether risks have increased or diminished, the contributions made by partner agencies and any different views expressed. Although a note about any challenge raised by the chair is made separately on the child's file, the content of this is not included. Core groups are recorded in a similar manner and although some social workers keep a separate note of the meeting, this is ad hoc and does not address the current weaknesses in recording practices seen during this inspection across the range of services.

28. Child protection conference chairs report that they have sufficient time to prepare for conferences. A conference observed during the inspection was well attended, chaired effectively and considered risks well. The vast majority of reports are available before the conference, but not all are provided early enough for families to absorb their content. The local authority has a 'notice of concern' and 'dispute resolution log' for conference chairs and IROs to use and track matters they have raised, including the occasional late presentation of some reports. This is used appropriately to notify social work managers and staff of shortfalls, but the IRO service acknowledges that it needs to chase up and escalate matters more robustly to achieve the improvement intended.

29. The local authority appropriately identified poor attendance by partner agencies at core groups as an issue of concern and has targeted this effectively. Performance has improvement significantly and core groups are now well attended and timetabled. However, inspectors saw a minority of cases where core groups had not been held in the expected timescales. In others, the child's record shows a core group meeting was held but the electronic template was not completed.

30. Inspectors saw many examples of good direct work with children, parents and carers by both social workers and family support workers that effectively reduced risk in families. Children subject to child protection plans are visited regularly and most children on a plan have support from both a social worker and a family support worker, increasing the range and volume of support and contact with the children and their parents. Good efforts are made to engage families, including those who are initially reluctant for various reasons. However, inspectors saw a minority of cases where the recording of visits did not make it clear what the purpose of the visit was, which children or adults were seen and spoken to, and whether statutory visits were meeting expected timescales. In a minority of cases, successive or frequent visits where no access to the family home was gained did not lead to a sufficiently detailed reflection between the social worker and their manager about whether an alternative approach was warranted. For a very small number of children on child protection plans, essential actions were underway but were taking a long time to be implemented and make a positive difference, such as the provision of specialist support services following referrals being made to help families tackle complex issues and improve the quality of their parenting.

31. 'Child in need' meetings are held regularly and attended well by appropriate agencies and family members. In the majority of 'step down' cases sampled, practice was good and led to appropriate less intensive support services. In two cases out of 10 sampled, there was insufficient consideration of all the risks to the children and young people and the step down plan was premature.

32. Some of the children and young people who spoke to inspectors complained about having too many changes of social worker. One young person with a child protection plan told inspectors she had experienced changes of social

worker 'very often' in CAT and now had a social worker from a long-term team whom she 'didn't see much'.

33. Some children's cases are recorded very well with a good level of description and analysis; others are too brief. A key impact of poorer quality recording is that it inhibits robust management oversight of social work practice. Some social workers benefit from thorough supervision, but the majority of supervision files seen during the inspection show that supervision is too infrequent. Some records consist mainly of summaries of current cases rather than detailed reflection and agreements about next steps. The local authority's routine quality auditing of cases was seen on cases sampled and these were thorough. The audits resulted in the majority of remedial actions being undertaken, but not all shortfalls were addressed in every case and there is a shortfall in the rigour with which follow-up occurs to ensure compliance. This limits the effectiveness of the quality auditing programme.

34. All children and young people in need of help and protection are allocated promptly to a social worker. In a minority of cases, children with a child protection plan are allocated to workers who are in their first year of employment. Newly qualified social workers (NQSWs) benefit from protected caseloads, specialist support from a senior practitioner mentor as well as management supervision and support. However, the variability in the records of supervision seen means that the local authority cannot be certain that the oversight of cases held by NQSWs through formal supervision is as strong as it needs to be.

35. The variability in recording, supervision and management oversight is a theme across children's social care and requires attention to raise the standard to consistently good.

36. Young people have been consulted about different service developments, including the early help strategy. Their involvement has led to improvements in some areas, for example the development of leaflets for those involved in child protection enquiries. In the vast majority of cases, children's views are documented in assessments and reports to child protection conferences. The extent of participation at child protection conferences is difficult to determine because the local authority does not clearly differentiate between children contributing to a child protection conference and looked after children contributing to their reviews. Of the 646 children over the age of four who were the subject of a review or a conference in 2014–15 597 attended or conveyed their feelings in some way, but only one young person has attended a child protection conference in the last six months. The commissioned advocacy service has been under-used, although this has improved from 29 referrals for advocates in 2013–14 to 59 in 2014–15. The local authority has recently amended the referral process for this service with the intention of triggering greater uptake, but further work is needed to increase awareness of the resource and use it to benefit children and young people who are subject to child protection conferences.

37. The quality of work in the children with disabilities team is generally good. A particular strength is direct work with children, increasing their awareness of safeguarding issues. The team has recently been strengthened with the addition of staff who have significant child protection experience.

38. Children's and families' diverse needs are considered well in assessments and plans, in particular for those minority ethnic communities who have been settled in Oldham for some time. The local authority is aware of the need to do more to understand the needs of more recent arrivals such as families from East European countries and Roma communities, which are significantly expanding in the borough.

39. The local authority's knowledge of the prevalence of domestic abuse, parental substance misuse and mental ill-health, extrapolated from the number of adults who are in receipt of a service, is used to good effect to estimate the impact on children. For example, from the 130 domestic violence notifications per quarter from the police, the local authority estimates that there are approximately 520 children living in households with domestic abuse. Similar exercises inform estimates of children living with a parent who suffers from mental ill-health or has substance misuse difficulties, and those who may be experiencing neglect. This provides a good baseline for planning service delivery and meeting children's needs where the potential for harm or neglect is apparent. The local authority is aware that more analysis is required to help identify children experiencing hidden harm and to provide or commission services that meet their needs.

40. Work to tackle domestic violence is well coordinated. All police notifications are considered by the MASH and sent for a social care assessment if required. The most serious cases of domestic abuse requiring multi-agency risk assessment conferences (MARACs) take good account of children's needs and the risks to them. Services for victims of domestic abuse have improved and independent domestic violence advisers (IDVAs) can now offer support to all victims, not just those at the highest risk. This has led to approximately 750 adults being supported, an increase of 75 on the previous year.

41. Regular meetings consider children and adults who are missing, children at risk of sexual exploitation or serious domestic abuse and known sex offenders. Led by the police and well attended by a range of agencies, these high quality information-sharing and problem-solving meetings enable effective and creative solutions to tackle complex issues including the identification of individuals who present a potential risk to children. For instance, there has been some good work tackling children going missing by photos being circulated through 'Pub Watch'.

42. Awareness-raising of female genital mutilation (FGM) is good, supported by pan-Greater Manchester guidance. There is good liaison with community leaders. Specialist local charities are supported to train professionals and provide support to victims. The community safety team's risk-mapping of local

minority ethnic communities has enabled targeted interventions to be focused on those schools which have high numbers of pupils from the most 'at risk' communities. No child victims of FGM have come to the attention of children's services, but hospital staff have recently referred two cases of pregnant women who had been subject to FGM. Appropriate child protection enquiries were initiated as a consequence to ensure that the mothers were able to protect their children in the future.

43. The long-established Phoenix team tackling child sexual exploitation includes specialist police and social workers and is effective. The team has recently been strengthened with additional social care capacity and further expansion is planned. There are good awareness-raising activities such as the 'week of action', which included visits to all the hotels in Oldham. It also included distribution of leaflets, wristbands being given out in schools and colleges, all secondary schools having two performances of a specialist play, bespoke sessions held for minority ethnic women's groups, and one teacher from every school attending a 'training the trainers' session. In total, over 10,000 children and young people have attended awareness-raising events in schools. Sixty imams have attended and more awareness-raising across all communities in Oldham is planned. While this is a strong aspect of the work to tackle child sexual exploitation, direct work with children is more variable. Eight children's files were sampled from a list of recent cases supplied by the local authority. In three of these cases, there had been an appropriate response with effective work leading to safer behaviour by the young people. In the other five cases, the response was not sufficiently robust, with weaker assessments, planning and interventions. Overall, the response from children's services to child sexual exploitation lacks consistency with some risks taking too long to identify and respond to.

