Rutland County Council

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

and

Review of the effectiveness of the Local Safeguarding Children Board[1]

Inspection date: 14 November 2016 to 7 December 2016

Report published: 13 February 2017

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

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

Executive summary

Children's services in Rutland require improvement to be good. While no children were found to be at immediate risk of harm and most have improving outcomes, the quality of practice in assessment, planning and management oversight is too variable. When immediate risks are identified, child protection enquiries are timely and thorough. However, emerging risks and concerns are often not recognised or addressed as swiftly as they could be, leaving some children vulnerable to further harm.

The last inspection for children looked after in 2011 judged the local authority as good, but this has not been sustained. Not all recommendations from the 2013 child protection inspection, such as clearly recording managers' decisions, have been achieved. During the past year, there have been numerous changes of staff at managerial and operational levels, which have led to fragmented service delivery. The director of children's services (DCS), backed by senior leaders and members, is determined to get the 'right' staff appointed, and recruitment and retention have been appropriately prioritised. This investment is leading to a more stable, permanent workforce with manageable caseloads and improved morale. The arrival of permanent, senior members of staff is beginning to improve management grip and quality of practice, but inconsistencies remain.

Governance arrangements between the Children's Trust Board, the Health and Wellbeing Board and the Local Safeguarding Children Board (LSCB) are well developed and effective. Elected members are visible and active, but more needs to be done to involve children looked after and care leavers with corporate parents so that they can provide feedback and help to develop services.

The local authority cannot be assured that it has accurate information to assist in its understanding of practice or to hold senior leaders to account. Performance management and monitoring are under-developed, with a lack of target setting and narrative to enable understanding of the local authority's data, and some relevant information is not recorded. The new electronic case management system is not yet embedded and there were errors in data provided to inspectors.

Early help services are providing good levels of support to children and families, and staff provide an effective range of services, often remaining helpfully involved when a statutory service is also required.

The risks to children of sexual exploitation are well recognised, and effective steps are taken to safeguard children. The information from return home interviews for children who have been missing is not consistently used purposefully to understand and reduce risk.

Decisions for children to become looked after are appropriate, but cumulative risks are not always identified or acted upon quickly enough. When children become

looked after, not all permanence options are always considered, which results in delays in securing permanence for some children.

The quality of assessments is too variable. Children's voices are not always clearly conveyed, fathers and significant males are not consistently involved, previous history is not well considered and there is a lack of attention to diversity or reference to research.

Plans across all statutory services lack specificity regarding the actions to be progressed, by whom and in what timescale. This means that it is not clear for parents what they need to do, or what the consequences will be if progress is not made. Social workers know children well, but not all visits occur as frequently as they should. Most direct work is undertaken by early help staff, which means that some social work visits lack focus and do not drive forward plans. Some plans are not sufficiently overseen, and there is a lack of challenge against progress by managers, child protection chairs and independent reviewing officers (IROs).

Children looked after live in stable homes where their educational and health needs are well met. There is good access to leisure pursuits and interests, and children are helped to maintain contact with their families. The local authority lacks sufficient numbers of foster carers to meet its needs, and its strategy to address this is ineffectual. The lack of growth in the availability of local foster carers means that just over half of Rutland's children looked after live over 20 miles from their home.

The local authority cannot be consistently assured that children are placed with foster carers who have been robustly assessed. In a small number of cases seen, foster carer assessments of connected persons, which were presented to the fostering panel, were delayed and incomplete. The fostering panel has not shown sufficient challenge in addressing this shortfall, and there is an absence of meetings between panel members and the agency to address practice issues and concerns.

The local authority has strengthened its commissioning and contract management of services. However, the service level agreement with a neighbouring authority, which provides adoption services for Rutland, has not been reviewed, and some aspects of the services provided, such as post-adoption support, are particularly under developed.

Life-story work is not available for all children, and the variable quality of some adoption paperwork, such as child permanence reports and later-life letters, means that children are not assisted in understanding their histories.

