

Ofsted
Piccadilly Gate
Store Street
Manchester
M1 2WD

T 0300 123 1231
Textphone 0161 618 8524
enquiries@ofsted.gov.uk
www.gov.uk/ofsted



8 May 2019

Mark Andrews
Strategic Director for People
Rutland Council
Oakham
Rutland
LE15 6HP

Dear Mark

Focused visit to Rutland County Council children's services

This letter summarises the findings of a focused visit to Rutland County Council children's services on 19 March 2019. The inspectors were Rachel Griffiths and Margaret Burke, Her Majesty's Inspectors.

Inspectors looked at the local authority's arrangements for contacts and referrals. They also considered the effectiveness of strategy discussions and section 47 enquiries, the quality of assessments and early plans, the effectiveness of the designated officer role in investigating allegations against professionals, and support for children who are subject to or at risk of exploitation.

Inspectors considered a range of evidence, including case discussions with social workers and team managers. They also looked at local authority performance management and quality assurance information and children's case records.

Overview

The recently appointed director of children's services and his senior leadership team are ambitious for children in Rutland. They have a realistic understanding of service strengths and areas that still require improvement.

The local authority has a permanent, stable and motivated workforce. Responses to child protection concerns are prompt. Investigations relating to allegations about professionals are thoroughly investigated by the designated officer, and responses to children at risk of exploitation are improving.

Although audits are thorough, highlighting both strong and weaker practice, they are not having sufficient impact on individual social work learning and practice, and ultimately on outcomes for children. The quality of assessments and plans remains variable. In less urgent situations, children are not always seen promptly or regularly, resulting in a delay in their needs being assessed and met. While social workers report feeling well supported by their managers, supervision is not sufficiently challenging or focused on the impact on children.

What needs to improve in this area of social work practice

- The consistency and quality of assessments. This needs to include completing them within a child's timescale and having a clearer focus on the child's experiences.
- The consistency and quality of plans.
- The timeliness of children being visited who have initially been assessed as not being at immediate risk of harm but who may be in need of support.
- The level of challenge and consideration of impact and outcomes for children during supervision and other management oversight.
- The impact that audits are having on individual and wider learning and on improving outcomes for children.

Findings

- Contacts and referrals received from a range of agencies are appropriate. The quality of information provided by agencies continues to improve. This is assisted by initiatives such as social workers regularly holding sessions with partner agencies to help them understand thresholds and how to make good referrals. Contact information is promptly scrutinised by the team manager, who makes proportionate and appropriate decisions about what needs to happen next to safeguard and support children.
- In situations where the threshold for statutory intervention is not met, social workers undertake relevant checks, speak with parents about the information provided, and consider with them whether the family would benefit from early help services before a 'no further action' decision is made. This provides families with the opportunity to have support to prevent smaller difficulties becoming bigger ones.
- When the threshold is met and contacts progress to becoming referrals to social care, children's cases are promptly allocated to a social worker. Consent is routinely considered, obtained or overruled appropriately.

- In urgent situations, strategy meetings, with contributions from all relevant partners, are held swiftly and the full range of information is discussed. The rationale for decisions and actions required to ensure a child's safety is clearly recorded. However, in situations where concerns have escalated during an assessment, or in some cases when a follow-up strategy meeting is required, strategy discussions often take a different form, comprising of a series of individual conversations with partners to inform decisions. This prevents important opportunities for multi-agency discussion to share, clarify and debate information and to reach a multi-agency decision about the best course of action to meet a child's needs.
- Child protection investigations are timely, children at risk of significant harm are seen promptly, and actions are taken to ensure and promote their safety. Initial child protection conferences take place in a timely way and children are routinely offered the use of an advocate so that their views are fully represented at such meetings.
- In less urgent situations, the service target is to see children requiring an assessment within three days. This target is not consistently met. Inspectors saw examples where there were delays from a few days to up to one month before children were seen, without a clear reason or rationale for the delay being recorded. Consequently, there is a delay in some children's needs being assessed and addressed.
- At the point of allocation for an assessment to be completed, clear management oversight is provided in respect of what social workers need to do and by when in order to progress assessments within the child's timescale. However, tasks are not consistently being completed in a timely way. For example, tasks such as updating chronologies, undertaking checks, completing initial risk assessments, and holding early child-in-need reviews are not being completed within the timescales set at allocation. This hinders the progression and quality of assessments.
- Supervision is not effectively steering case progression. Inspectors noted that team managers did not consistently check or challenge the completion of specific actions. Nor do they fully consider the impact of this on children.
- The quality of assessments is variable. Stronger assessments demonstrate that all risks have been considered and clearly articulate the views of children, thus reflecting good-quality direct work. It is clear that the views of all relevant professionals and family members have been taken into account. Conversely, other assessments are superficial, and provide limited insight into what children say and what life is like for them. Some assessments do not demonstrate consideration of the views of absent parents or all professionals involved with the family. This results in an analysis which is not based on full information and hinders effective planning to improve outcomes. Additionally, a lack of management challenge in respect of the quality of assessments limits the potential for improvements in assessment practice.

- The vast majority of assessments are completed within maximum timescales set by national guidelines. This is not, however, always proportionate to levels of need and risk. Despite some assessments concluding after one visit to a family without follow-up work, they still take 45 days to complete. This has left some families waiting for a conclusion and waiting too long to access the appropriate support services.
- A small number of children are re-referred to children's social care for the same or similar issues. In repeat assessments, while historical concerns are outlined, they are not always used to fully inform the analysis and plan interventions to achieve sustained improved outcomes.
- Children's plans, deriving from their assessments, are too often vague, with a lack of focus on what needs to change to improve the child's circumstances. Contingency plans are not routinely included to enable families to know what is likely to happen should the child's circumstances not improve.
- The local authority's designated officer conducts thorough and timely investigations when allegations are received about professionals in Rutland.
- Reducing risks relating to child exploitation is a priority for senior leaders in Rutland. Leaders have developed an action plan which they are rolling out to ensure that all professionals across Rutland have knowledge about contextual safeguarding issues and understand how to respond to all types of suspected exploitation. Although it is too soon to see the full impact of this plan, to date, the employment of a specialist exploitation worker is having positive results. The relationship-based social work that this worker is undertaking with some vulnerable young people has resulted in them becoming safer and achieving improved outcomes.
- Since the last inspection, workforce stability has significantly improved. All managers and social workers are permanent. Feedback provided by staff during the visit was unanimously positive about working in Rutland. All staff report feeling well supported and they appreciate training and development opportunities provided to them to improve their practice.
- An improved audit and quality assurance framework, which includes scrutiny of performance data, monthly and quarterly reporting, peer challenges, feedback from families and regular audit activity, is enhancing senior leaders' understanding of performance. Although audits are thorough, highlighting both strong and weaker practice, more needs to be done to demonstrate what actual impact audits are having on individual social work learning, wider practice and, ultimately, outcomes for children.

Ofsted will take the findings from this focused visit into account when planning your next inspection or visit.

Yours sincerely

Rachel Griffiths
Her Majesty's Inspector