44. During 2014–15, not all children who returned home or back to care after a missing episode received a timely return interview. The local authority commissioned a new provider from April 2015 to deliver a service for children who go missing from home as well as those who go missing from care. Current performance data shows an improvement in the percentage of return home interviews with young people within 72 hours and is currently above 80%. While this is an improving picture, there is more to do to ensure that all children and young people who go missing are offered an interview on their return. The record made of the return interview by the commissioned service is not always sent through to be added to the child's electronic record, and this means the information gleaned from the interviews does not promptly and routinely inform the child's plan.

45. When young women go missing, the risks associated with child sexual exploitation are considered. Risk assessment tools are completed, referrals to the Phoenix project are made and direct work is undertaken that reduces risk. However, when boys and young men go missing, the risks associated with child sexual exploitation are not automatically considered, so these young people may be left at risk.

46. There are good arrangements to record, monitor and investigate children who are missing from education. The authority makes extensive efforts to locate children who require a school place but are missing from education. Attendance officers visit every family whose children do not attend school to encourage attendance. Good use is made of legal powers: in the 10 months leading up to this inspection, 35 school attendance pre-order letters were sent to parents resulting in 28 enrolments. Seven school attendance proceedings are in progress. Every child of school age is allocated a place within 10 days of being notified. In the academic year 2014–15, 1,067 children moved into and out of the borough.

47. Good tracking of the 75 children who receive less than 25 hours of education per week in Oldham is undertaken by the local authority and broad information about their activities is collated. This needs to be more detailed and include, for example, the topics which children study in alternative provision. The virtual school does not scrutinise these children's educational plans, so is unable to be assured that the provision will increase the children's chances of joining mainstream provision and succeed. A minority of children receive only a few hours of education per a week and the virtual school does not know how these children spend the rest of their time. As a consequence of these gaps in knowledge, the virtual school has initiated a full review of the 'less-than-twenty-five-hours' provision to improve its effectiveness.

48. In 2015, there has been almost a three-fold increase in the number of children who are home educated – 100 children at the time of the inspection. The local authority monitors these children closely, provides support to the children and their families, and monitors trends. All families are visited and given advice. Safeguarding issues seen are passed promptly to children's social care.

49. There has been good work to raise awareness of private fostering across agencies and the wider public. A good leaflet and practitioners' guide have been produced, and a range of awareness-raising events took place in July 2014, with plans to conduct similar activities this year. Pilot work with one secondary school has led to a private fostering notification and this is to be rolled out to other schools in the future. Despite this, the number of referrals remains low at three. The quality of ongoing social work support these children receive is inconsistent, although all have had an assessment of need and suitability.

50. Good arrangements are in place to support 16 and 17 year olds who present to the aftercare service or the housing department as homeless or at risk of homelessness. These include mediation services to help resolve family problems, the adolescent support unit which provides short term accommodation and intensive family support to help resolve the issues that led to the young person leaving the family home. All homeless young people are jointly assessed within 24 hours by a social worker and housing officer, using an appropriate assessment tool.

51. The LADO has undertaken good awareness-raising work with representatives of the local Muslim community, such as imams, regarding the role of the LADO and wider safeguarding issues. This has had a positive impact and referrals have increased to 103 in 2014–15 – an increase from 98 in 2013–14 and 69 in 2012–13.

52. Although awareness-raising by the LADO is good, records of what happens with individual adults who are referred are weak. They do not make clear what actions are to be taken and by which agency or personnel. Contact with other agencies is not noted and there are no clear outcomes. This means it is not clear which agency is responsible for specific actions. This risks both omissions and duplication of effort.

The experiences and progress of children looked after and achieving permanence	Requires improvement

Summary

The majority of children looked after have good assessments of their needs which are updated regularly and inform planning. In a small minority of cases the assessments need to be more thorough and updated. This variability reflects the variability seen for children who receive help and protection services.

Reviews are timely and take good account of the views of children and young people. Because of high workloads, independent reviewing officers (IROs) do not always speak to children privately before their reviews, do not always monitor their progress between reviews in sufficient detail, and have not been able to challenge drift. Additional capacity has now been provided for the service to rectify this.

There is a good range of placements and most children are placed close to home, with brothers and sisters, and do not move unnecessarily. Children looked after are cared for well by foster carers and other carers.

Children looked after and care leavers have their health needs met promptly. The child and adolescent mental health service (CAMHS) is beginning to show a positive impact.

The Children in Care Council is active and its members are influential participants in the corporate parenting group.

Children who need an adoptive family have their needs met very well. Recruitment processes are successful and good post-adoption support is provided.

Return interviews for looked after children and care leavers who go missing are improving, but records of these need to be included on their files to inform planning. The risks to boys and young men who go missing are not considered well enough.

The virtual school keeps a good overview of the progress of children looked after and care leavers, and there is a clear understanding of what improvements are required to help children do better. The quality of personal education plans is inconsistent and too few children looked after achieve five good GCSEs. The overall impact of the pupil premium is unknown although individual children have benefited.

Children who require legal protection are not systematically tracked from the earliest point to the making of final orders to reduce drift and delay. Family group conferencing needs to be developed further to help families support their children.

Care leavers are positive about the support they receive and have good relationships with their support workers. However, their pathway plans lack ambition for them and need to be more specific about the support young people will receive. Care leavers do not have written information about their entitlements from Oldham. The care leaving service does not have robust performance data to help drive forward service improvements.

Inspection findings

53. Children become looked after when they need to. Risk is identified and responded to well in most cases, and is reduced because appropriate decisions for children to become looked after remove them from risky situations.

54. The quality of frontline social work practice is too variable. The quality of assessments is not consistent and some do not cover all the key issues. Others have weak analysis of the information presented. Better assessments are thorough and analytical, with some appropriately presented as social workers' reports for children's looked after reviews.

55. Case recording is too variable. In some cases it is detailed and describes a child's circumstances well; in others it is limited, lacking clarity about the chronology of events so it is not always easy to follow a child's story.

56. Plans are not sufficiently robust in a majority of cases. They are not always up to date and some are too basic or are reactive to events rather than driving forward planned improvements. This means it is not clear what is to be done, who will do it and when it will be done by.

57. Multi-agency working is positive in a majority of cases, with effective communication and joint working by social workers with other agencies such as schools, placement providers and CAMHS. Where this is not done as well, liaison is not effective, and agencies are not regularly kept up to date or consulted about planning.

58. There is a well-established system to ensure that the local authority is notified when a child goes missing. The MASH receives a list of missing children each day. It is clear which children have gone missing from care and includes detailed information about the length of time missing, and events that occurred immediately upon their return. Social workers are advised promptly. This is monitored on a daily basis by senior managers in children's social care. There is a clear escalation process of meetings in place and this is accurately reflected in children's electronic files. At the second stage, missing meetings are chaired independently by an IRO. However, although meetings do consider key issues such as 'push' and 'pull' factors, they do not always produce clear plans with specific objectives and outcomes.

59. Return interviews following missing episodes are not routinely recorded on children's files, either in the form of records of the actual interviews, or in case notes indicating that young people have been spoken to. This means that opportunities to learn and protect some children from these episodes are lost. The local authority is currently developing its electronic case recording system to enable return interviews to be captured, but this is not yet fully developed.

60. Most assessments where children are returned to their parents after a period of care are good. These children continue to receive social work support for a period, once home.

61. In the large majority of cases where children are placed with parents under a care order, assessment is appropriate. However, plans to revoke care orders for children placed with parents are not consistently pursued in a timely fashion, so some children remain in care for longer than they should. As at 31 March 2014, 13% of children looked after were placed with parents compared with 8% for statistical neighbours and 5% nationally.

62. Overall, the quality of pre-proceedings work undertaken in line with the Public Law Outline is inconsistent and not all of this work progresses as quickly or as effectively as it should. The local authority does not track cases from pre-proceedings work through to the conclusion of proceedings. This means that managers cannot see when cases are not moving forward in children's timescales.

63. Social workers have access to legal advice through legal planning meetings offered weekly by the local authority's legal services. Arrangements are in place to provide legal advice at short notice in emergencies. Letters written to parents when the local authority is considering entering legal proceedings are clear about the concerns and what parents need to do, though they are not always written in language that would be easy for parents to understand.

64. The local authority has commissioned only a small number of family group conferences; this area of work is not sufficiently well developed to consistently allow families to participate in developing plans for children or to identify alternative carers for them.

65. The timeliness of court proceedings for the year to date as at the end of the fourth quarter of 2014–15 shows that the local authority is completing proceedings in an average of 33 weeks. Timescales outside the expected 26 weeks are seen across other local authorities in the region and the local authority has been involved in work with partners on the Local Family Justice Board (LFJB) to understand why this is. This work has led to actions to reduce these timescales being agreed between the local authorities represented on the LFJB and the judiciary, although the impact of this work has yet to be seen.