Services for care leavers are good. Dedicated workers are in touch with all care leavers, and high numbers live in suitable accommodation and are successfully engaged in education, employment and training. However, more needs to be done to increase numbers in staying-put arrangements.

Contents

The local authority

Information about this local authority area[2]

Previous Ofsted inspection

- The local authority operates no children's homes.
- The previous inspection of the local authority's arrangements for the protection of children was in January 2013. The local authority was judged to be adequate.
- The previous inspection of the local authority's services for safeguarding and children looked after services was in October 2011. The local authority was judged to be adequate for safeguarding and good for children looked after.

Local leadership

- The chief executive has been in post since 2006.
- The DCS has been in post since September 2014.
- The DCS is also responsible for education and adult services and is also the deputy chief executive officer.
- The chair of the LSCB has been in post since June 2011.
- The LSCB is shared with Leicestershire County Council.
- The local authority has commissioned its adoption services, including support and matching, from a neighbouring local authority.

Children living in this area

- An estimated 7,716 children and young people under the age of 18 years live in Rutland. This is 20% of the total population in the area.
- An estimated 7% of the local authority's children are living in poverty.
- The proportion of children entitled to free school meals:
  - in primary schools is 6% (the national average is 17%)
  - in secondary schools is 5% (the national average is 15%).
- Children and young people from minority ethnic groups:
  - in primary schools is 9% (the national average is 31%)
  - in secondary schools is 6% (the national average is 28%).

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

- The largest minority ethnic group of children and young people in the area attending state-funded primary and secondary schools in Rutland is White Other (2%).
- The proportion of children and young people who speak English as an additional language:
  - in primary schools is 3.41% (the national average is 20%)
  - in secondary schools is 2.84% (the national average is 16%).

Child protection in this area

- At 31 October 2016, 154 children had been identified through assessment as being formally in need of a specialist children's service. This is an increase from 153 at 31 October 2015.
- At 31 October 2016, 31 children and young people were the subject of a child protection plan. This is an increase from 22 at 31 October 2015.
- At 31 October 2016, no children lived in a privately arranged fostering placement. This is no change from 31 October 2015.
- Since the last inspection, no serious incident notifications have been submitted to Ofsted, and no serious case reviews have been completed or were ongoing at the time of the inspection.

Children looked after in this area

- At 31 October 2016, 38 children were being looked after by the local authority (a rate of 49.2 per 10,000 children). This is an increase from 30 (38.9 per 10,000 children) at 31 October 2015. Of this number:
  - 16 (42%) live outside the local authority area
  - Two live in residential special schools[3], both of whom live out of the authority area
  - 33 live with foster families, of whom 45% live out of the authority area
  - None lives with parents.
- In the last 12 months:
  - there has been one adoption
  - one child became subject of a special guardianship order
  - 12 children ceased to be looked after, of whom none subsequently returned to be looked after

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

- one young person ceased to be looked after and moved on to independent living
- no children and young people ceased to be looked after and are now living in houses of multiple occupation.

Recommendations

1. Ensure that senior leaders have access to comprehensive, high-quality performance management information in order to understand frontline practice and fully hold senior managers to account.

2. Ensure that all staff receive regular good-quality supervision, with an appropriate balance of critical challenge, case direction and opportunities for reflection.

3. Ensure that assessments and plans actively consider all risks to children, including emerging and new risks as circumstances for children change. Improve social workers' understanding of neglect and the impact on children.

4. Improve the quality of assessments and plans across the service by ensuring that they are informed by children's wishes and feelings, involve the views of men and fathers, consider diversity and historical factors, which are specific to individual children's needs, and have explicit outcome-based actions.

5. Ensure that personal education plans are completed for all children looked after, and that they include a thorough assessment of needs and set targets for improvement.

