Metropolitan Borough of Rotherham

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: 16 September – 8 October 2014

Report published: 19 November 2014

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

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

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

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

Contents

The local authority

Summary of findings

Children's services in Rotherham are inadequate because:

Leadership, management and governance

- Serious and widespread failures in child protection work mean that children and young people are not adequately protected. Partnership working in child protection, particularly between the local authority and the police, is ineffective.
- Deteriorating performance has not been effectively identified or challenged. Insufficient action has been taken in relation to recommendations from previous inspections and reviews.
- There is a lack of clear leadership and accountability for children's services and currently no permanent Director of Children's Services.
- Elected members have not been kept sufficiently informed by senior managers to enable them to have a clear picture of the quality of their services.
- Although senior managers and elected members have conducted regular visits to meet with children and young people, the feedback from their experiences has not sufficiently impacted upon the design, delivery and improvement of services.
- Senior managers do not ensure that they have sufficient oversight of the quality of practice.
- The local authority and its statutory partners do not meet their statutory duties towards vulnerable children and the Local Safeguarding Children Board (LSCB) has failed to ensure that partner agencies are held to account.

Quality of practice

- Social work practice is not robust and management oversight is weak.
- Arrangements to tackle child sexual exploitation are fragmented. Moreover, the local authority and its partners have not identified these weaknesses.
- Children and young people who go missing from home or care do not receive a good enough service.
- Social workers do not see children frequently enough. Many social workers do not have up-to-date records and children's views are often not included in assessments and plans.
- Looked after children do not receive good enough care and they wait too long for permanent homes. Too many children and young people are placed out of the borough because there are not enough local placements.

- Children have returned home from care without sufficient background checks, assessments and visits to ensure that they are safe.
- Care leavers are not given enough support to achieve their potential.

What does the local authority need to improve?

Priority and immediate action

Leadership, management and governance

1. Secure effective leadership across children's services.

2. Carry out effective performance management and quality assurance arrangements and ensure that they are well understood.

3. Coordinate leadership and commissioning across the Health and Wellbeing Board, the LSCB, the Children's Partnership Board and the Corporate Parenting Board to establish and deliver against jointly agreed priorities.

4. Ensure that social workers have an electronic social care record that encourages good practice and supports managerial oversight and accurate performance information.

5. Strengthen partnership working arrangements in child protection between the local authority and South Yorkshire Police, at both a strategic and operational level.

Management oversight of social work practice

6. Significantly strengthen the strategic management and oversight of all interventions for children and young people at risk of child sexual exploitation, including those placed out of the area, so that they are all fully protected and helped.

7. Ensure that all child protection work is managed robustly and that appropriate decisions and actions are agreed with partner agencies.

8. Ensure sufficient workforce and managerial capacity to manage staff effectively.

9. Ensure that the complexity of work allocated is appropriate to the experience and skills of social workers and that they have manageable caseloads.

10. Ensure that all children who have returned home from care have sufficient background checks, assessments and visits to ensure they are safe, and that these occur before any more children return home.

Areas for improvement

Enable looked after children and young people to live in permanent homes

11. Ensure that all available routes to permanence for children and young people are maximised, including child arrangements orders and special guardianship.

12. Ensure that children's progress towards permanency is accelerated by permanency being considered early enough. Ensure the swift initiation of legal processes, good assessments and effective oversight of all children in need of legal protection.

13. Improve the sufficiency of placements within the borough to meet current needs and strengthen the strategy so that good planning ensures enough places for the future.

Thresholds

14. Secure full agreement from partner agencies to implement and monitor the threshold for referrals to children's social care so that most referrals, including notifications from the police, are appropriate.

Assessment, planning, recording and reviewing children's progress

15. Improve the quality of all plans for children and young people, ensuring that they are underpinned by thorough assessments, measure progress clearly and are kept up to date.

16. Ensure that children's files are up to date, that they include all key documents, including chronologies, and that outstanding tasks are completed.

Looked after children

17. Ensure that all looked after children's educational, health and social needs are met in a timely manner and to a good standard.

18. Increase placement choice within the borough so that only those children who would benefit from living outside of the authority's boundaries do so.

19. Ensure that children and young people who are placed out of the borough have this additional vulnerability taken into account in planning and in the provision of services to meet their needs.

Care leavers

20. Improve the quality of services for care leavers, including prompt access to emotional well-being and mental health services and effective support to improve their engagement in education, training or employment.

21. Develop a clear profile of the needs of current and future care leavers to inform the commissioning of provision, taking full account of care leavers' views. Ensure that the service is supported by an effective performance management and information system.

22. Ensure that all looked after children and young people and care leavers have a clear understanding of their rights and entitlement to services.

23. Ensure that care leavers have up-to-date risk assessments, detailed and meaningful pathway plans and regular reviews.

Direct engagement with children and young people

24. Ensure that the voices and experiences of the most vulnerable children are routinely heard at all levels within the local authority and that they inform strategic planning and commissioning.

25. Ensure that children and young people can develop meaningful relationships with their Independent Reviewing Officers (IROs) so that their views and wishes are fully taken into account in planning.

26. Ensure that social workers have enough time, and the skills, to develop meaningful sustained relationships with children in need of protection and looked after children, so that they understand the children's feelings, views and experiences, and this knowledge informs their assessments and plans.

The local authority's strengths

27. Early help services are well established and coordinated, and include a wide range of initiatives and provision.

28. Most child protection investigations involving children with a disability are co-worked with an experienced worker from the disabled children's team. This helps to ensure that children's individuality and needs arising from their disability are understood.

29. The participation of children in child protection conferences is increasing, with good use of advocates.

30. Arrangements for monitoring and tracking children missing education are strong.

31. The local authority now has more children leaving care through adoption than its statistical neighbours. In 2013–14, 36 children were adopted and 47 were placed for adoption.

32. Good progress has been made to stabilise the children's social care workforce from a service previously characterised by high levels of turnover and agency staff. The vast majority of staff are now permanent and vacancies are filled promptly. Practitioners are positive about the support they receive.

Progress since the last inspection

33. The last inspection of Rotherham's services for looked after children was in July 2010. The last inspection of arrangements for the protection of children was in July 2012. The local authority was judged to be adequate in both inspections.

34. However, many urgent and important recommendations from these inspections have not been addressed quickly enough. Some have not been addressed at all. Shortfalls in practice remain and some areas have deteriorated.

35. Serious deficits remain in the quality of referrals, child protection assessments and planning, and the support for looked after children and care leavers. Progress has been made in some areas, such as providing advocates to support children at child protection conferences. Overall, the scale and speed of progress against the recommendations has been inadequate.

36. Poor performance management and limited quality assurance processes have contributed to the authority's lack of effective action to address deteriorating performance.

Summary for children and young people

- When children and their families have serious problems and need a social worker they have got one, but it may have taken too long to decide on the help that they needed. Social workers have not always visited often enough or asked children what they want and what they think needs to be done.
- Some children and young people have had a lot of changes of social worker. Sometimes this has meant that plans take too long to get going and that they might have had to tell their 'story' again, which can be difficult.
- When children cannot live with their family and are cared for by the local authority, they make a plan and ask children for their views. But there is not enough choice about where children live, and too many young people have been placed outside Rotherham, which has made it hard to keep in touch with family, friends and school.
- It has taken too long to find permanent homes for children in care. This has been with adopters, foster carers or children's wider family. The time it has taken is getting gradually shorter, but this still needs to improve.
- Some children and young people in care have not been looked after well enough; not visited regularly by their social workers and not having all their health and education needs met. The local authority understands this and is now working to make improvements.
- Care leavers have had a good choice of accommodation, with support to help them become more independent. But many young people who live in children's homes have had to move at 18, even if they didn't feel ready. Care leavers need support, such as counselling and emotional support, to deal with the difficult experiences they have had. Half of all care leavers over the age of 18 are not in education, employment or training, and the local authority needs to do more to help care leavers become independent and be successful in their lives.
- When children, young people and families have problems they have good help from children's centre workers, youth support workers and other family projects.

Information about this local authority area[3]

Children living in this area

- Approximately 56,000 children and young people under the age of 18 years live in Rotherham. This is 22% of the total population in the area.
- Approximately 23% of the local authority's children are living in poverty.
- The proportion of children entitled to free school meals:
  - in primary schools is 20% (the national average is 18%)
  - in secondary schools is 17% (the national average is 15%).
- Children and young people from minority ethnic groups account for 15% of all children living in the area, compared with 22% in the country as a whole.
- The largest minority ethnic groups of children and young people in the area are Asian or Asian British and 'mixed'.
- The proportion of children and young people with English as an additional language:
  - in primary schools is 11% (the national average is 18%)
  - in secondary schools is 8% (the national average is 14%).
- A large number of Slovak and Czech Roma families have moved to central Rotherham since 2004, with over 600 pupils now in school. English is an additional language for nearly all Roma children and young people, and many of their parents do not speak any English.