66. The Children and Family Court Advisory and Support Service (Cafcass) is positive about the work the local authority presents to court in care proceedings. Social workers and IROs work well with children's guardians, keep them up to date and involve them appropriately in the planning for children.

67. In most cases, children and young people are visited regularly by their social workers, their views are sought and they are involved in developing plans for their futures. In some cases, parents are also well engaged in the planning for their children. However, children are not always clear what these plans are and their relationships with social workers are not always strong because many have had several changes of social worker.

68. Most children and young people have permanence considered by the second looked after review, but this is not always followed through robustly where the permanence plan does not include adoption. Some children experience delay in achieving permanence. Some permanence options have broken down and no alternative is identified within the child's timescale. In better cases, permanence planning meetings are held and clear plans put in place in a timely way. Positive work has been undertaken to formalise the placements of children in long-term foster care.

69. The virtual school headteacher has a clear and detailed understanding of the provision that children looked after receive, and understands areas for further development. The virtual school's self-evaluation is thorough and accurate and sets out well the school's ambitions for children looked after. This analysis has resulted in a range of improvements, for example the attendance rate of children looked after has improved to 94%. In 2014, 13% of children looked after attending secondary schools had low attendance rates, which is much higher than the rates for all Oldham pupils. The local authority acknowledges further improvement is required to close the attendance gap between these children and all Oldham pupils. The number of children looked after who are absent for 25 days or more continues to decrease. In 2012–13, 42 were absent for 25 days or more; in 2013–14 this had improved to eight. Currently there are no children looked after who have been absent more than 25 days.

70. Effective partnership working between the virtual schools and other schools has ensured that no looked after child was excluded from a school in 2014. In the current year to date, no children looked after have been permanently excluded.

71. In 2014, the proportion of children looked after gaining level 4 and above in reading, writing and mathematics at Key Stage 2 improved to 78%, 62% and 69% respectively. This is above the national averages for similar children. The gap between looked after children's achievements and other children in Oldham narrowed. Further improvements are required so that the achievement gap between these children and other children continues to reduce.

72. In 2014 no children looked after with special educational needs achieved level 4 in reading, writing or mathematics. In the same year, the proportion of children looked after achieving five good GCSEs including English and mathematics declined sharply and was low at around 8%. This is a sharp increase in the achievement gap between children looked after and other children in Oldham. Current information provided by the local authority indicates that only four (20%) children looked after are expected to achieve five good GCSEs including mathematics and English, which is poor.

73. Careful attention is paid to ensure that children looked after attend schools that suit them best. The vast majority of looked after primary-aged children attend good or better schools. Approximately 58% of all looked after secondary-aged children are able to attend good or better schools. For those attending a secondary school in Oldham this reduces to 40% because only four secondary

schools in Oldham are judged to be good or better. Around 30% of children looked after attend schools outside the local authority. Oldham receives some information about the progress of these children. This needs to be more detailed and frequent so that staff can provide timely support to improve performance.

74. The 'life chances' team provides good support for looked after children who are at risk from bullying and harassment. The team works closely with those who are at the highest risk of dropping out of school and those who have very poor performance. During the spring term they supported 82 children looked after – 30% of the entire cohort – organising various enrichment activities. They provide good training to foster carers and advice regarding children's emotional well-being and behaviour management. Carers report this has helped them to provide better care for the children they look after.

75. The quality of personal education plans (PEPs) requires improvement; some are very poor. They lack sufficient focus on educational attainment and skill development. Too many do not include ambitious or aspirational targets and are broad and non-specific. As a consequence, they are not sufficiently useful for looked after children to be clear what they need to do or to enable progress to be measured against targets.

76. The advice and guidance service for children looked after is provided by a commissioned service but there are no clear arrangements whereby this advice can inform children's PEPs and pathway plans. This means that education planning does not take account of the holistic advice that the young people have received.

77. Many children looked after benefit from pupil premium funding, for example with extra teaching sessions, educational trips and learning resources. However, the arrangements to allocate and monitor the impact of pupil premium funding are under-developed and its impact cannot be demonstrated as a whole. The local authority recognises this and new arrangements are being developed that are intended to strengthen the allocation and monitoring of impact.

78. Children, including those placed out of authority, are supported and encouraged to pursue hobbies and leisure interests. Carers are aware of and able to exercise delegated authority appropriately.

79. Children looked after benefit from a wide range of enrichment activities and financial support. For example, they attend educational events and activities that develop their self-confidence and team working. However, their entitlements are not promoted well enough, either through the local authority's website or via clear locally produced written information.

80. Almost all children looked after (97%) have health assessments when they should do. The nursing service for children looked after oversees reminders for

initial health assessments and reviews to ensure these are undertaken within expected timescales. Initial health assessments are undertaken by paediatricians, with reviews carried out by health visitors or school nurses as appropriate. The nurse for children looked after undertakes health assessments for young people aged 16 and over. She is available for consultation about more complex cases. Children looked after living outside the borough have their health assessments completed near to where they live unless it is convenient for them and their carers to come to Oldham.

81. The nurse for looked after children offers training in completing health assessments to other health professionals to try to ensure consistency and raise standards; a sample is audited quarterly to check compliance. However, health assessments seen by inspectors are not always completed well. Only half the sample have assessments that would clearly help a carer understand and meet that child's health needs. Strengths and difficulties questionnaires are regularly completed for children aged four and over, but the outcomes from these often do not feed into health assessments, weakening their value.

82. The CAMHS service for children looked after is comprehensive. There is a tiered range of interventions to meet different levels of need. This includes training for foster carers, consultations for social workers and carers about individual children, and a service providing assessment and support for individual children and young people. Early evaluation of training for foster carers that focused on attachment issues was positive and shows they became more resilient as carers, thus promoting greater placement stability.

83. Short term placement stability is improving, with the local authority reporting 8% of children having three or more placements during 2014–15. This compares with 11% in 2013–14, and a statistical neighbour rate of 9%. For longer term stability, there has been a steady improvement over the three years up to 2014. This improved to 62% in 2013-14 but is still below statistical neighbours (69%) and England (67%) rates and requires further improvement.

84. The percentage of children looked after aged 10 and over who were convicted or subject to a final warning or reprimand during the year to April 2015 was 5.5%. Although this was an increase from 4.5% in the previous year, it was lower than both the statistical neighbour and national levels for 2013–14.

85. Placements meet children's needs and have a positive impact on them in a large majority of cases, for example by helping them change negative behaviours. Some examples were seen of inappropriate placements for older children, attributable to the shortfall in choice for the older age group.

86. Although the number of approvals of new foster carers in 2014–15 was lower than the previous year, overall the in-house fostering service has been successful in recruiting carers. There is a sufficient choice of placements for most children but less choice for older children. The local authority recognises that it has more to do to ensure that all adolescents can be offered a foster

placement when they become looked after rather than going to a children's home.

87. Where assessments determine that young people should be placed with their brothers and sisters this is achieved in most cases. Children are supported well to have contact with their siblings, although some say they do not see the adults that are important to them as often as they would like, for example grandparents and friends. Most children looked after (87%) are placed within 20 miles of the local authority.

88. The local authority advises that it encourages foster carers to apply for special guardianship orders where this is in the child's best interests, but carers report reluctance because this legal arrangement gives them less assurance about sustainable income than fostering does. The local authority is aware of this and is working to increase the reassurance it can provide to foster carers. Currently, the local authority financially supports 119 child arrangement and special guardianship orders outside of public care.

89. Assessments of connected persons are not always completed swiftly enough, with children experiencing drift and delay as a result. For other children in these circumstances, assessments are timely; they identify strengths and risks, and appropriately consider options for the children.

90. Foster carers feel well supported, and a large majority (79%) have met the national standards for training, support and development.

91. The fostering panel is well-chaired, effective and ensures good quality information is available to inform its decision-making. Careful consideration is given to approving carers and matching children. The fostering service's decision maker has full information available to enable them to make considered decisions promptly.

92. Looked after reviews are held regularly and almost all are held on time (98%). The participation of children is evident in a majority of cases. However, IROs have not always spoken to children privately before their reviews due to high workloads. The IRO service has recently had its capacity increased and this is a key improvement target for the future, but performance so far has not been good enough. The high caseloads have also meant that IROs have not monitored children's progress with sufficient robustness between reviews to identify any potential drift and delay that require challenging. This is also a key improvement target for the service.