6. Review and strengthen management and panel oversight of the fostering service to ensure that there is effective challenge of the quality of practice. In particular, ensure that foster carer assessments and investigations of allegations and concerns are thorough and robust, contain all relevant information and are completed in a timely way.

7. Ensure that the corporate parenting board is effective in driving improvements and monitoring outcomes for children looked after and care leavers. Increase opportunities for children looked after and care leavers to participate in decision-making and service development and for their achievements to be celebrated.

8. Improve social work practice by ensuring that social workers visit children regularly, in line with the children's plans or statutory guidance, and take account of their feelings and wishes when making plans for the children. The frequency and quality of visits should be monitored by managers.

9. Increase the effectiveness of management oversight across the service, ensuring that the rationale for decisions and actions set is clear. Managers, child protection chairs and IROs in core groups, reviews and key meetings should actively challenge drift and delay, and support the progress of plans and the reduction of risk.

10. When children go missing, ensure that social workers and managers fully understand the risks and vulnerabilities of the young people and take

appropriate action. Ensure that the information gathered during return-home interviews is used to reduce risk and inform individual planning and broader service needs.

11. Develop and implement a robust sufficiency strategy, which informs the provision of services and, in particular, the recruitment of foster carers, for children looked after now and in the future.

12. Review the service level agreement with the neighbouring local authority, which delivers adoption services on behalf of Rutland County Council. Ensure that services are sufficient and of good quality to meet all needs of children, families and adopters prior to and beyond the making of an adoption order.

13. Ensure that birth parents have access to support from someone independent of their child's social worker when adoption is being considered.

14. Ensure that all options for achieving permanence for children are given proper consideration, including, when appropriate, parallel planning and foster to adopt.

15. Improve the quality of information which children have access to, both now and in the future, such as child permanence reports and later-life letters. Ensure that all children in permanent placements receive life-story work.

16. Ensure that children have timely access to health services, including specialist provision.

17. Increase the extent to which workers consider the long-term arrangements when placing children looked after with foster carers, so that more are able to stay put when they become 18 years old.

Summary for children and young people

- Services for vulnerable children in Rutland need to improve, but the service for care leavers is good.
- Managers and council leaders are determined to employ the 'right' staff to provide good services, and new social workers and managers are making improvements.
- Staff act quickly to keep children safe when people tell them that they are worried about a child.
- Social workers know about children's lives but do not always visit them as often as they should to find out what is going well for them and what they might be worried about.
- When families are having difficulties, they receive the right help and the support that they need.
- Social workers, teachers, police officers, foster carers and others work well together to keep children safe if they are at risk of sexual exploitation. When children go missing, social workers do not always show, from what they write, that they are making sure that children are safe or that they use information to prevent further harm occurring.
- The right decisions are made by social workers when children cannot live at home, but sometimes these decisions are not made soon enough. Social workers place children with people, who might be family members or friends, who can look after them well and help them to do well in education and to enjoy hobbies.
- When children can no longer live at home, social workers work hard to find the right families. Some children, however, do not have enough clearly written information about their life stories to help them to understand why they no longer live at home.
- Social workers and other professionals work well together to look at plans to help to improve children's lives, but they do not challenge each other enough when improvements are taking too long.
- Young people leaving care receive a good service from staff who know them well. Staff make sure that they keep in touch with people and support them to live independently, stay in education or find a job. They also help them to keep healthy and to find somewhere to live where they feel safe.
- Managers and leaders want to improve services, but need to do more to hear the views of children and their families about the services that they receive and how they could be improved.

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

Summary

Most steps taken to improve outcomes for children in need of help and protection are recent developments and are not yet fully embedded into practice.

Early help services are effective. A wide range of evidence-based interventions provided are successfully helping to improve circumstances for children and families.

Effective systems are in place to ensure that appropriate and timely decisions are made about contacts and referrals. Child protection enquiries are generally timely and thorough. Immediate risk to children is recognised, and appropriate action is taken to protect them. However, emerging risks and ongoing concerns are not as well identified and, in these cases, it is not always clear that children's views have been carefully considered.