Child protection in this area

- At 30 September 2014, 1,915 children had been identified through assessment as being formally in need of a specialist children's service. This is an increase from 1,851 at 31 March 2014.
- At 30 September 2014, 393 children and young people were the subject of a child protection plan. This is an increase from 332 at 31 March 2014.
- At 30 September 2014, five children lived in privately arranged fostering placements. This is an increase on 31 March 2014. Data for earlier periods are restricted due to low numbers.

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

Children looked after in this area

- At 30 September 2014, 398 children were being looked after by the local authority (a rate of 71 per 10,000 children). This is an increase from 392 (70 per 10,000 children) at 31 March 2014. Of this number:
  - 193 (or 48%) live outside the local authority area
  - 51 live in residential children's homes, of whom 32 (63%) live out of the authority area
  - two live in residential special schools[4], of whom one lives out of the authority area
  - 281 live with foster families, of whom 107 (38%) live out of the authority area
  - 20 live with parents, of whom three live out of the authority area
  - No children are unaccompanied asylum-seekers.
- In the last 12 months:
  - there have been 38 adoptions
  - one child became subject of a special guardianship order
  - 141 children ceased to be looked after, of whom nine (6%) subsequently returned to be looked after
  - 24 children and young people ceased to be looked after and moved on to independent living
  - No children and young people live in houses of multiple occupation.

Other Ofsted inspections

- The local authority operates five children's homes. The most recent full inspections judged one home to be good, one was adequate and one was inadequate. The most recent interim inspections on the other two homes found one to be declining in effectiveness from a previous full inspection judgement of good, and the other making good progress from a previous full inspection judgement of adequate.
- The last stand-alone inspection of the local authority adoption service in January 2011 judged the service as good.
- The last stand-alone inspection of the local authority fostering service in July 2013 judged the service as good.
- Child protection arrangements were last inspected in July 2012 and were judged to be adequate.

[4] These are residential special schools that look after children for fewer than 295 days.

- Services for looked after children were last inspected in July 2010 and were judged to be adequate.

Other information about this area

- During this inspection the Chief Executive advised that he is currently fulfilling the statutory duties of the post of Director of Children's Services.
- The chair of the LSCB has been in post since September 2013.

Inspection judgements about the local authority

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

Summary

Serious and widespread failures in child protection work mean that children and young people are not adequately protected.

Inspectors referred 13 cases back to the local authority because of serious issues of concern. The local authority agreed that seven out of the 18 cases it audited were inadequate.

Strategy discussions, including those where children are believed to be at risk of child sexual exploitation (CSE), are not compliant with statutory guidance. This means that key information held by other agencies may not be taken into account, and potential risks to children may not be considered. There is ineffective working between social workers and police officers.

The recent co-location of the contact, assessment and referral team (CART), the CSE team, and phase one of the multi-agency safeguarding hub (MASH) has yet to lead to improvements in the identification of risk and support to children and young people, including victims of CSE.

Arrangements to identify and protect children who go missing from home and care are inadequate.

Caseloads of individual social workers are too high.

The quality of assessments and the identification of risk are insufficiently robust and do not support safe planning or improved outcomes for children and young people. Assessments are too descriptive, and fail to analyse risks or consider the impact on the child. The lack of analysis leads to unfocused plans.

When children's circumstances deteriorate and risks to them increase, this is not always recognised, or recognised swiftly enough, leading to delays in taking action to make children safe.

Children and young people are not seen regularly enough by their social workers and their voices are too often absent from assessments and plans.

Children and young people are not helped enough to understand what is happening to them.

Managers are not sufficiently involved in the oversight and quality assurance of practice.

37. Early help and support are available to children, young people and their families through a broad range of local services underpinned by a detailed early help strategy. Early help is coordinated through the Early Help Assessment Team (EHAT) either at the emergence of a problem or when the threshold for social care intervention is not met. Children and families are stepped up to children's social care when risk increases and early help is no longer meeting children's needs. Assessments are undertaken through the Family Common Assessment Framework (F-CAF). However, too many do not meet a good enough standard and fail to capture the views of children and their families, or to include clear action plans.

38. Family support is delivered through 22 children's centres, the very large majority of which were judged to be good or better in their most recent Ofsted inspections. In the past year, 717 families (with 1,402 children) received early help, which prevented the need for more intensive support. The Integrated Youth Support Service (IYSS) provides good support for older children and young people, resulting in a steady drop in the number of young people who are not in education, employment or training, a reduction in teenage pregnancies and an increase in young people accessing sexual health services. The number of young people subject to anti-social behaviour orders is reducing.

39. The Families for Change programme, funded through the Troubled Families initiative, has achieved effective change with 435 (65%) of the 730 families worked with. The Family Recovery Programme (FRP) has had a positive impact on families, which include adults with problematic substance misuse, mental ill-health and who are subject to domestic abuse. Since August 2013, 13 out of 75 families have successfully completed year-long interventions and have been stepped down to universal services.

40. The authority has failed to act upon the recommendation from previous inspections to improve the consistency and quality of referrals, including notifications from the police. The threshold for intervention by children's social care is not understood by all partner agencies. The quality of many referrals is poor and not all agencies complete the multi-agency referral form (MARF). This results in a significant number of inappropriate contacts to children's social care. In September 2014, 1,128 contacts were received, of which 568 (50%) required no further action. The number of contacts is significantly inflated by domestic violence notifications from the police, with 1,164 (72%) in the past six months requiring no further action. This high volume of inappropriate contacts limits the capacity of the CART to make timely decisions. In the period April to September 2014, 33% of decisions were not made within the expected period of 24 hours.

41. Re-referrals to children's social care are in line with the national average. Data and information on cases which step down to universal services or step up to children's social care are not collated.

42. The very recent co-location of the police and other partner agencies with children's social care in phase one of the multi-agency safeguarding hub (MASH) arrangements has not yet led to good quality information-sharing and coordinated responses to children and families in need of help and protection. Phase two of the arrangements to develop the operational processes, policies and procedures has commenced.

43. The recording of contacts and referrals is poor, with significant gaps in key information. Consent is not always recorded on cases where this is necessary in order to share information. Management oversight of practice is not robust, leading to drift and delay for some children, who do not receive a prompt response to reduce risk and improve their circumstances. Most decisions to progress referrals to child protection (section 47) enquiries and/or a single assessment are appropriate, but they are not always made quickly enough.

44. The vast majority of child protection strategy discussions have no management oversight recorded on files. Most strategy discussions held are solely between children's social care and police representatives, which means that key information from other agencies about the child and their family is not taken into account and the opportunity to understand potential risks to children and develop safe plans with other relevant professionals is missed. In addition, the local authority's data are unreliable; the information does not reflect the true number of strategy discussions due to the high number which are not recorded. For example, 17 of the 18 current investigations seen by inspectors had no strategy discussion recorded. The last inspection identified the need to improve strategy discussions and section 47 enquiries as immediate areas for improvement but this has not happened.

45. Actions following strategy discussions tend to be single agency. Most child protection investigations are undertaken by social workers on their own, even in some cases when a crime may have been committed. This has led in the past to situations where alleged perpetrators of child abuse have not been investigated and prosecuted, thus allowing the potential for further abuse to occur. Findings of investigations are not routinely recorded and managers do not monitor outcomes. Children's files do not show that they are always seen or asked about their views and feelings. As a result, risks are not fully assessed and managers cannot be satisfied that children and young people are safe. Eight cases were seen where managers had agreed that matters should progress to a child protection conference on the basis of verbal reports from social workers, without any written evidence of investigation findings or assessments.

46. When there is not an immediate risk to a child, there are significant delays progressing multi-agency planning meetings and single assessments. This means that children and young people are experiencing delays in their needs being assessed and responded to in a timely way.

47. Social workers were unsure of what was required of them when undertaking child protection enquiries and they lacked adequate management support and direction. However, social workers were positive about their access to informal supervision and valued the 'open door' policy of managers. Not all social workers receive regular and sufficiently detailed and reflective formal case supervision; some workers had not had this for a number of months.

48. Caseloads in the duty teams and 'children in need' (CIN) teams are too high. At the time of the inspection two experienced duty workers had caseloads of 41 and 46 respectively, which included new child protection investigations and single assessments. Both workers had difficulty finding the time to complete less acute work which was also important. The impact of high caseloads is that too many children are experiencing delay in their needs being assessed. Not all assessments, statutory work and decision-making are undertaken by suitably qualified and experienced social workers; too many complex cases and child protection cases are held by newly qualified or inexperienced social workers.