93. Young people are aware of their right to complain and have access to advocates to support them. One young person described a positive experience of getting a children's rights worker involved in a complaint about a placement move, which had a positive outcome for her.

94. The Children in Care Council is influential and active, and well supported by participation officers. There are good links with the corporate and regional

youth participation network, resulting in successful bids for funding for development projects. Children in Care Council members are valued and influential members of the corporate parenting board and are instrumental in delivering the annual work plan. Five corporate parenting board priorities for this year derive from the Children in Care Council's review of the local authority's pledge to children looked after.

95. Diversity issues are considered well in a majority of cases. Inspectors saw examples where they had clearly informed the choice of foster placement and adoptive family. However, in a small minority of cases children's diversity needs are mentioned in records but it is not clear how they have influenced the child's plan and services received.

The graded judgement for adoption performance is that it is good

96. There is a strong and successful commitment to secure permanence through adoption for those children who need it. A positive focus on adoption is enhanced by the involvement of the adoption team in the early stages of children's care planning.

97. Attendance of the adoption team manager at the weekly final care planning meetings ensures that the progress of every child who has a plan for adoption is as streamlined as possible. Delays are avoided or minimised and this is well evidenced by the data seen on inspection.

98. Early co-working between the child's social worker and the adoption social worker means that the child permanence report (CPR) and family finding profile are prepared promptly and are informed by the workers' knowledge of the child. The CPRs are good and enable the agency decision maker to make sound, well-informed decisions. Co-working facilitates the early identification of potential links which can be formally pursued once a placement order is granted. The adoption team has up-to-date intelligence about prospective adopters gained from well-established collaborative arrangements with Bury and Rochdale Councils and membership of a placement group along with five other north west local authorities.

99. Adoption workers are very effective at preparing children for adoption with skilled direct work and life story work. The quality and sophistication of matching practice has prevented disruptions. Some children are placed very quickly because of early linking, with one child placed within 12 days of the placement order being granted.

100. Targeted family finding is accelerated and strengthened by workers' skills and up-to-date knowledge about potential adopters. The local authority routinely accesses regional resources such as Adoption 22 (the consortium of 23 local authorities in the north west of England) and explores specialist voluntary adoption agencies regionally and nationally. It makes good use of the adoption

register. Overall, family finding activity and practice is highly developed, successful and tenacious. The local authority has commissioned and used three concurrent placements that have enabled children's plans to be progressed swiftly.

101. In 2014–15, 33 children were placed for adoption. Twenty-five were over a year old and eight had Black, Asian or Eastern European heritage. This year so far 23 children have been placed for adoption including older children, brothers and sisters, children of various racial and faith backgrounds and children with complex needs and difficult family backgrounds. This reflects very good attention to meeting children's diverse needs.

102. Currently 15 children have an adoption plan and 10 have a placement order, with legal proceedings ongoing for the remainder. Family finding is challenging because eight are aged four to seven years old. Seven require placing with brothers and sisters and four have minority ethnic heritages. It is good that the authority is tenaciously pursuing potential matches nationally. For a very small minority, the plan has changed appropriately and permanence has been achieved with existing carers.

103. Timeliness as measured against the national adoption scorecard reflects steady improvement in two out of three key indicators, and the Adoption Leadership Board considers that performance is improving. However, continual improvement is needed to meet national targets that are being stretched annually.

104. For 2014–15 the data submitted to the Department for Education shows that the average time between a child entering care and moving into their adoptive placement has improved to 472 days from the 538 days average between 2011 and 2014. For children who have waited less than 18 months between entering care and moving into their adoptive placement there has been an improvement to 78% from the 61% average between 2011 and 2014. Performance for the average time between a placement order being granted and a match with adopters has declined to 220 days from the 2013–14 average of 213 days. This is 99 days from the national target.

105. The authority has an in-depth understanding of the reasons underpinning this performance. A key factor is the length of time it has taken to find the right adopters for particular children. Although the impact on the scorecard is negative, practice reflects the very positive and successful commitment to finding adoptive homes. The service's increasingly sophisticated ability to analyse data and monitor trends results in a realistic picture of performance. During 2015–16 several adoption orders will be granted for children who have waited a long time; the local authority is aware of the negative impact this will have on its future scorecard average.

106. Oldham's recruitment strategy is successful, with 128 enquiries in 2014–15 – an increase on the 96 made in 2013–14. The strategy is creative and multi-faceted, and informed by the needs of children waiting.

107. Prospective adopters receive a good timely response and can attend preparation groups quickly because of the effective tri-borough arrangement with Bury and Rochdale. Adopters spoken to were very positive about their experience and the insight gained from preparation training. All spoke positively about the skills, knowledge and sensitivity of the social workers throughout the assessment process. Comments included 'the assessment process was really thorough', 'a very personal service', and 'the worker made sure it went at our pace'.

108. Assessments are of good quality, comprehensive and analytical. The panel chair confirms this view. Feedback and learning from the panel are used positively to develop practice and maintain high standards. The panel chair reports that applicants are prepared for and well supported at panel. There are robust and effective arrangements in place so that the agency decision maker can make prompt decisions.

109. In 2013–14, 13 households were approved. Eight of these were carried out under the previous process and were completed within seven months. Of the five households approved using the stage 1 and stage 2 processes, all were approved within timescales. In 2014–15, 22 adoptive households were approved, a further improvement in numbers from the previous year. Twenty were approved under the new staged process, with 12 being approved within six months and eight taking longer than this. The increase in approvals is good and proactive steps have been taken to streamline processes at stage 1 to avoid delays that are within the local authority's control. Some delays are due to overseas checks and cannot be expedited. This is a consequence of the success in recruiting families from Asian backgrounds.

110. Very good support is provided throughout introductions and into placement, and this continues until the adoption order is granted. Social workers skilfully build on the preparation and life story work done with children prior to placement to enable them to make relationships and develop attachments. Practical and emotional support for children and their adopters is responsive to need. Adopters spoke very highly of the positive impact their workers had, for example: 'the worker sorted it out so the clinic stopped using our child's birth surname', 'our child's social worker has brought in the life chances team and virtual school head to work with the new school so he gets the support and understanding he needs'. Adopters value the ongoing availability of support groups, workshops, celebratory events and training. They were able to explain how this had helped them understand their children and better meet their needs.

111. Arrangements to provide post-adoption support are good and are well used. In addition to support groups, children's groups and ongoing training, the team

co-ordinates 321 letterbox arrangements and supports 14 direct contact sessions. Seventy-one adoptive households receive financial support.

112. All adopters are aware of the Adoption Support Fund and the criteria to access therapeutic help. They receive individual letters as well as public information through a variety of media and awareness-raising activities. The local authority is actively involved in regional work to develop and increase the range of therapeutic services available.

113. The local authority commission suitable, independent support for birth relatives at any stage of their adoption experience, including access to birth records and intermediary service for adult adoptees. In 2014–15 the service responded to 12 referrals: five for access to records or intermediary services, three for support in letterbox contact and four supporting birth relatives through adoption of a child, evidencing that this is a valued and effective service.

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

114. Care leavers transfer to the after care service at a time that is right for them, but generally around their 16th birthday. Young people are consulted about the exact time of transfer to avoid times of stress such as exams or key changes in their lives. Care is taken to minimise the number of changes of allocated workers a young person experiences.

115. The aftercare service is a generic social work service for all young people between 16 and 18 years of age who have been looked after or are in receipt of a child in need or child protection service. Former relevant young people receive a service beyond the age of 18, potentially up to the age 25 as needed.

116. The service comprises a stable team of enthusiastic qualified social workers who demonstrate commitment to the young people they work with. They form strong positive relationships with many young people and are persistent in maintaining contact with them even through periods when they are reluctant to stay in touch. In 2013–14, the service was in touch with 98% of its care leavers aged 19 to 21 who were looked after when they were 16 years old. This is better than the statistical neighbours' average (78%) and the national average (83%).

117. Care leavers who spoke to inspectors say they feel safe, have confidence in the service provided for them and appreciate the consistency and commitment of their workers. They feel treated as adults and supported to make their own choices. Workers speak positively about the young people. It is not uncommon for young people who no longer need or receive a service to keep in touch with the team, for example to request a reference or to share new achievements.