Recent assessments reflect improved timeliness and the use of a recognised social work model, but the quality is variable. Fathers and significant males are not consistently well considered in assessments or involved in children's plans, and diversity is not sufficiently explored. Some plans are effective and show improvements in children's lives, but others are not specific enough to individual children. They are not clear about what parents need to do to change, actions to be taken, timescales and what will happen if risks do not reduce.

There is evidence of good multi-agency working to support families in addressing drug and alcohol misuse and mental health concerns.

Social workers do not always visit children as often as is agreed in the children's plans. Children's views are not consistently recorded or evidenced in some cases, and it is not clear how children's views and feelings are being used to inform and influence planning. Core groups and reviews are held regularly with a good range of professionals, but written plans do not always show the progress made.

Social workers report manageable caseloads and feel valued and supported. Inspectors noted improvements over recent months in management oversight, although this remains inconsistent.

When children are identified as going missing, information from return-home interviews is not being used in a purposeful way to understand and reduce risk. When children are clearly at risk of child sexual exploitation, risk is recognised and appropriate steps are taken to safeguard them.

Inspection findings

18. Recent actions taken to improve social work practice and outcomes for children in need of help and protection are not yet embedded, and therefore the positive impact for children is limited.

19. When children and families have emerging problems, early help services provide a wide range of responsive interventions, which are preventing some families from needing more formal, statutory involvement with children's social care. The early help service is using an evidenced-based model of intervention effectively to support children and families. This model is reflected in assessments and plans, and the quality of these is consistently good. This model is also evident in case recordings and is used effectively in staff supervision to identify progress made, current risks and needs and what action needs to be taken.

20. Early help and social care teams work well together to provide support for children and families when they need it. Children subject to child in need and child protection plans benefit from the full range of early help services in addition to statutory assessment and monitoring. Many cases show evidence of improved outcomes for children, particularly in increasing play and learning opportunities, addressing health needs and assisting parents in developing parenting skills.

21. Effective management of contacts and referrals by the duty team ensures that decisions about whether to progress cases for assessment are made on the same day. In cases seen, the rationale for decisions made is clearly recorded.

22. Referrals are received from a range of agencies and are generally appropriate and of a good quality. Permission from families is obtained, when necessary, before sharing information about them. Recent decisions made by the duty team are appropriate, but there have been missed opportunities in some cases to intervene earlier. In particular, some children have been left too long in cases when long-term neglect is a factor, without sufficient action being taken to protect them. (Recommendation)

23. When children and young people are at immediate risk of harm, this is recognised by workers, and responses in the majority of cases are swift and appropriate. Child protection enquiries are undertaken by suitably qualified social workers. They are timely and, in most cases, information gathered is sufficient to make an informed decision. Investigations are informed by decisions made in strategy discussions. However, the majority of these discussions, viewed by inspectors, comprised of a series of individual telephone calls, which means that the opportunity for a richer, multi-agency discussion and the sharing and clarification of information is lost. Most children are seen and spoken to on the same day as the strategy discussion,

but it is not always clear that their views inform planning and interventions. When an investigation results in the need for an initial child protection conference, these are held appropriately within 15 working days.

24. Immediate risks to children, such as an unexplained injury or self-harming, are well recognised and responded to. However, the impact of ongoing and emerging risk from long-standing issues, such as living in families where domestic abuse or poor parental mental health is a concern, is less well recognised. In these cases, it is not always clear that children's wishes and feelings have been considered or that social workers have gained a sense of what life is like for individual children. (Recommendation)

25. Out-of-hours services are provided by a neighbouring authority. Workers have until very recently been unable to directly record notes on children's files, although they are able to read them. This meant that information about repeat contacts was not captured and used to build a picture of concern about a child.