49. Case recording is not up to date in many cases, including those enquiries and interventions undertaken by the out of hours (OOH) team. The OOH team is not supported by a dedicated manager, which means that social workers working outside office hours do not have sufficient guidance, management oversight or supervision.

50. Management 'grip' of operational work is poor, and the combination of lack of oversight, irregular supervision and high caseloads for social workers means that managers are unable to prioritise workers' time. This leads to poor support for staff, ultimately poor practice, and potentially greater risk for children.

51. The single assessment, introduced in April 2014, is not ensuring that children and young people's needs are met in a timely way. The true situation may be worse than the local authority's performance data suggest, as inspectors saw 15 cases where single assessments had commenced but had not been recorded within the child's social care system. A number of these cases had drifted considerably, with no visits to the child after the initial child protection assessment visit. Delays in recording the start of an assessment on the child's social care system mean that managers are unable to monitor the true volume, pace and progress of assessments.

52. The majority of assessments do not give sufficient consideration to historical concerns about a child and their family. Risk and protective factors are neither clearly explored nor analysed. Chronologies are not used to support assessments; this limits the ability of social workers to see the cumulative impact of events on children, particularly in cases of neglect and abuse. The use of tools to help staff undertake assessments, such as the graded care profile and the CSE screening tool varies considerably across the workforce. The lack of robust risk analysis leads to unsafe planning for children and young people.

53. The previous inspection found that children were being left in neglectful situations for too long, with insufficiently decisive action being taken to protect them. The review of 59 cases of serious neglect led by the LSCB in August 2013 found poor performance in risk assessment, care planning, supervision, and a lack of consistency of workers. Similar poor performance has been seen in this inspection. Despite neglect being a priority for the LSCB, progress has been slow and the neglect strategy is not due for completion until December 2014.

54. Files show little evidence of direct work with children and young people, and good examples are rare. Only a few children's files were seen which showed how their views influenced their assessments and plans, or how they are helped to understand what is happening to them. Almost a quarter of visits to children and young people on children protection plans do not meet the local authority's own standard of a visit at least every two weeks. Overall there is a lack of purposeful visiting and a lack of evidence of positive intervention. A vital element of safeguarding work is therefore missing in many cases.

55. Children's needs arising from their ethnicity, culture, and other individual characteristics are not sufficiently explored or addressed and there is not enough focus on the child's experience. Not all children and young people in need of help and protection have a plan. Plans are not specific or outcome-focussed and do not always fully address all the key risks and needs; it is difficult for parents and professionals to see who should do what, by when, and why. The last inspection identified the need to improve the quality and consistency of children in need (CIN) and child protection plans, with a particular emphasis on risk assessments; this has not happened.

56. Of 1,522 open CIN cases, 940 (62%) children have no plan or a plan which has been updated in the last three months. CIN reviews are not held routinely and no data are collected in relation to CIN reviews. This makes it difficult to establish if children's outcomes are improving or deteriorating and this risks them remaining too long in harmful situations without action being taken.

57. Of the 393 children and young people who should have a child protection plan, 20% either do not have a plan, or do not have an up-to-date plan. Child protection core groups are not always timely and some are poorly recorded, which makes it difficult to measure progress against the plan.

58. Conference chairs are beginning to have an impact on improving the quality of plans and have escalated their concerns about aspects of children's cases in 38 out of 197 conferences. This is evidence of their vigilance and proactivity, but it is also indicative of the prevalence of poor practice.

59. The vast majority of child protection conferences are timely and children's participation is increasing. Good arrangements are in place to ensure that children are well supported by advocates. There is good participation from parents, but their views are not routinely recorded. The most recent information shows that 62% of social work reports were submitted less than 48 hours before the conference and 15% were provided only on the day of conference. This means that children and families do not have the time or opportunity to see and digest what has been written about them, to comment on the content of reports, or to be well prepared for the conference.

60. Twenty-six children have been on a child protection plan for longer than two years. The local authority has only just begun to monitor this cohort, following an audit commissioned by the LSCB and reported on in March 2014. The audit found that lengthy plans were attributable to a lack of confidence that parents would sustain early improvements, and two cases were raised with senior managers because of concern about drift. There is no current detailed oversight of this group by the local authority to ensure that drift and harm are avoided.

61. Overall, there is no regular aggregated and comprehensive information on child protection performance provided to senior managers or the LSCB, so senior managers do not have a detailed understanding of the quality of practice or the effectiveness of child protection arrangements. The last inspection identified the need to collate feedback from children and young people subject to the child protection process, to use this to inform service development, and to collate all practice issues and other quality assurance work to inform the LSCB of progress. This has not been achieved.

62. For children living in households where there is a high risk of domestic abuse, the Multi-Agency Risk Assessment Conference (MARAC) is well established and attended well by most partner agencies except children's social care. This lack of engagement is hampering information exchange and the effectiveness of the MARAC. This issue was highlighted in the recent national review of MARAC arrangements, leading to an immediate positive response from children's social care. However, further improvements are still required, with consistent representation by a sufficiently senior manager who will share and disseminate information appropriately.

63. Domestic abuse services are well-coordinated and victims have access to a good suite of services including refuge provision, freedom projects, victim support, counselling and dedicated independent domestic violence advisors (IDVAs). There are no perpetrator programmes, which is a significant gap.

64. Support for women from minority ethnic communities is also lacking. There is a lack of access to specialist services and insufficient cultural understanding in some risk assessments about the obstacles preventing women from reporting abuse. A specialist support group for minority ethnic women reports a mixed response from children's social care, and also a lack of financial and practical support for women and children fleeing abusive relationships.

65. Young people experiencing domestic abuse benefit from a children's IDVA. A specialist young person's risk assessment tool has been developed to assist in identifying domestic abuse, stalking, honour-based violence and CSE risks. The tool, launched in June 2014, has already led to a higher number of referrals to IDVAs as the training is rolled out across children's services.

66. Young people who present as homeless benefit from joint assessments undertaken by a commissioned service or the local authority, depending on their circumstances. No young people aged 16-17 are without suitably assessed and safe accommodation.

67. Arrangements for monitoring and tracking children missing education (CME) are strong. At the time of the inspection 120 children were not in education for a variety of reasons; 71 cases were active. Almost all of the remaining cases were awaiting school placements, either as new arrivals to the local authority or moving to a new placement. The CME officer goes to great lengths to trace the whereabouts of children. Performance reporting is regular and robust, with comprehensive data collection and routine sharing of information with senior managers, coupled with scrutiny from elected members and the LSCB. The database is updated weekly and new referrals are responded to swiftly. Effective information sharing protocols have been established with key agencies such as health, housing and schools.

68. The local authority collects comprehensive data about those children attending alternative education provision in the two maintained sector pupil referral units (PRUs), and those who are educated at home.

69. Both PRUs were judged as good at their most recent inspections. All pupils attending this provision receive a minimum of 25 hours a week of education during term time. Pupils are subject to close tracking and monitoring of their attendance, progression, behaviour and attainment. Personalised programmes are implemented for those children who require more specialist or intensive support.

70. Procedures for identifying and tracking children missing from home and care are inadequate. Shortfalls are exemplified by the disparity between the 200 missing episodes notified to children's social care by the police during the most recent quarter, but only 35 return interviews being completed in the same period. No information has been supplied to the local authority from the commissioned service about the content, quality, trends and emerging evidence from 'return home' interviews. This missing information is significant and is impacting on the ability of the local authority and its partners to identify trends and patterns in other CSE data and intelligence. The local authority recognises this and recently launched a new missing person's protocol. It is as yet too early to see its impact.

71. Some positive actions have been taken to tackle CSE. The LSCB has delivered awareness-training about CSE across the partnership. There has been good work to raise awareness in key business sectors such as hotels and taxi companies. The local authority accepts that more awareness-raising needs to take place so that risks relating to CSE are recognised at an earlier stage by communities and partners and that this should be evaluated for impact.

72. The local authority has recently launched a multi-agency CSE risk assessment tool. At this stage not all social workers and partners have received training, including social workers in the specialist CSE team. Some workers in this team are unclear about their role in the new arrangements. The number of strategy meetings convened when CSE is suspected is increasing, although the multi-agency response is not yet consistently robust. Working arrangements with the police are still not effective. In some cases seen during the inspection, the quality of practice and recording of work was poor. Not all young people who may be at risk of CSE received a timely response. There was ineffective assessment and planning, resulting in some children and young people remaining in vulnerable situations and not receiving appropriate support. The lack of plans meant that progress could not be measured, and increasing risk is not clearly identified.