118. The aftercare service is co-located with a variety of commissioned services in a young-person-friendly venue where a range of universal and targeted services can be accessed. This includes substance misuse services and personal counselling. The co-location of many services in the same place where young people are happy to drop in supports a holistic approach to meeting care leavers' needs, and timely coordination of personalised interventions.

119. There is good recognition and referral for older young people who may be at risk of sexual exploitation or those who go missing. Awareness of risk factors is high in the aftercare service and other commissioned providers. Young people who are identified as potentially at risk are referred to the Phoenix child sexual exploitation team for screening and assessment. There is increasing expertise and good partnership working across the voluntary and statutory sectors to identify and keep safe young people who are at risk of forced marriage.

120. Pathway plans are usually completed within three months of a care leaver's 16th birthday and are reviewed by an IRO twice a year, which provides a good level of independent scrutiny of progress. However plans are not consistently updated between reviews and do not always reflect the work being undertaken, which is often more detailed and of a better quality than is recorded. Plans take good account of the views of young people, which are consistently recorded well. Many workers are not using the plan to record the details of independence skills the young person needs to develop, and how they will be helped to develop these. Staff and young people can describe the work which is underway in better detail than can be gleaned from their case records. Goals are often too generic and do not set out who is responsible for which actions and what the expected completion timescales are. Plans take good account of contact with family members but need to set out more clearly how young people are going to be provided with the emotional support necessary to help them cope with the demands of living independently.

121. The service is good at providing stability and support for young people, and staff have a good understanding of why some young people struggle to maintain a college or work placement, or keep a tenancy. Workers are tenacious and make good efforts to help young people pick themselves up and have a 'second chance'. However, there is little evidence of direct work being done with young people to help them develop insight into why things have broken down in the past, and how they can develop strategies and resilience to reduce the likelihood of repetition in the future. Workers are able to describe the need to do this, but this needs a strong focus.

122. Transition planning for care leavers with a disability or complex needs is not always sufficiently timely to ensure good forward planning. This is particularly important for those young people who are not eligible for adult social care support services but nevertheless require, and are eligible for, an aftercare service. Examples were seen of young people who had gaps in support because of this.

123. There are very good opportunities for care leavers to achieve external accreditation for activities undertaken as members of the Children in Care Council and to gain experience of using their skills in the wider local authority environment. For example, care leavers deliver 'Total Respect' training, participate in staff selection processes, and work as members of the corporate parenting board.

124. The youth offending service facilitates restorative justice interventions to help maintain young people in their placements. This helps children and young people understand the consequences of their behaviour and make amends without unnecessarily criminalising them. This is expanding by training peer mentors. So far six young people have been trained in restorative justice, and it is planned to link them with children's homes. This could make a positive contribution to keeping more children out of the criminal justice system where appropriate, but it is too early to see its impact.

125. Three local authority traineeships and two apprenticeships are ring-fenced for care leavers. However, too many care leavers are not in education, training or employment. In 2013–14 this accounted for 45% of care leavers aged 19–21. The current figure reported by the local authority is that 42% are not in education, employment or training. The gap between care leavers and other young people in Oldham is widening. The aftercare team and other commissioned services work hard to support a significant minority of this group, around 13% of who have multiple challenges such as engaging in criminal behaviour or substance misuse problems. Four care leavers are in higher education. Overall there is an urgent need to increase the proportion of care leavers staying in employment, education or training.

126. Transitional plans need to extend young people's horizons when they are considering options for their future and to be more stretching. The quality of advice provided to care leavers about options does not sufficiently promote the development of their own skills in this area. For example, they are not offered advice on how to explore different options. The progress of care leavers in education, employment or training is monitored too infrequently on a collective basis to prevent drift or patterns of inactivity becoming established. Their progress is not recorded systematically. The careers advice and guidance that care leavers receive is not routinely shared with their social workers so does not inform their pathway plans, and this limits the benefits of the advice. The council has identified the need to improve its understanding, analysis and forward planning with regard to care leavers' engagement and progress in education, employment and training, but this is not yet in place.

127. The nurse for children looked after is proactive and effective in encouraging care leavers to have health assessments. There is equally robust attention paid to those young people who live outside the borough, and also to young people who are the responsibility of other local authorities, but who live within the borough. This ensures that young people's health needs are met well and they are encouraged to lead healthy lifestyles.

128. Young people can easily access a wide range of health prevention and treatment services which are all co-located with the aftercare services, including drop-in sessions and a prescribing nurse. The co-location of different health services supports prompt and coordinated responses to the various health needs that a young person might have. One example was seen when a care leaver sought help for one matter and the opportunity was taken to bring his immunisations up to date. Care leavers who are young parents are able to access a specialist midwife and the family nurse partnership programme along with other drop-in facilities. Up-to-date information about how to register with doctors and dentists including those accepting new patients is readily available.

129. In April 2015 an accessible tier 2 community-based mental health service for all ages was commissioned to provide counselling and support to prevent self-harm. This new service supplements another community-based emotional support service which is exclusively for young people. These services provide choice, improve capacity, and enable continuity of help into adulthood if necessary. It is too early to see the impact of the new service yet.

130. Care leavers are provided with some important documentation such as national insurance numbers, passports and income benefit entitlements, but they are not provided with an account of their health history. A current pilot is testing out a method of providing health histories but this has not yet led to this gap being addressed.

131. The council has been slow to implement formal 'staying put' arrangements and to date only four are in place. The new policy is clear about respective responsibilities and includes comprehensive information on the financial and legal implications of arrangements. There is more to do to promote and embed this option for those young people who would be best supported through a 'staying put' arrangement.

132. When young people leave care to return home aged 16 and 17, this is in accordance with their care plans. Risk assessments are of good quality and decision-making is clear. Account is taken of the timing of the return home of brothers and sisters. There is good joint working between partner agencies to support these young people, and child protection plans are put in place when necessary. Care leavers over the age of 16 who no longer need a child protection plan continue to have their progress reviewed in conjunction with younger brothers and sisters who remain on child protection plans. This ensures effective joint working between all the children's social workers. It also takes good account of the relationships and contact between family members.

133. Almost all care leavers (95% in 2013–14) are reported to live in appropriate accommodation. There are two designated places in supported accommodation for young parents and this meets their needs well. Three young people were in custodial institutions at the time of the inspection. Two semi-independent units with full-time on-site support are classified as 'houses of multiple occupancy' but meet the support needs of their residents very well. Young people

inspectors spoke with were happy with their accommodation but disliked the proximity of the accommodation to a children's home because of perceived stigmatisation.

134. The local authority acknowledges that the quantity and range of supported accommodation is insufficient to meet young people's needs. Staff told inspectors this means that some young people have to move on before they are ready for more independent accommodation. Others wait too long for a place with the right level of support. It is possible for young people to return to accommodation where a higher level of support is provided, but this depends on availability. Inspectors were also told that a planned reduction of staff in the aftercare service has reduced the availability of staff to help young people develop independence skills, although this need is identified as a key message following a review of the pledge. The local authority's sufficiency strategy recognises this shortfall and its impact on care leavers. The current business plan includes a review of aftercare support to develop independence skills, but no improvements are yet evident.

135. There are effective agreements between the local authority and housing providers. Tenancy applications are made before they are needed and then activated when required, helping to reduce waiting times. Care leavers have priority but not a right to a tenancy. In practice this is reported not to be problematic. Young people can elect to have the monthly rent element of their universal benefit paid direct to the housing provider to help with their budgeting. Those who make mistakes such as causing damage to their accommodation or failing to pay their rent are not deemed intentionally homeless or criminalised. Alternative means to address this are not yet in place, but restorative justice approaches are at an advanced stage of development.

136. Care leavers are confident about the advice they receive from their workers about their entitlements. They are sure that any reasonable requests for support will be met. Care leavers spoken with knew how much money they would get to set up home. This is discretionary, up to a maximum of £2,000, which is less than the nationally recommended amount of £2,000 as a minimum grant. Arrangements to support those in higher education are made on an individual basis. Care leavers benefit from a wide range of enrichment activities and financial support, for example contributions towards driving lessons and outfits for special events. However, there is limited young-person-friendly written information about entitlements available from Oldham. Information is not available electronically via the council's website. The current arrangement, which depends on staff advising young people individually, is unsatisfactory because it risks partiality. There are plans to rectify this with a dedicated area on a new council young people's website.