26. Management oversight to ensure that assessments are completed within the child's timescales has significantly improved over recent months. A new 10-day timescale has been introduced for all cases, to ensure that there is a more individualised approach to assessment completion. Any assessments taking over 35 days receive closer management scrutiny, including recording the reason and rationale for any delay. Social work practice is beginning to reflect the use of a nationally recognised model, and recent assessments reflect what is working well and what needs to change.

27. Social work assessments are not leading to a consistently comprehensive understanding of risks and needs. Recent chronologies seen are concise and purposeful, but social workers are not routinely considering historical factors to provide an overview of the most important events and decisions in children's lives. Fathers and significant males are not as well involved or considered as in assessments and plans as mothers are. Their views and comments are not well recorded and it is not clear that continued attempts have been made to keep in touch with them, especially if they are reluctant to engage. (Recommendation)

28. Some recent plans using a recognised social work model are more specific, but the overall quality of written plans is variable. Social workers can describe positive practice and actions in care planning for children better than is reflected in case notes. Many child in need and child protection plans are not specific enough to support effective measurement of progress and risk reduction. They do not include measurable outcomes or set timescales for actions. Some plans are not specific to individual children and too many contain copied case notes from files of other children in the family. This means that children's case notes contain information not specifically relevant to them, and plans are not made from their individual perspective. Contingency planning is not clearly stated, so when circumstances do not

improve for children it is not clear what needs to happen next. (Recommendation)

29. Children's individual needs arising from diversity are not fully identified or consistently well considered in their plans. Some cases address diversity well from a wider perspective, including, for example, social isolation and living in poverty. However, many cases do not address diversity issues of faith, religious beliefs, gender and culture in any meaningful way. (Recommendation)

30. Children are being seen regularly by early help workers or other agencies, but inspectors saw a small number of cases in which social workers are not visiting children as regularly as required in their child protection plans. This means that social workers are missing opportunities to get to know children and understand their experiences to inform future planning. Most direct work is completed by early help staff and therefore some social work visits lack purpose, do not inform planning and can result in drift and delay. (Recommendation)

31. Evidence that research and theory are being routinely used to inform social work planning and practice is not recorded in casework. This means that social workers are not evidencing learning and development of their practice in meeting children's needs more effectively. In addition, feedback from children and families is not systematically used or analysed to help to inform and improve services. (Recommendation)

32. Early help services are effective in providing support and meeting the needs of disabled children. The help provided is proportionate to risk and presenting need. Disabled children are well supported through appropriate child in need planning, when appropriate, and there are clear arrangements in place to manage any safeguarding concerns effectively. Step-up and step-down arrangements for all children, including those who are disabled, are appropriate.

33. Child protection chairs are not consistently challenging poor-quality assessments and plans or delays in improving outcomes for children. A small number of cases were seen in which children were taken off plans too soon, before changes and improvements were sustained. These children became subject to repeat plans because of the same risks and concerns that had been identified previously. The lack of contingency planning and consideration of pre-proceedings work means that some children experience drift and delay in securing improved outcomes. (Recommendation)

34. Management oversight is not routinely ensuring that there is sufficient support and challenge to monitor the progress of casework, but inspectors noted an improving picture over recent months. Some supervision records are thorough and purposeful, but others are brief and lack reflection. Managers do not routinely record their challenge of practice, which falls below the authority's

practice standards. Decisions made about children are not always agreed and signed off by managers. When decision-making is recorded, this is mostly appropriate, but the rationale for decisions taken is not always clearly recorded. (Recommendation)

35. There is effective shared strategic planning to tackle problems associated with drugs and alcohol, adult mental health and domestic abuse. Refreshed commissioning arrangements have strengthened responses to families when drug and alcohol issues are a concern. Inspectors saw some effective practice to support parents who have drug, alcohol and mental health problems. An adult mental health practitioner is available for consultation to children's social workers, and adult and children's duty teams are co-located, which assists in sharing information and advice.