73. The local authority has a well-developed strategy to raise awareness across agencies and the community about private fostering. Targeted training is underway with education professionals, school admissions and European Union migrant outreach workers, to identify children who are registered at schools and nurseries and to clearly establish who holds parental responsibility for each child. Staff in the early years and education sectors are also assisted to understand different concepts of 'families' in specific minority ethnic communities, to ensure that they make the relevant enquiries.

74. The local authority is not discharging its full statutory duties towards children who are identified as being privately fostered as there are significant delays in undertaking assessments, files do not contain evidence of parental consent to these agreements, plans are missing, and there are no regular reviews or visits. The local authority cannot therefore be satisfied that these children are safe or that the arrangements meet their needs.

75. Allegations against adults who work or volunteer in positions of trust are managed effectively by a full time dedicated Local Authority Designated Officer (LADO). Establishing a dedicated LADO post has helped to raise the profile of this work. There has been a steady increase in the number of contacts to the LADO in the last 12 months, which demonstrates good partnership working and an increased awareness of the LADO role. However, raising awareness of the LADO role in faith organisations and delivering multi-agency training to the voluntary sector have been slow to develop, as has addressing issues identified in the last annual report such as the lack of referrals from health and the youth offending service.

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

Summary

There continue to be serious weaknesses in services for looked after children including delays in initiating court proceedings and delays in the consideration of permanency.

Many looked after children have had long periods without being seen by their social worker and this has led to drift and plans not being progressed. The frequency of looked after children being visited by their social worker has improved, but it is still not good enough.

Not all looked after children have an up-to-date care plan and assessments and plans are not updated when there is an important change in a child's circumstances.

Education support for looked after children is poor and health care for this group of children and young people is inadequate, with only 41% of children having an up-to-date dental check.

Plans for children to return to live with family and friends are not rigorous enough and lack background checks and assessments.

The fostering service is not recruiting sufficient carers, including carers from all sections of the community, so that too many children and young people have to be placed outside the borough. Overall the local authority is not meeting its sufficiency duty.

Young people placed further away because of their vulnerability to CSE do not always have sufficiently well-developed safety plans, risk assessments or robust responses to further incidents of concern.

There are too few independent visitors and advocates to support all looked after children, particularly those placed outside the borough.

Permanency for children through adoption is improving, but other routes to permanency are not considered often enough or well enough.

Looked after children and care leavers are not aware of their rights and entitlements and care leavers do not have good access to emotional support and mental health services. Not enough care leavers are in education, training or employment.

76. The use of the public law outline (PLO) and court proceedings have not been initiated swiftly enough when children are at risk of, or are experiencing, significant harm. This has led to poor care planning prior to applications for care orders. However, when cases are referred to the legal gateway panel, the local authority takes prompt action to initiate proceedings. The legacy of insufficient use of public law outline processes and poor quality social work practice has led to the local judiciary declining some applications for care. Two cases were seen where applications to remove children from their parents were refused, with the decisions being influenced by previous poor quality work. The District Judge confirmed that the local authority has not always produced the required reports for court, nor complied with court orders, and that this has led to delays in progressing care proceedings. The local authority does not currently have tracking arrangements to ensure that all children in legal proceedings are proceeding swiftly enough to their final hearing.

77. Earlier this year the local authority carried out a robust audit of services for looked after children and judged arrangements to be poor. Many looked after children did not have regular visits, children and young people were not consistently seen by the same social worker and, in some cases, were not seen for six to eight months. This poor practice has resulted in under-developed relationships between children and their social workers, delays in progressing plans, and essential actions not being completed.

78. The creation of specialist looked after children teams has resulted in improvements for looked after children allocated to social workers in these teams. They are visited regularly and have clear plans. Standards of social work practice are higher in the looked after children teams, reflecting the greater experience of staff and lower caseloads. Staffing and management capacity have been increased for these two teams and each are almost fully staffed with enthusiastic, experienced workers who have chosen to work with looked after children and have manageable caseloads. They benefit from robust management oversight and regular supervision, including periodic in-depth discussion about particular children. However, records of these detailed discussions are not always transferred to the child's file as well as being held on the supervision file.

79. The children with disabilities team provides good support for looked after children and the social workers have good knowledge of their children. Most social workers in these teams understand the importance of children being seen alone, taking their full history into account and recording their views.

80. Many looked after children are allocated in other teams to less experienced social workers, with higher caseloads and who are also completing child protection work. The overall service provided to looked after children is still not good enough with, for example, 41% of all looked after children still not being visited in a timely manner.

81. Assessments of looked after children are rarely updated, even when there have been significant changes in their circumstances such as a change of placement or a decision for the child to return home. This weakens the quality of planning. About 20% of children do not have an up-to-date care plan. For those who do, the plans are mostly of a reasonable quality and take into account the child's needs and their views. Too few plans are specific, ascribe tasks and responsibilities, include timescales, and make it clear how children's progress is to be measured. For many children and young people there continues to be work outstanding from periods when they have not been properly supported by the local authority. This includes a need to undertake checks, assessments and visits when children are returning to live with their families. There are currently too many gaps on children's files to provide assurance that these tasks have been done to a sufficient standard to protect children who have already returned home; retrospective remedial actions are required.

82. There is good direct work with children undertaken by the experienced looked after children social workers and the 'looked after and adopted children's therapeutic team' (LAACTT). This includes life story work, therapeutic support and the development of children's communication skills and confidence. However, apart from children who are being adopted, other looked after children do not have up-to-date life story work being completed. Children and young people spoken to had variable views about the support they had had from social workers. They said their workers knew them and helped them but some also said that they have too many changes of social worker; one young person described having four different social workers this year.

83. Case recording is variable. On many cases there are gaps on children's files, including records of key decision-making. This makes it difficult to understand the child's journey. The electronic recording system does not support good practice: it is common for staff to be unable to locate previous documents. Chronologies are rarely up to date and most have significant gaps. These issues militate against social workers developing good plans and risk assessments, based on full background information.

84. Virtual school arrangements are under review because of weak performance in some key areas. The inspection in 2010 recommended strengthening the role of the virtual school to improve the attainment of looked after children. The new Head has already instigated a series of audits and reviews of procedures and processes since taking up post in September 2014. Challenge and scrutiny by the Corporate Parenting Board have been ineffective until recently, but new governance arrangements and management oversight are now being strengthened.

85. Attainment by looked after children at both Key Stage 2 and Key Stage 4 has declined in 2014. Attainment of pupils in Year 6 achieving Level 4 at Key Stage 2 has declined significantly in mathematics, writing and reading in 2014, although this was from a strong performance in 2013, which was above the national average. The cohort of 14 children is small, and 11 have special educational needs. Outcomes at Level 5 improved in the last academic year in reading and writing, but declined in mathematics. At age 16 years, the number of looked after children achieving five or more A* to C GCSEs including English and mathematics has dropped from 22% in 2013 to 15% in 2014. While this remains in line with the national average, the number of looked after children achieving good outcomes falls well below standards achieved by all other children in Rotherham and nationally. Cohorts are comparatively small and, of the 26 children eligible to sit these qualifications in 2013/2014, 19 (73%) had special educational needs.

86. Although the local authority prioritises narrowing the achievement gap for vulnerable groups, including looked after children, the gap between these groups and all pupils in Rotherham has increased and is too wide at both primary and secondary levels. Pupil tracking systems have been improved recently to make sure that all looked after children's progress and attainment are closely monitored and recorded centrally, including data on those children placed out of the area.

87. Attendance is monitored centrally for looked after children both in Rotherham and out of the authority and swift action is taken to make sure children and young people attend regularly. In 2013–14 average attendance was good at 93%. Only one looked after child has been permanently excluded, although the number of fixed term exclusions has increased for all pupils across the borough.

88. The most recent data for October 2014 show that 87% (142) of children looked after in the borough are attending good or better schools. Fourteen pupils are in schools which require improvement and seven are in inadequate schools. The out of authority profile is proportionately weaker. Of the 96 pupils who live outside the borough, 60% (58) are in good or better schools and 29% (28) in inadequate schools. The virtual school checks that the needs of each child are being monitored and reviewed by each school as well as centrally, but a lack of capacity within the team means that more regular follow up work is limited.

89. A small 'Get Real' team provides general support to schools and more focused 1:1 learning support for those children where a need has been identified. This ensures that some children make better progress. Owing to the team's limited capacity, the majority of children do not receive this support and the role of the team is under review to determine best use. The role of designated looked after children's teachers within schools has been under-utilised and this, too, is facing scrutiny.

90. The very large majority of personal education plans (PEPs) – 87% (228 of 261 at September 2014) – were completed in the required timescales. However, the quality of the PEPs sampled was inconsistent and the majority were poorly completed. Insufficient information about current progression and attainment has meant target setting is too often nonspecific and unhelpful. Children's views were not recorded on the PEPs reviewed by inspectors.