137. Young people spoken with reported they knew how to make a complaint; no complaints have been made by care leavers in the last two years. Young people told inspectors their workers would sort out any issues they raised. The 'children's champion' scheme is being relaunched with senior council officers

acting as champions for individual young people and both senior officers and young people spoken to were extremely positive about this. Good attention is being paid to matching and providing training for champions. Anecdotal examples of the mutual benefits of this scheme are described by officers, but a more systematic evaluation over time is necessary to determine its impact.

138. Staff in the aftercare service benefit from regular monthly supervision. However, supervision records mostly consist of brief factual updates with respect to individual young people. There is little evidence that workers are encouraged to reflect on their interventions with the young people, to revise goals or consider how to improve outcomes for young people.

139. The aftercare service does not have good quality performance data about the progress being made by young people, the reach of the service, or other information that would help determine the extent to which services meet needs. At present, information is gathered from a variety of council and partner sources and is in different formats, which impedes its collation and analysis. Managers are aware of the shortfalls in reliable data and there is a strong desire for this to be improved. The quality of data is currently too variable to confidently inform service developments and this needs rectifying to support future commissioning decisions and continuous service improvement.

Leadership, management and governance	Requires improvement

Summary

Oldham was rated good in its safeguarding and looked after children inspection in 2012. Since then, although aspects of good practice have been maintained, there has been insufficient focus on ensuring the quality of frontline practice across children's social care.

Senior managers demonstrate ambition and commitment to improve services for children and young people. There are examples of strong strategic partnerships and innovation in some areas, which have led to the development of some good quality services.

Strategic arrangements between senior officers and elected members are good, with positive challenging arrangements between the senior leadership team, the lead members and other political leaders. There is a strongly voiced commitment to being good corporate parents and both senior officers and members understand the requirements of this role.

The quality of practice and the management oversight of work done with children who need help and protection, children who are looked after, and care leavers is not yet consistently good. This means that practice is not achieving improving outcomes for too many children and young people.

Performance management and quality assurance systems are not fully developed and are not effective in ensuring senior managers have a good enough understanding of the quality of frontline practice.

Oldham has achieved a largely fully-staffed social care workforce against a backdrop of fierce competition for social workers. However, the workforce strategy lacks sufficient attention to social worker recruitment and retention and to competing approaches from other local authorities. This inhibits its ability to retain and develop the workforce. A high proportion of social workers are newly qualified; good arrangements are in place to support those who are in their first year of employment.

Oldham has responded strongly to some key areas of existing and emerging risk such as child sexual exploitation, and the links between these and other areas of criminality which impact directly on the safeguarding of children and young people.

Despite a strong shared commitment to improving outcomes for vulnerable children, some areas need more attention to be good, for example the educational attainment of children looked after and the numbers of care leavers who are in education, training or employment.

The views of young people are taken into account well when commissioning services.

Inspection findings

140. The council's restructuring in 2014, leading to different elements of children's services being delivered by three directorates, has had a positive impact on establishing a broader, shared ownership and commitment to children's services. The combination of the roles of DCS and Director of Adult Services into one post of Executive Director for Health and Wellbeing has been subject to a local assurance test in March 2015, which demonstrates that measures are in place to mitigate any risks posed by these arrangements. While the matrix management arrangements add complexity to the structure, the shared responsibilities have embedded the concept of children being 'everyone's responsibility' across the council. A fortnightly children's assurance meeting attended by senior officers considers children's issues to a good level of detail.

141. The elected lead member sits on the LSCB as a participating observer and is a member of the Health and Wellbeing Board, but has only recently taken on responsibility for children's social care, having previously been the lead for adult safeguarding and health. The relocation of health to a different portfolio will enable the lead member to concentrate on children's social care services better in the future. The lead member has significant experience and a good understanding and knowledge about safeguarding issues, particularly in respect of child sexual exploitation, the education of children looked after, and diversity. Weekly meetings between the lead member and the Executive Director provide good opportunities to exchange information and provide support and challenge. Both parties describe an effective, open and suitably challenging relationship based on shared goals and mutual trust.

142. In addition to the LSCB and Health and Wellbeing Board, local governance is provided via the corporate safeguarding accountability meeting (CSAM). The CSAM is attended by the LSCB and the Local Adult Safeguarding Board (LASB) chairs, receives regular reports on services for children, in addition to those provided to the overview and scrutiny committee, and reports to the leader of the council and the chief executive. Both groups ensure political leaders, including opposition members, have knowledge and understanding of safeguarding issues, and that there are opportunities to challenge the services being provided to children and families.

143. Leadership within the council demonstrates ambition and vision for services for children and young people and there are examples of some strong strategic partnership working having an impact on areas of service, for example the continued development of the MASH and the strategic response to child sexual exploitation.

144. There are strong local partnership arrangements in response to the 'Prevent' agenda, tackling radicalisation. A regular multi-agency panel is well represented by a wide range of appropriate agencies. The panel produced the joint safeguarding agreements for both the LSCB and the Local Adult Safeguarding Board (LASB) and has been engaged in raising awareness across agencies. The

number of referrals is increasing from a wider range of sources. The panel ensures that children, young people and adults have bespoke interventions that aim to assess and reduce the risk they may pose.

145. The chief executive operates within clear lines of accountability and governance. There are distinctions between political, strategic and operational roles. Effective working relationships between the chief executive, the lead member and the DCS ensure children's issues are given a high priority and safeguarding issues are a standing item on the weekly executive management team meetings. Although some officers and members are represented on different strategic boards, there are no formal governance arrangements between strategic boards such as the LSCB, the LASB, the Community Safety Partnership and the Health and Wellbeing Board. It is acknowledged by the local authority that these arrangements should be strengthened to ensure local priorities are effectively addressed.

146. The corporate parenting panel is well attended and chaired effectively, with good representation from young people who are very active and influential members. The debate and questions from officers and elected members demonstrate that they are a knowledgeable and committed group of corporate parents, although there is evidence of slow progress in some areas, with reports to the panel being deferred several times at successive meetings. Initiatives such as the children's champion scheme demonstrate a commitment to developing the role of corporate parents, although this is a relatively recent initiative.

147. The local authority has some systems in place to manage and monitor performance in children's social care, but this has been impeded by significant difficulties in extracting accurate data from the children's electronic recording system. Progress has been made and there is now some useful data available for scrutiny. This has led to improvements in the timeliness of assessments and initial conferences. However, the data presented is of limited value because it lacks analysis, is repetitive and is limited in terms of showing trends or providing hypotheses about unexpected performance. The local authority acknowledges that the information presented on scorecards requires improvement. Frontline and mid-tier social work managers cannot easily access information relevant to their areas of responsibility to contribute to improving the service. A new software package is currently being populated and is intended to enable managers to interrogate team- and service-level data but this is not yet available. Currently, performance management information at this level is poor.

148. The oversight of children who require a legal intervention to safeguard them is under-developed. A rudimentary spreadsheet is maintained by legal services but this is insufficient to ensure that all children who require an intervention under the Public Law Outline (PLO) receive one in accordance with agreements and in a timely manner. Management oversight of this key area of practice

needs to be strengthened to ensure there is no drift and delay for children and their permanence plans are progressing swiftly.

149. The local authority has developed a positive working relationship with the Children and Family Court Advisory and Support Service (Cafcass) and is an effective participant in the local Family Justice Board. This is helping the local authority achieve legal orders for children where these are necessary. Joint work with other local authorities and the judiciary is attempting to address the timeliness of proceedings through the court process, which is currently below expected national standards.

150. The local authority consults well with young people about service developments, for example the development of the early help strategy and the development of the special educational needs and disability (SEND) programme. There are mechanisms to use learning and feedback from complaints to influence practice, and examples were seen of improved practice in the quality of direct and life story work. This is directly attributable to a number of complaints from children about contact arrangements. The 'children's interest group' reports via senior managers and attempts to ensure those children's views feed into service developments via the professionals who work directly with them. However, while the group does raise issues that are relevant and of importance to children and young people, the membership of this group does not include young people and this is an area for development.

151. Social workers spoken to during the inspection were generally positive about working in Oldham and many described good working relationships and informal support from their managers. There is a wide range of training available which reflects current priorities and helps social workers to meet the needs of vulnerable children better. Training opportunities are described positively by workers. Many workers could outline findings from serious case reviews, confirming that messages are widely disseminated. However, not all workers could describe what impact the findings had had on their practice.