36. Multi-agency risk assessment conferences (MARAC) have recently been prioritised by children's social care and are now attended by duty social workers who complete actions in a timely way and provide feedback on their work. The MARAC chair reported good information sharing and actions being completed to ensure that risk is being recognised and acted on.

37. When children are at risk of sexual exploitation, risks are recognised and appropriate action is taken to safeguard the child. Inspectors saw creative and bespoke packages of support being provided to children by youth and early help services to help to reduce risks.

38. When children go missing from home, they are usually offered a return-home interview. However, not all risks to children who go missing are responded to appropriately by staff, and some case recordings demonstrate a lack of understanding of the issues and pressures faced by children and young people. Information from return-home interviews is not being used to explore and identify trends and patterns of missing episodes and, thereby, to reduce risks. (Recommendation)

39. The local authority maintains an up-to-date register of children who are missing from education and has appropriate processes in place by which to find these children. All cases have been successfully resolved. Schools report persistent absentees to the local authority every half term. When the school is unable to secure improvements, the local authority's legal team takes appropriate action.

40. Pupils who are permanently excluded are supported to access other schools, and the local authority has effective processes in place to find and support children whose parents fail to register them with a school.

41. The local authority has appropriate procedures in place to check on the welfare and education of children whose parents elect to educate them at home. There are no children looked after or children who have disabilities who are home educated. Parents of all currently home-educated children agree to

annual visits from local authority staff who check the appropriateness of the curriculum.

42. There are currently no known cases of private fostering arrangements. There has been some awareness raising across agencies, but managers are aware that this work needs to continue to raise awareness through a targeted campaign.

43. The designated officer role is currently undertaken by the head of children's social care. This does not provide a suitable level of independence when allegations are received about professionals or carers within this service. The local authority is aware of this, and a restructuring of the role is underway. In a small number of recent cases involving foster carers, there have been significant delays, which have impacted on the carers and hampered the service's ability to learn and to apply lessons from these cases.

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

Summary

The right decisions are made to accommodate children, but, in some cases, children should have become looked after earlier. Social workers and managers do not recognise well or consistently the cumulative impact of risk, and therefore there are missed opportunities to bring some children into care in a planned way. The local authority does not sufficiently consider pre-proceedings and parallel planning or use all pathways to permanence, which means that some children experience delay. Management oversight is too variable, with decisions not always well recorded. Managers and IROs do not provide sufficient challenge to delays in securing permanence.

There are an insufficient number of foster carers in Rutland, and, therefore, currently just over half of the children looked after live over 20 miles from home. Not all children are visited in accordance with statutory guidance. Some children's needs are not fully identified or addressed, due to a lack of updated assessments, and the subsequent plans are of poor quality.

The fostering service is not sufficiently robust. Inspectors saw a small number of cases in which carer assessments or investigations were delayed or incomplete, but such shortfalls in practice are not being addressed by the panel and the local authority. In contrast, oversight of foster carer reviews and attention paid to carers' training and development are much better.

Despite the variations in practice, outcomes for children are mostly good. Children benefit from stable homes, and many live with connected persons. Children's health needs are appropriately met, and they are supported to achieve well throughout their education. Children are helped to maintain contact with their families and pursue leisure interests. Young people at risk of sexual exploitation are identified and assessed and receive effective interventions to keep them safe.

Good working relationships between the Children and Family Court Advisory and Support Service (Cafcass) and the courts, along with good-quality court paperwork, mean that care proceedings are completed without delay.

Adoption is considered as a permanence option for all children who cannot return home, but it is not achieved as quickly as it could be. Post-adoption support is poor. Life-story work is not undertaken consistently to enable children and young people to understand their histories or experiences.

Rutland care leavers receive a good service and effective support during their transition to adulthood, but more needs to be done regarding staying-put arrangements.