91. The allocation of pupil premium funding has stalled and there is considerable under-spend of this budget. Until recently the allocation and oversight of this award had not been well managed by the local authority. In 2013-2014 only 85 pupils out of a possible 279 who were eligible, benefited from this funding. This means the majority of looked after children did not receive the additional support to help raise their attainment or aspiration. Clear guidance has been issued to all schools which clarifies the criteria for use of pupil premium funding to improve and enhance the educational outcomes for children who are looked after.

92. Targeted initiatives focused on raising attainment and achieving the potential of looked after children have been implemented successfully for those children who have participated. Such initiatives include 1:1 tuition for children and young people requiring additional support with literacy and numeracy or behaviour; attendance at university summer schools and specialist activities to raise their aspiration. Outcomes for these events have been recorded and achievements celebrated through special presentation evenings, which are given a high profile by good attendance from senior officers and elected members.

93. The Looked after Children Council has been effective in lobbying for more funding and better access to activities and leisure facilities. All looked after children receive subsidised access to leisure facilities in Rotherham, and those placed out of the authority are given free access to leisure activities where they are living, supported by placement contracts. Reviews, including PEP reviews, are used well to identify children's and young people's hobbies and interests. They are encouraged to attend a wide range of after school activities, which are popular. Activities involving children and young people with their carers are also encouraged and supported. Older young people have been successfully encouraged to attend activities over the summer to help them plan for future destinations post-16. There is a good partnership with the Sheffield Universities and encouragement for looked after young people to attend the 'Go Further, Go Higher' summer school.

94. Health care for looked after children is poor. The most recent health data show that only 24% of initial health assessments are held in timescale, and this reduces to 9% for those placed out of borough. The performance on review of health assessments is better, at 86% in timescale. At the end of September 2014 only 41% of looked after children had an up-to-date dental assessment.

95. The LAACT team ensures that children can access therapeutic support without delay. Many of the children and young people's files seen by inspectors had evidence of LAACT team support and some of this was excellent. There are 38 children and young people accessing longer term support through the team, including art therapy, family therapy and a range of training options.

96. The most recent data for looked after children offending show improvements. Four per cent (8 out of 197) of looked after children aged 10 to 17 and looked after for a year or more had a criminal court disposal, reprimand or a final warning in 2013–14, which was a reduction on the 6% figure in the previous year (11 out of 186).

97. Contact arrangements with family and friends are considered well in reviews and supported by dedicated contact workers in the looked after and disabled children's teams. However, foster carers have raised concerns that the turnover and volume of people involved in contact arrangements has negative consequences for children, including an expectation that they should be willing to travel with adults they do not know, which is not good practice.

98. At the time of the inspection, 137 out of 398 (38%) of all looked after children and young people were placed outside the local authority, including 32 placed in children's homes. Some are placed outside the borough appropriately, for their own safety or because they have specific needs such as being part of a large family. However, the local authority's own analysis suggests that too many are placed outside as a result of insufficient local options. The local authority is therefore not meeting its sufficiency duty.

99. In April 2014 there were 154 fostering households that had provided homes for 242 children and young people over the previous year. Short-term breaks are also provided to 23 children with a disability. There are also 21 'connected persons' (family and friends) foster carers. In 2013–14 the service approved 34 new foster carer households and de-registered 15, resulting in a net gain of 19 households. However, there are no vacancies for children over ten years of age, for young parents and their infants, or for young people with challenging behaviours. This lack of choice results in children having to be placed outside the borough, with the consequential detrimental impact on maintaining family, friend and school links. Foster carers have sufficient training, including on delegated authority.

100. At the end of September 2014, 70% of all looked after children who had been looked after for over two and half years had been in the same placement for at least two years. Placement stability is slightly better for children and young people placed with the local authority's own foster carers. Special guardianship orders are not used enough as a means of securing permanence for some children, with only one looked after child achieving permanence through this route in the last year. Overall, the full suite of routes to achieve permanence for looked after children, including child arrangements orders, is not considered fully enough.

101. The independent chair of the fostering panel is positive about the quality of work presented to the panel and work seen was of an adequate standard. The panel has also had positive feedback from foster carers about the quality and availability of support they receive. The fostering service's annual report 2013–14 is suitably detailed and highlights the progress made and areas for further development. The last stand-alone fostering inspection in July 2013 judged the service as good. Fourteen foster carers who were spoken to as part of this inspection confirmed that they felt well supported to meet the needs of the children they look after. This includes good access to support in the evenings and at weekends, a range of support groups, and training courses. All have development plans which stretch their skills.

102. Work to identify permanent placements for children who require long term fostering is not taking place early enough after they start to become looked after, resulting in unnecessary delay. Permanency is not always considered at the child's second looked after review, resulting in them living in temporary situations for too long.

103. There are a high number of children for whom the permanence decision has changed. From 2010 to 2013, 20% had a decision changed from adoption, which is twice the rate of statistical neighbours and the England average. Analysis suggests that this is likely to be a consequence of historical poor practice, slow case planning, and insufficient consideration of alternative options such as child arrangements orders and special guardianship orders. Significant delays in revoking placement orders also have a negative impact on the time it takes for children to be settled in alternative permanent homes.

104. There are five children's homes in the borough to support looked after children, including two for children with disabilities. During this inspection, four of the homes were simultaneously inspected. Two were found to have declined in the overall quality of their services. One full inspection judged the home to be inadequate from a previous position of making good progress; one interim inspection found declined effectiveness from a previous position of having been judged good. Shortfalls identified in the inspections included inappropriate matching of young people to the home, subsequent disruption and bullying of other residents, and problems filling staff vacancies. The third home had improved and was judged to be adequate from a previous position of making inadequate progress. The fourth home was judged to be good, from a previous full inspection judgement of adequate.

105. For those children and young people placed out of the borough because of concerns about their vulnerability to CSE, a number were found to lack thorough risk assessments, with instances of poor coordination between agencies when young people went missing again. There is evidence of ineffective work between children's social care and the police. Not all children benefit from a return interview after going missing. For one young person who went missing repeatedly, the police refused to respond, thus evidencing poor understanding of the issue. Overall, care plans for looked after children who are at risk of CSE lacked depth and did not consider the emotional and therapeutic needs of the child.

106. The vast majority (98%) of looked after reviews are held on time. Many children attend their reviews and are consulted by their IROs, but some are not seen prior to their reviews, so their wishes and feelings are not fully heard. Relevant professionals attend and good efforts are made to involve parents. The quality of reviews is variable, with some being appropriately challenging and thorough, but others do not focus enough on the pace of children's progress. IROs provide feedback to managers when they identify deficits, and this generally leads to improvements for the child. Recording of reviews is adequate but there are delays in the minutes being circulated. IROs have high caseloads, and this is compounded by the need to travel distances to chair reviews for all the children and young people placed out of the borough.

107. The looked after children (LAC) Council meets regularly, supported by a dedicated worker. Opportunities for younger children and those placed out of the borough to get involved are much more limited and ways of widening participation are being explored. Recently the LAC Council consulted with 62 looked after children and care leavers about the support they received. Some young people were positive about their opportunities, the help they got from staff, and the good relationships they had with staff. Others said they had poor support and too many changes of social worker; they disliked having to get to grips with different rules in different placements, were not satisfied with contact arrangements with their families, and felt powerless. 78% of the contributors wanted additional support, including financial support. Respondents were not aware of their rights and entitlements. These consultation findings provide a good basis for the local authority to further improve its services for looked after children, but it is not yet clear how it intends to capitalise on these findings.

108. The Rights2Rights service provides independent visitors and advocacy services, which children like. However, it is under-resourced and can only provide 12 independent visitors and seven advocates. There are 21 children awaiting support and many more are eligible. The 'Rother-link' service is currently being piloted and is aimed at those placed further away being able to have regular contact by phone or the internet with a volunteer, but it is too early to see its impact.

109. Most children and young people looked after are white, with increasing numbers from the Roma and Slovak communities. Needs arising from their ethnicity are usually taken into account, but there is insufficient differentiation between these two ethnic groups and they are often referred to interchangeably. There are good examples of social workers researching ethnic needs and using this knowledge to improve their practice. Interpreters are used for children who do not speak English. Not all children with minority ethnic heritage are placed with carers from similar backgrounds, as most foster carers are white British.

The graded judgement for adoption performance is that it requires improvement

110. The delay experienced by children in going to live with an adoptive family is reducing, but further progress is required. Performance management of adoption has improved, leading to better outcomes with clearer targets. In this performance year so far, children are waiting an average of 469 days, which meets national targets and is better than the picture for 2013–14, when children were waiting an average of 634 days before being placed for adoption. Despite this improvement, weaker previous performance means that the local authority may not meet the national target for the three year period 2012 to 2015.