152. The quality of social work practice experienced by children, young people and their families is too variable. Some assessments, interventions, plans and reviews are good or very good, but others require improvement. This variability was seen across children's social care services and reflected similar variability of the management oversight of practice. Management decisions are not always evident on children's files and are not always effective in ensuring children and young people receive a consistently good quality service and that plans are progressed in a timely way.

153. The supervision of social workers follows this pattern of inconsistency. Some good supervision of social workers was seen but in other cases, there is little evidence of workers having regular formal supervision with their managers. Staff told inspectors that their managers were readily available to them and informal supervision and advice is a feature of the workplace. Where supervision has taken place, the quality of the recording of this on children's

files was often poor, with little evidence of detailed reflection or the rationale underpinning decisions. The supervision policy for social work staff, updated in April 2015, now includes specific requirements for social workers including an expectation of reflective supervision but this is not yet embedded across the service. More robust implementation is required to rectify current custom and practice.

154. The local authority has a regular programme of quality assurance of children's case files and a policy specifies that 10 case audits should be completed each quarter. On cases seen that have been audited, appropriate strengths and weaknesses are identified. Recommendations for remedial actions are clear and these have led to many deficits in recording and practice being addressed. However, in a minority of cases, some recommendations have not been followed through, and this needs more robust oversight to ensure the audit process is effective. The audits have not been instrumental in demonstrating improved good practice across all of the service. More work is needed to ensure that case auditing embeds improvements.

155. Until recently, the workloads of the IROs inhibited their ability to execute the entirety of their role, for example monitoring the progress of children, speaking with children before reviews, and improving the attendance of children at conferences. Senior managers have responded to the rising demands on the service by recently increasing capacity, and these are key priorities for the service. It is expected that the IRO service will increase its independent scrutiny and challenge. At the present time, this remains under-developed.

156. The council's workforce development strategy is not sufficiently focused on the recruitment and retention of social workers. The challenges and current approaches are set out in a recently produced children's social care workforce development action plan. Good arrangements are in place to support social workers at the earliest stages and there is a revised career development pathway for them. However, currently only 32% of social workers are 'level 3' (at least two years post-qualified) against a target of 40%. The turnover of staff has been mitigated by successful recruitment campaigns which have kept vacancy rates relatively low. However, the profile of the workforce is changing, with a steadily increasing proportion being newly qualified social workers. The local authority has begun to forward-plan, taking into account other pressures such as competition from nearby authorities offering apparently better employment conditions. However, a clear strategy to offset risk should the recruitment climate change is not yet in place, leaving the local authority potentially vulnerable and reactive to changes in the employment market.

157. The workload management system effectively ensures that social workers have manageable caseloads. It is used well in most teams. However, information that could be extracted from the workload management system is not being used to analyse and plan for pressures in specific areas of service or with specific groups. Safeguarding services are particularly vulnerable as over 40% of the 54 full-time equivalent social worker posts are filled by newly qualified

workers and more careful attention is required to ensure that less experienced staff have sufficient supervision and support and can provide good quality help for children on their caseloads.

158. The local authority understands sections of its community well, such as details about children looked after and the changing ethnic profile of the borough, and uses this information to inform the commissioning of appropriate services and to respond to emerging needs. The work undertaken to create a streamlined CAMHS service demonstrates positive partnership working to use budgets to best effect to commission a range of services across all levels of need, although the process has been lengthy. Other examples of refocusing existing resources to improve their impact include changing the function of a children's home into an adolescent support unit providing outreach and some residential provision, and the development of a therapeutic in-house fostering scheme. Both of these initiatives are too recent to demonstrate impact, but they illustrate the local authority's capacity to re-model resources in response to changes in demand. The views of young people have been taken into account well when commissioning services. However, there is no over-arching joint strategic needs assessment that incorporates the needs of all children, young people and their families in the borough and which can inform fully cohesive joint commissioning. This is a shortfall.

159. The sufficiency strategy has been effective in delivering enough suitable placements for most looked after children, particularly with regard to foster home places. This has resulted in low numbers of children living more than 20 miles away from their communities. The current fostering sufficiency and retention strategy acknowledges future challenges and sets suitable objectives and targets to increase provision through a range of methods. There is a lack of choice of suitable accommodation for care leavers, and this has been identified as an area for development.

The Local Safeguarding Children Board

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.

A Local Safeguarding Children Board (LSCB) **requires improvement** if it does not yet demonstrate the characteristics of good.

Executive summary

The governance and structure of the LSCB meets its statutory requirements. It is independently chaired and has appropriate agency membership. Regular meetings are held between the independent chair of the LSCB and the Director of Children's Services (DCS) to facilitate accountability. These meetings should be minuted to ensure transparency and provide an audit trail. The board monitors its impact via a challenge log but this requires further development and more robust follow-up to demonstrate good impact.

The board scrutinises frontline performance where data is available to enable this to occur. Good efforts are underway to improve the quality of performance data so that the rigour of the board's scrutiny of frontline practice across all partner agencies is improved; this is not sufficiently well developed yet.

The board's review of early help services in Oldham was inclusive and wide-ranging. This has resulted in a better coordinated and coherent early help offer for children and families, supported by clear threshold guidance. The guidance is strengthened by the inclusion of clear escalation arrangements which are reported on positively by partner agencies.

The annual report includes appropriate information about key services such as arrangements to manage adults who may pose a risk to children and analysis and findings of the child death overview panel. It provides an accurate overview of performance in children's social care, but there is insufficient analysis of partner agencies' performance. The LSCB business plan was only partially complete at the time of the inspection. Its priorities reflect the needs of the most vulnerable well but it is awaiting clear outcome-focused targets that can be measured to determine whether services have improved the outcomes for children and young people.

The board delivers a wide range of training which is readily available to partner agencies and is appropriate to the needs of children and families. Individual training and awareness-raising events are evaluated for impact upon delivery, but there is more to do to evaluate the impact of training as a whole and establish the difference

it makes to frontline practice.

Quality assurance commissioned by the board has appropriately identified strengths and weaknesses in key areas of practice such as the support available to children in need. This has had a positive impact on practice but the board needs to ensure that follow-up actions are robust and agencies are held to account for improvements required. Agencies report self-assessments of safeguarding standards in their organisations but more supporting evidence is required to provide assurance.

The board's sub-groups have developed and driven many important areas of practice such as co-ordinating efforts to tackle child sexual exploitation, and have been effective in identifying and lobbying for services to address the challenge of consanguinity in the borough.

The board's re-organisation has been slow to come to fruition and there has been a lengthy consultation period. However, partners are positive about the proposals and expect future arrangements to accelerate progress in achieving the board's priorities. It is too early to see the impact of this.

Recommendations

160. The board should ensure it has mechanisms in place to robustly evaluate the quality of frontline practice, delivered to children and young people, in all partner agencies.

161. Partner agencies should provide clear performance data to the board, which includes both narrative and analysis and is explicit about whether aspects of performance are improving or deteriorating. Data should be sufficient to enable partners to challenge and hold each other to account.

162. An agreed programme of audit work, including section 11 audits undertaken by partner agencies, should be supported by evidence so the board is assured of the quality of safeguarding practice across the partnership.

163. Safeguarding practice should be supported by a protocol for assessment, in line with statutory guidance.

164. The impact of multi-agency training across the partnership requires more detailed monitoring and analysis to ensure it is meeting partner agencies' training needs and is responsive to changing demands.

165. Ensure the business plan for 2015–16 is updated to clearly identify the outcomes sought for children and young people, including how these will be measured.

166. Ensure that there is a clear audit trail and note of meetings held between the DCS and the independent chair of the LSCB.

Inspection findings – the Local Safeguarding Children Board

167. The governance and structure of the LSCB meets statutory requirements. It is independently chaired and has appropriate agency membership. The LSCB has adopted the Greater Manchester learning and improvement framework that includes procedures regarding the initiation of serious case reviews (SCRs), multi-agency and individual agency reviews. Oldham adopts the Greater Manchester child protection policies and procedures, which are sufficiently detailed, meet requirements and are available on the LSCB website. Additional guidance on Oldham-specific arrangements is also available.