111. The local authority now has more children leaving care through adoption than its statistical neighbours, and more than double the England average. In 2013–14, 36 children were adopted and 47 were placed for adoption. This includes children who are considered harder to place. From 2010-13, 9% of children adopted were over five years of age and 16% had minority ethnic heritage. There is currently a wide range of children placed for adoption, including those who are harder to place. It is to the local authority's credit that adoption continues to be the right option for these children, but it does result in longer times to find suitable homes overall, which is reflected in the adoption scorecard performance. There are currently 27 children placed for adoption.

112. In 2013–14, 14 children had a plan for adoption changed. This is twice the rate of statistical neighbours and the England average. This is due to previous ineffective practice and slow or stalled progress on plans. Permanence options for these children have been reviewed, which has led to all these children living with carers in permanent arrangements through different legal routes.

113. The time between children being made subject to placement orders and being matched with adoptive families has reduced, but it is not yet good. The average for 2013–14 is 284 days, which is 132 days over the target set. The local authority's most recent data show that children are currently waiting an average of 218 days.

114. Family finding arrangements for adoption have been improved, with specialist staff who are proactive in starting to find families once children have a 'should be placed for adoption' (SHOBPA) decision and undertake a wide range of family finding activity. The adoption team supports children's social workers and monitors the progress of family finding. There are currently 23 children who have a placement order but are not yet placed. Of these, only five do not currently have a clear link or match to an adoptive family. The team is also family finding for an additional 11 children who have a SHOBPA decision but no placement order.

115. Investment in the adoption service through the adoption reform grant has resulted in greater staffing capacity, which has translated into more adopters being recruited and approved. In 2012–13, 18 adopters were approved, which increased to 31 in 2013–14. This improving performance has continued in 2014–15 and is currently on target for 42 adopters to be approved in the year. Recruitment is orientated towards finding carers for the cohort of children waiting and is wide-ranging. There are currently 18 adoptive households approved, with nine currently linked to a child. Of the remaining nine, four are willing to consider sibling groups, which is in line with the needs of those children waiting.

116. All initial enquiries from potential adopters are followed up promptly and vigorously. Adopters who spoke to inspectors confirmed that they preferred Rotherham because of the quality and speed of the initial response. The two-stage adoption process has been effectively implemented and timescales achieved are good. Adopters feel valued, well supported and trained. Adoption staff are regarded as experienced and knowledgeable, helping adopters understand complex issues well in order to improve their care, for example, regarding the importance of contact with birth families. 'Fostering to adopt' has been introduced recently and there are three children in such placements now.

117. Matching processes are appropriate, with effective management oversight and decision-making; the disruption rate is low. This is assisted by 'life appreciation days' being held for all children prior to matching, and adopters find these effective. Life story work and later life letters are provided, and are often available at the point of placement.

118. The adoption panel is effective, has good access to medical and legal advice, is constituted by members with relevant knowledge, and is independently chaired by a suitably experienced person. The panel takes good, careful account of children's individual needs including, where relevant, their disability, ethnicity and faith, and gives thorough consideration of prospective adopters.

119. The quality of prospective adopters' reports is good, with thorough information gathering and evidence of good analysis. The quality of child permanence reports (CPRs) is more variable, with the panel advisor and the agency decision maker (ADM) both undertaking significant work with social workers and their managers to ensure that the reports meet the required standards.

120. Decision-making by the ADM is good and takes account of all the available information. There is evidence of robust challenge in relation to SHOBPA decisions, which has led to care plans for some children being reconsidered.

121. Children have good adoption support plans and there is a range of services readily available to families, which means that children can get help throughout their childhood and also in later life. The LAACT team is highly responsive and ensures that children can access adoption support without delay. The team supported 72 children in 2013–14 with a range of help including art therapy, play therapy, direct work and family therapy. Other good quality services are provided, including training for staff and adopters.

122. A commissioned service supported 115 birth parents, some adopters and adult adoptees during 2013–14. Support groups for adopters are commissioned in partnership with neighbouring local authorities and provide good help, for example, helping adopters understand issues from a child's perspective.

123. Children's contact needs are assessed and included in their adoption support plans. Arrangements for post adoption contact are managed well and appropriately. Birth parents and adopters entering into letterbox contact agreements have good support from the outset and then ongoing support wherever possible. There are currently 440 children with one or more letterbox contact arrangements in place. There is good evidence from adopters and from some children's files that the range of support available is making a positive difference to children and helping adopters to meet children's sometimes complex needs.

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

124. The leaving care service provides support to 176 care leavers. Until April 2014 the service was delivered by an external provider. This service has now been brought in-house, but there is no evidence yet of improvements to the service or outcomes for care leavers. Care leavers spoken to by inspectors were dissatisfied with the re-integration of the service. They felt that their personal advisors are less accessible, and that the service is less flexible; they miss the valued drop-in facility and are unhappy with the location of the facilities. The local authority is aware of the need to improve service design and delivery for care leavers, but is not sufficiently involving them in the plans and proposed changes.

125. Insufficient information is available to senior managers to understand the quality of service that care leavers are receiving and to help them plan for the development and improvement of the service. The current performance management system does not provide aggregated data to support the oversight of care leaver provision, nor to predict future demand and types of needs. Data systems are rudimentary and require manual updating.

126. Case recording on care leavers' files is incomplete and lacks analysis. Case files do not demonstrate that young people are seen regularly and there is no routine auditing of case files. Data and information on individual files are not collated to enable an understanding of the needs of care leavers, for example, who and how many care leavers are at risk from drug or alcohol use or from sexual exploitation, and therefore require services to address these needs. Staff and managers were unclear how many care leavers are pregnant, or how many are young parents. This is particularly concerning given that many care leavers have experienced high levels of neglect or abuse, and are likely to need significantly higher levels of support to succeed in life. As a result of these shortfalls, the local authority cannot assure itself that young people are safe and are having their needs met.

127. Some personal advisers know the care leavers that they work with very well, and can articulate their histories and the support they need. Others are less clear, particularly about young people's backgrounds, and this limits their capacity to ensure current plans and support packages are fully meeting their needs.

128. Pathway planning is ineffective and the quality of pathway plans seen was inconsistent; they varied from inadequate to good, but most seen were inadequate. Care leavers spoken to did not know what their pathway plans were for and said they had not been given copies. Files do not make it clear if copies have been given to them and most plans seen by inspectors were unsigned. Care leavers' plans are not aspirational and the planning is not specific, measurable, achievable, realistic or timely. Pathway plans do not provide an overview of the young person's health needs. Care leavers reported that they do not receive their health history as part of leaving care arrangements. Planning does not always start early enough or take sufficient account of young people's history to predict their future welfare needs or what services they are likely to require. Too many care leavers do not have sufficient support to guide them into adulthood and independence.

129. Care leavers do not have priority access to CAMHS, which means they may have to wait eight weeks or more to be seen. CAMHS managers do not know how many care leavers are accessing their service. The LAACT team plans to extend their service to care leavers, but the team is currently only supporting two young people.

130. Where there are indicators of CSE, the management oversight of assessment, intervention and planning for care leavers is inadequate. It was unclear from case files what actions the local authority had taken for some young people. In some cases, CSE strategy meetings had been held, resulting in support services, but for too many young people there was little evidence of appropriate planning and interventions to reduce risk and provide support. There were no clear assessments that analysed aspects of CSE such as the 'push/pull' factors, nor assessments that monitored the escalation or de-escalation of risks. The CSE risk assessment plans on files were inconsistent in both format and review timescales. In those cases where young people were identified as at risk of CSE, there was a lack of correlation between the various risk assessments and pathway plans, and weak management oversight of discrepancies. For example, one young person was identified as at 'medium risk' with a concurrent note to review circumstances in 6 months' time, but the worker's supervision notes stated that the young person should be reviewed at least every three months.

131. The local authority reports that 97% of care leavers are in suitable accommodation. The monthly multi-agency panel, which supports all young people to access appropriate housing in the borough, gives priority to care leavers. Care leavers can attend this panel with their personal advisor. Some care leavers are helped to produce a detailed work book, 'Moving on', as evidence that they are ready to live independently. The 'Moving on' work book is a good example of collaboration between staff and care leavers to develop a young person-friendly useful tool, although its effectiveness has not yet been evaluated.

132. Care leavers spoken to were satisfied with the quality of their accommodation, but it is unclear how the local authority intends to ensure sufficiency of accommodation in the future. Figures of how many young care leavers are registered as homeless are not collated. No young people are placed in houses of multiple occupancy or bed and breakfast. Care leavers spoken to by inspectors reported that they feel safe in Rotherham.

133. 'Staying put' arrangements, when care leavers remain with their foster carers beyond the age of 18 years, remain under developed, although the number of young people in such arrangements has increased from five in January 2014 to 13 in September 2014. Another weakness in transition arrangements for care leavers is that young people who live in children's homes have to leave at the age of 18; in one case seen by inspectors this resulted in homelessness.

134. Not all care leavers know about their entitlement to services. The care leavers' group could identify some of their entitlements but were unaware of a care leavers' pledge. The local authority gives every care leaver a grant of £1,500, with a discretionary additional amount of up to £500 which can be applied for. This is below the national minimum recommended grant of £2,000.

135. The Integrated Youth Support Service (IYSS) tracks and monitors well all looked after children and care leavers for post-16 access to education, employment or training. Robust transition arrangements prepare looked after children before they leave school at 16 years to move smoothly on to further education or training placements. IYSS workers arrange information, advice and guidance meetings to help young people prepare for transition in Years 10 and 11. These meetings link pathway plans to school PEPs if a young person prefers this review process. The college youth support worker based in the IYSS monitors all those care leavers in education and training placements and liaises closely with designated care leaver tutors on college sites. This ensures that young people keep on track with their studies or training, have good and sustained attendance, make the expected level of progress and achieve their potential.

136. Good partnership arrangements are in place to identify and secure sufficient training and employment opportunities that match the needs of the post 16-18 looked after children and care leavers. Work is underway to find bespoke provision for those who have additional needs and to ensure that enough provision is available to meet the 'raising the participation age' (RPA) requirement. Local employers, the two general further education colleges, and the 6th form college are very supportive of the needs of care leavers. They work collaboratively with the local authority to accommodate those who meet their requirements into appropriate further learning, training or employment.

137. Five young people are currently in apprenticeships with the local authority and this is in line with the profile for all young people in apprenticeships in Rotherham. Figures for all young people not actively engaged in work or training are reducing steadily.

138. Of the 99 care leavers aged between 16 and 18 years, 74 have employment, education or training placements. A high number of the remaining 25 are 'difficult to place' and work is ongoing to support them. Of these, three are awaiting college placements, one is in custody and three are unavailable.

139. Of 77 care leavers aged 19 years and above, 24 are not in education, employment or training and a further 15 are disabled or otherwise 'difficult to place'. This is a high number, amounting to approximately 50% of the older care leaver cohort who are not in education, employment or training. Although there is an improving picture for young people aged 16 to 19, the lack of detail and understanding by the local authority of those who are 19 plus with poor outcomes undermines this improvement. The prognosis for older care leavers is poor and there is no clear overview of their progress, difficulties, needs or plans.

140. Financial support to gain higher educational qualifications is available and allocated appropriately. Currently six care leavers are in higher education. All have received access to bursaries to support further learning and progression to higher qualifications.

141. The local authority celebrates the achievements of its young people, including through a yearly award ceremony for young people aged 16 years and over, including care leavers, which is hosted by the Mayor and with elected members in attendance.

Key judgement	Judgement grade
Leadership, management and governance	Inadequate

Summary

The local authority does not understand many of its shortfalls in performance and there has been insufficient pace and focus on driving change. Many essential building blocks for effective change management are either not in place, or not well coordinated or monitored.

Governance arrangements are mostly in place but elected members and senior officers are not sufficiently well informed about the quality and performance of services.

There is little routine direct communication with children and young people, particularly those in receipt of child protection services and those who are looked after and placed out of area. There is limited communication with front line practitioners.

Where poor performance has been identified, there is little evidence of robust, targeted action to address deficiencies.

Strategic planning and commissioning are ineffective and the local authority is not meeting many of its statutory duties, including its sufficiency duty.

The local authority's 'improving lives' select commission has not had sufficient knowledge and understanding to test and challenge the performance of services. Matters have taken too long to be considered, and follow up has been largely ineffective.

The creation of a stable, qualified workforce in social care gives a good base for the future, but it needs greater nurturing. Child protection and children in need services have an imbalance of experience and expertise and there is inconsistent supervision, guidance and direction for staff. Some workloads are already too high, with the service experiencing increasing demand.

142. There has been insufficient communication between senior managers and elected members and those involved in front-line service delivery. Senior managers have relied heavily on performance compliance data and have not understood the impact of practice on children and families. Senior officers and members have not routinely engaged with practitioners in children's social care nor routinely considered the views of children and their families. This has led to an absence of feedback, insight and learning by the local authority and its partners.

143. Partner agencies express commitment to improved joint working, but there are few examples of this leading to improved outcomes for vulnerable children. For example, a recent consultation on health assessments for looked after children has not improved the timeliness of initial health assessments, and other aspects of health care for looked after children and care leavers continue to be poor.

144. Thresholds for children's social care and information-sharing between partner agencies are long-standing problems, both of which have a serious negative impact on the quality of services for children and their families. The pace of change in tackling these issues has been too slow and serious deficits remain.

145. The local authority's ability to measure the performance of children's social care is limited by the capacity of the electronic recording systems which primarily report on compliance measures such as timescales. Considerable data cleansing is required to eliminate human input errors. The retrospective nature of much performance information, coupled with questionable integrity, creates an incomplete picture of real performance and therefore the identification of problems and slow pace of improvement.

146. Many aspects of poor performance have been known to managers in children's social care, such as drift in the timely completion of both assessments and plans. Deteriorating performance has not triggered vigorous interrogation or robust improvement planning. Detailed audits of children's files take place but although they have the potential to improve performance, they are not sufficiently independent and are not utilised to effectively disseminate the learning obtained from this activity. Some critical learning is yet to be fully acted upon, and change is not pursued quickly or fully enough, such as in relation to CSE.

147. Governance and accountability arrangements have been maintained throughout a period of great turbulence. However, the post holders in some of the most pivotal roles have changed in a very short period of time. New senior managers have, in a short time, shown a rapid and accurate understanding of the strengths and weaknesses in children's social care, although this is clearly work in progress. The current priority is on tackling immediate issues of concern but there is a need to undertake more fundamental problem solving.

148. Previous regular meetings between the Director of Children's Services (DCS), the Chief Executive, and the independent chair of the LSCB show clear communication and identification of relevant issues, but there is insufficient evidence of these leading to swift improvements. The last Lead Member, recently appointed as Leader of the local authority, considers performance information carefully and interrogates it appropriately. However, the depth of challenge has been limited by the quality, integrity and depth of data available, and this requires improvement. The newly appointed Lead Member for children's services understands previous and emerging issues of concern but it is too soon to see any improvements.

149. Although formal local authority scrutiny takes place, and has a strong focus on children's social care, matters take a long time to be considered and any consequent actions take too long to implement.

150. Links between the local authority, the LSCB, the Health and Wellbeing Board and the Children's Partnership are not strong enough, resulting in a lack of focused commissioning and strategic planning. Priorities are neither well aligned nor driven in a coordinated way. Children's issues are becoming increasingly important for partner agencies, based on a needs assessment, with two of the six priorities of the Health and Wellbeing Board focusing on children. However, it is too early to see the impact of this.

151. The sufficiency assessment shows that the local authority understands only the broadest needs of children in the area and it lacks detailed analysis of the needs of the most vulnerable children. This contributes to inadequate commissioning of services to meet identified needs and poor medium and longer term planning.

152. The local authority cannot show sufficient direct improvement as a consequence of findings from external evaluation or internal performance reporting. An example is that a quarter of all complaints about children's services are not responded to in a timely way, and young people are not routinely advised about the complaints process nor helped to access it. There is little evidence of learning from complaints. This undermines the stated commitment to hearing from children about their views, and exemplifies how commitments do not translate into clear actions.

153. Some services for looked after children have been improved, for example, creating specialist social work teams, increasing the number of children being adopted and introducing 'fostering to adopt' and 'staying put' arrangements. However, many of these are recent, some are limited in scale, and all are not well connected to a sufficiency assessment and plan.

154. The local authority is a regular attender and good contributor to multi-agency public protection arrangements (MAPPA), coordinating arrangements to protect the public from serious offenders in the community. Although the local authority engages with Cafcass, the family courts and the regional Family Justice Board, this engagement is not leading to improved practice, and poor practice continue to contribute to delays in legal proceedings for children.

155. First and middle managers in children's social care do not all carry out quality assurance activity or manage performance sufficiently well. There is poor practice in the supervision of staff, recording of management decisions, and overseeing the content and recording of assessments and plans.

156. Substantial progress has been made on the staffing profile in children's social care. Two years ago there was a high turnover, high use of agency staff and low morale. The workforce is now predominantly permanently employed staff, with the few vacancies being covered promptly with use of agency staff. Practitioners report good support from managers. Many social workers in their first year of practice benefit from reflective casework consultations with their allocated consultant practitioner and structured learning. However, workforce stability has been achieved through significant recruitment of newly qualified social workers, and this inexperience needs to be borne in mind when considering the capacity of the service.