168. The independent chair, who has been in post for 12 months, has led significant development work over that period to review and revise the structure and functioning of the board. The chair has also set strategic priorities in line with children's identified needs in the borough. Revised arrangements are due to be implemented in July 2015. Although this has been a lengthy process and may have contributed to slower progress in some areas, partner agencies are positive about the consultation process and are confident that the revisions will result in a more effective board. Revisions allow the continuation of seven sub-groups covering the board's core functions, such as policies and procedures, the child death overview panel (CDOP) and performance. An additional six 'priority issues' groups have been established to take forward key areas of development. These priorities include early help, child sexual exploitation, children who go missing, neglect and special education needs and disability (SEND) issues. Greater clarity is required regarding the terms of reference of the priority issues groups to ensure their work and achievements are aligned with not only the board's strategic priorities, but also the priorities of the Health and Wellbeing Board and the Community Safety Partnership.

169. The LSCB has oversight of key relevant reports such as the private fostering, CDOP and local authority designated officer (LADO) annual reports. These are presented and discussed at the board and priorities identified within the reports are appropriately included in the board's business plan.

170. During 2014–15 the LSCB led an effective and inclusive multi-agency review and update of the threshold document for partner agencies. This is valued by partners who described it as clear and helpful. Guidance now includes a clearer escalation arrangement so that partner agencies who feel that a child or family has not had a response appropriate to their needs are able trigger a prompt review of decision-making. The national requirement for the local authority to develop a protocol for assessment with partners, and for this to be approved by the LSCB and published, has not been met. As a result, although partner agencies are clearer about thresholds and there has been an increase in issues being appropriately escalated where disagreements have taken place, there is

not a shared understanding of the contributions that agencies should make to assessments and how these will be undertaken.

171. The most recent annual report available (2013–14) describes the activity completed during the previous year in some detail and does evidence some lessons learned from audits, SCRs and the CDOP. The report outlines performance in key aspects of children's services such as safeguarding and services for children looked after, but does not contain enough analysis of frontline practice across all partner agencies. This is a key priority for the board.

172. The LSCB business plan for 2014–15 identifies appropriate priorities which reflect those identified by other key strategic groups such as the Health and Wellbeing Board. It sets out the priorities for areas of work to be undertaken by the sub-groups, but more work is required to make it clear what outcomes are being sought for young people, and how they will be measured. Until this is in place, it is unclear how the board will be able to determine what, if any, influence its actions are having. This shortfall will reduce its ability to evaluate and report on its own effectiveness. The board also needs to ensure that all the recommendations of the last annual report have been followed through or discontinued and to be clear about rationale and progress on each.

173. Links between strategic boards such as the LSCB, the Health and Wellbeing Board and the Community Safety Partnership are in place but require strengthening to confirm responsibilities, accountabilities, reporting arrangements and mutual impact of refreshed priorities. While there are some links through shared membership of different boards, strengthened governance would benefit all the strategic partnerships and help avoid duplication or gaps in effort.

174. The DCS is a member of the LSCB and has only recently taken over as chair of its audit and scrutiny sub-group so it is too early to see any impact from this. The DCS has regular meetings and discussion with the independent chair of LSCB but minutes are not taken. As a result, there is no written record of any challenge or of the parties holding each other to account. This is acknowledged as an area for development.

175. CDOP operates effectively and its work has consistently identified consanguinity as a significant issue in the borough. The LSCB has lobbied effectively for resources to address this. A recent agreement from the clinical commissioning group to fund a specialist nursing post to increase awareness of the risks of marrying close relatives has now been agreed. The post holder will also develop appropriate services such as genetic counselling as part of this role. This is a good example of the LSCB having an impact on commissioning on an issue that is very significant for some communities in Oldham.

176. The LSCB and the LASB oversee a suitable and comprehensive programme of training which is delivered by enthusiastic and committed staff. It is delivered in a range of ways to maximise participation. There are some examples of

innovative developments in respect of e-safety and 'letting children be children'. Feedback from participants on the impact of training helps to shape the quality and delivery of individual courses well. However, there is no system to evaluate how training is influencing or improving practice across the partnership. As a result, the board cannot determine if the full range of development and training opportunities is having the desired impact on practice across all partner agencies.

177. The board has concentrated its scrutiny on performance in children's social care but recognises that it should be extended to partner agencies in equivalent detail. It has adopted the Greater Manchester performance data framework, which is detailed but requires data from partner agencies; this has been slow to be received. A fully populated dataset has not yet been achieved although the board continues to seek data on specific issues pending this 'going live'. In the interim, it scrutinises 'exceptional' data. In quarter 4 of 2014–15, the board scrutinised, for example, the percentage of children missing who had an independent return interview within 72 hours of their return, the percentage of initial child protection conferences undertaken within expected timescales and repeat referrals to children's social care. The board is appropriately concentrating on those areas of greatest concern, but in some cases where performance has been weak over time, such as the completion of return interviews for missing children, this has only relatively recently been identified as a priority requiring further enquiry and challenge. The sub-group responsible for overseeing strategic approaches to tackling child sexual exploitation and children who go missing is fully aware of performance to date and the new chair is aware of the challenge and improvements required for all partners.

178. Three separate audits of different areas of practice have been commissioned by the board within the last 12 months. These have been independent and thorough, with the outcomes and learning being reported to the board. Actions identified as a result of audits have not been routinely and effectively followed up to ensure that shortfalls identified have been addressed and practice has improved as a result. The board does not have an agreed forward programme to undertake regular multi-agency audits of casework by partner agencies and this is an area for development which would increase partner agencies' understanding of each other's services and operational contexts.

179. Section 11 audits have been completed by all partner agencies. The board acknowledges that these did not provide sufficient supporting evidence for the self-assessed judgements made. A revised method of undertaking section 11 audits is in progress, which will ensure agencies provide evidence that triangulates the self-assessed position. This will provide a more robust assurance of the quality of safeguarding practice in Oldham.

180. The SCR sub-group considers and makes appropriate decisions about when to undertake a SCR. Five SCRs have been commissioned during 2014–15, three of which are now completed. All have resulted in good, detailed action plans that are based on the learning identified. There is evidence of the recommendations

being acted upon, for example by awareness-raising or training on issues. Recommendations have also impacted on frontline practice, such as health visiting staff now using genograms to good effect. The impact of learning from SCRs would be strengthened by more robust oversight and monitoring by the board to ensure the swifter implementation of actions.

181. The well-established child sexual exploitation and missing from home sub-group has a sophisticated and detailed understanding of the issues that underpin these areas of concern for children. Partner agencies work well together and demonstrate good commitment to this area of work. Although services to address child sexual exploitation have been in place for some time in Oldham, there is no sense of services or the sub-group 'standing still' and arrangements have continued to develop over the last 12 months. Feedback from an independent audit commissioned in late 2014 has resulted in the Phoenix team being given additional capacity to improve the social work service to children and young people and improve the links with early help. However, the feedback given from the Ofsted thematic inspection regarding the variable quality of frontline practice with young people at risk of child sexual exploitation has not been the subject of further analysis and is an area that requires further scrutiny. The paucity of boys and young men identified as at risk of child sexual exploitation is being raised at a strategic level. The sub-group is aware there is likely to be unidentified risk and that there is a need to ensure frontline practitioners are sufficiently skilled at identifying and responding to boys and young men at risk.

182. Work in the sub-group in respect of children missing from home is at an earlier stage of development compared with arrangements to tackle child sexual exploitation but arrangements continue to improve. Good awareness-raising across the partnership has been undertaken. The service to provide return interviews was re-commissioned in April 2015. However, the sub-group and the board were slow to respond and did not raise enough challenge in response to evidence of shortfalls in return home interviews during the year to April 2015. Concerns were expressed but this did not result in immediate remedial action being taken. The current service is reporting improving reach and timeliness of interviews.

183. The board does not currently have robust enough arrangements in place to ensure it can monitor the progress of the work of all of its sub-groups and hold them to account for it. The sub-groups are not required to provide frequent written reports of progress to the board. While there is a great deal of very positive work being undertaken by the sub-groups, their progress and impact is variable and is not being driven consistently and effectively by the board.

184. The board is seen by the chair and its members as having identified the right strategic priorities. There is good commitment to partnership working from key statutory agencies as well as good engagement with the voluntary sector. The board's priorities are appropriately matched to the identified needs of children and young people in the borough. It is acknowledged that although there have

been positive developments in the board's impact and structure, the board is still evolving and developing, and much of the planned change has yet to be implemented.

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 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 eight of Her Majesty's Inspectors (HMI) from Ofsted and two additional inspectors.

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