157. Overall, social workers' caseloads are too high when taking complexity, volume and experience into account. This was an area for development at the last inspection which has not been addressed. Caseloads in the child protection and children in need teams, which have the most inexperienced social workers, are high. Caseloads in the looked after children teams where the staff are proportionately more experienced are lower. The majority (55%) of social workers have more than 20 cases, 28% have more than 25, and 11% have more than 30 cases. High caseloads make it difficult for staff to deliver good quality practice or benefit from the learning and developmental opportunities available from the local authority and the LSCB. Some staff said they had not been able to prioritise their learning needs over the demands of their caseload. This is particularly important given the high percentage of inexperienced staff and the need for staff to concentrate on issues that are most relevant to the local area, such as CSE.

The Local Safeguarding Children Board (LSCB)

The Local Safeguarding Children Board is inadequate
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 are inadequate.

Summary of findings

The LSCB is inadequate because:

Performance and evaluation

- The pace of change and improvement delivered by the LSCB is insufficient, with change taking too long and the impact of changes not being clear or evaluated.
- There is little evaluation of the impact of the LSCB's work.
- The LSCB has failed to recognise the inadequacies in the local authority and partner agencies. Some are now being recognised, but overall the LSCB has not provided sufficient scrutiny or challenge.
- The LSCB is not yet effective in holding all partner agencies to account for the delivery and impact of work.
- The LSCB frameworks for performance monitoring, reporting and evaluation do not yet enable the robust evaluation of performance across all partners, and practice issues and deficits have not been identified.

Coordination with strategic and commissioning activity

- The LSCB cannot demonstrate that it has taken the necessary steps to encourage and support partners to make sufficient improvements.
- The LSCB does not have sufficient impact on other strategic partnerships, such as the Health and Wellbeing Board.
- The LSCB does not have a link or influence on the joint commissioning arrangements in the area.

Hearing and understanding experiences

- The LSCB does not have a good understanding of the experiences of the most vulnerable children and young people in the area and those placed outside the area; their 'voices' are not heard. This inhibits the opportunities for the LSCB to drive forward appropriate improvements.
- Poor practices in response to CSE are not known by the LSCB.
- Practitioners could not describe the impact of the LSCB on their practice.

What does the LSCB need to improve?

Priority and immediate action

Performance, challenge and improvement

158. Increase the pace of both change and coordination of LSCB-related improvement and the evaluation of impact.

159. Ensure effective performance reporting and quality analysis of the experience of the most vulnerable children through aligned performance data from all partners.

160. Ensure that a robust programme of multi-agency audit activity, aligned with priorities, is used to evaluate the impact of the required improvements in practice.

Coordination with strategic and commissioning activity

161. Increase the LSCB's engagement with the Chief Executive, the DCS and the Lead Member for children's services.

162. Take steps to maximise the influence of the LSCB on strategic planning and commissioning through stronger representation on the statutory partnerships and, in particular, the Health and Wellbeing Board.

Areas for improvement

Hearing and acting on the experiences of others

163. Establish robust mechanisms through which the LSCB can hear about the experiences of vulnerable children, including those placed outside the area.

Learning and development

164. Ensure that the LSCB understands the impact of training on practice in all partner agencies and the link with improved outcomes.

165. Enhance the profile of the LSCB among the wider workforce, so that staff understand its priorities and impact and that learning from serious case reviews (SCRs) is disseminated.

166. Ensure that multi-agency policies and procedures are kept up to date, aligned with current expectations and learning from reviews, SCRs and audit and performance analysis. Ensure that learning and change are implemented swiftly.

Inspection judgement about the LSCB

167. The independent chair, just completing the first year of this role, exhibits visible and robust testing and challenge towards all partner agencies and appropriately initiated a self-assessment to reshape the LSCB. Within the last year, the LSCB has been restructured, has taken early steps towards performance reporting and has started to seek links with other bodies responsible for strategic development and commissioning. Funding for the LSCB is secure, with a recent increase to support performance reporting.

168. The chair has been well supported by the Chief Executive in his efforts to raise the profile and priorities of the LSCB, particularly in meetings with the previous DCS. Given the current turbulence within the local authority and changes of most key senior personnel, establishing and renewing relationships to maintain the current momentum of improvement will need to be a priority.

169. There has been appropriate focus by the LSCB on agreeing and progressing business plan objectives and improving mutual challenge from members and the evaluation of performance. While the direction of travel is positive, it is too early for these efforts to show evidence of positive impact on practice.

170. Members of the LSCB's new executive board support the board's direction of travel and are sufficiently senior in their organisations to effect change. Executive board members also chair the sub-groups, which should ensure that efforts are directed towards the agreed priorities. Despite recent commitments, long-standing problems remain, such as the ineffective implementation of the threshold guidance across all agencies, poor quality referrals and the poor use of the multi-agency referral form, poor health outcomes for looked after children and the lack of support available for care leavers.

171. The annual report, business plan and sub-group arrangements align well with the LSCB's recently agreed priorities of CSE, neglect, domestic abuse and early help. These priorities largely align with the Children's Partnership Board but are yet to be sufficiently aligned to the Health and Wellbeing Board's priorities. Until very recently, there was no acceptance or understanding that the LSCB should be routinely involved in discussions concerning vulnerable children and contributing to the decision-making in relation to commissioning. Further work is needed to cement the links with the Corporate Parenting and Community Safety Boards.

172. The findings of several external evaluations over the past few years relating to the authority's response to CSE, including the Independent Inquiry in Child Sexual Exploitation in Rotherham 1997-2013, have been accepted by the LSCB. Findings have led to much activity, but this has been ineffectively coordinated, with insufficient integration of effort - the pace of change has been too slow. The recent establishment of CSE as a priority for the LSCB, led by a sub-group, is shedding light on aspects of planning, commissioning, availability of services, local procedures and training. This has led to the establishment of a system for tracking and monitoring cases. Poor practice in relation to CSE indicates the urgent need for these areas to be robustly addressed.

173. Some multi-agency audits have been undertaken by the LSCB, for example of CART contact and referrals. However, the impact of these audits on practice is ineffective. Despite the audits and their findings, too many CART contacts, including domestic violence notifications, continue to be inappropriate. This volume negatively impacts on the timeliness of decision-making. The LSCB completed a section 11 audit programme during 2014 to a good standard as part of a biennial audit programme.

174. Learning and development are coordinated well by a sub-group. Training priorities are regularly refreshed and updated in line with emerging evidence and findings in relation to best practice. Evaluation of training takes place at several stages after delivery, recognising the challenges in identifying the effectiveness of training and the impact on practice.

175. There have only been two serious incident notifications to Ofsted over the last four years and no recent SCRs have been undertaken. These figures are too low when compared with the serious issues that have come to light through systemic reviews in the area. They suggest that the LSCB has not been applying the thresholds effectively and has failed to recognise issues of serious concern. The decision to initiate a SCR earlier this year was correct, but required the independent chair to disagree with the recommendation of the sub-group. The review identified serious shortfalls in section 47 arrangements and inexperienced social workers holding cases that were too complex. The report's recommendations are yet to be published and implemented. Learning from previous local and other national SCRs has been disseminated, but many practitioners have little knowledge of the key findings or the role of the LSCB in informing their day-to-day practice.

176. The LSCB annual report for the current year provides an assessment of the performance and effectiveness of local services, identifying areas for improvement. However, the analysis and evaluation of performance are limited. The LSCB's impact on performance has been hampered by insufficient performance information from partner agencies, and partners have been slow to contribute to a joint performance framework. Efforts are now underway to consolidate performance measures from health partners and the police in addition to children's social care.

177. The LSCB does not currently hear any direct testimony from vulnerable children about their experience of local services and this is identified as a weakness. The last safeguarding inspection identified fully implementing the proposed quality assurance framework as being an area for development. This included regular collation of practice issues noted by child protection chairs and findings from all quality assurance work to be reported to LSCB. The framework has not been implemented.

178. Policies and procedures require attention to ensure that they are up to date and comply with new statutory guidance and best practice guidance. Some, for example the missing children policy and procedures, have been recently reviewed but further work remains. The absence of a common understanding and application of thresholds has been identified as problematic across the partnership but, although a document has been agreed, effective improvements in practice are yet to be achieved.

179. The child death overview panel (CDOP) is well established and contributes effectively to promoting changes in the wider community to reduce the risk of accidental child deaths.

What the inspection judgements mean

The local authority

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

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

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

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

The LSCB

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

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

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

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

Information about this inspection

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

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

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

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

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

The inspection team consisted of eight of Her Majesty's Inspectors (HMI) and one Additional Inspector from Ofsted.

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