Inspection findings

44. Correct decisions are made to accommodate children, and swift action is taken to safeguard them when risks are clear. For a small number of children, decisions to bring them into care are not timely. Chronic risks, such as neglect, are not well identified, and the cumulative effects on children are not fully considered. Consequently, risks for these children are not reduced at the earliest opportunity. (Recommendation)

45. Some children experience delays in achieving permanence. Not all available pathways to permanence are used by the local authority and pre-proceedings, parallel planning and foster to adopt are not always considered. The local authority has recognised this, and recently strengthened the 'At Risk of Care/Looked After Children' (ARC/LAC) panel, set up to monitor children who are subject to longer-term child protection plans, and actively considers permanence at an earlier stage. The local authority has developed tracking systems to monitor pre-proceedings, court proceedings, permanence and adoption, but some of these are very recent. Tracking systems are disjointed and missing key information, such as dates of planning meetings or when letters before proceedings are used. These do not, therefore, provide a rigorous overview of children's journeys to permanent homes or identify delays effectively. (Recommendation)

46. The structure within children's social care keeps the number of changes of social workers that children experience to a minimum, with a single transfer point following intervention from the duty team. This promotes the development of consistent and positive relationships with social workers who know the children well.

47. A lack of more specialist knowledge and the absence of a permanence policy contribute to practice being inconsistent and delays in achieving permanence for children. For example, there is a lack of urgency in matching carers with children needing permanent placements with foster families. Inspectors saw some children living in homes for long periods without formal matching taking place. Consequently, this leaves uncertainty for children and their carers. (Recommendation)

48. Good working relationships between Cafcass and the courts and good-quality court paperwork mean that care proceedings are completed without delay. The local authority is thorough and well prepared in presenting evidence in court. Social workers benefit from the support of a highly regarded legal service, which quality assures all social work reports. Recent stability in the workforce has led to improvements in the quality and timeliness of court applications, and most proceedings are concluded at 22 weeks. This is an improvement from 27 weeks between 2012 and 2015 and is better than comparators. Following changes in management, a review of children's cases,

including the use of section 20, resulted in an appropriate increase in court applications to ensure that children's needs are met through a legal order.

49. A small number of children are not visited in line with statutory requirements, leaving them without regular social work support. However, the small number of children spoken to also reported some strong relationships with their social workers. Social workers know their children well. However, recording on children's files does not always reflect this or the work completed. Gaps in recording mean that children's views and experiences are not clear. When children are too young to verbalise views, practice is variable in describing their presentation and responses. Advocacy services are available, yet the local authority cannot assure itself that all children and young people are aware of this provision, as no children have used this since the beginning of the year. Independent visitor services are not available. The local authority is currently considering this.

50. Assessments and written care planning for children are not consistently good, which results in some delays in securing permanence. Assessments are not routinely updated, and for some children it has been several years since their last full assessment. Six-monthly reports, produced for children looked after reviews, are used as the updated assessment. This process is unreliable, as reports seen by inspectors did not provide a comprehensive analysis of children's experiences, and their histories are not used in order to understand their current needs. Consequently, most plans seen by inspectors lack focus on achieving permanence or considering how changing needs will be met. Despite this, inspectors saw some good-quality work with young people, for example, preparing them for contact with their family and working with schools to rebuild key education foundations when significant neglect had limited children's progress. (Recommendation)

51. The management of the fostering service is an area of weakness, and, in a small number of cases seen, prospective foster carer reports presented to panel were out of timescales or missing key information. This has delayed decision-making in some instances, and, in others, the fostering panel has recommended approvals based on poor-quality reports or incomplete information, which potentially places children at risk of harm. Complaints against foster carers are not well managed, and lengthy investigations lead to distress and uncertainty for carers. In addition, the panel does not fully consider the specific skills of foster carers to indicate which children in the nought to 18 age range they are best suited to work with. There are no formal avenues for feedback between the panel and the agency decision-maker. This is a missed opportunity to understand the quality of the work and to improve practice. (Recommendation)

52. Foster carers have not received consistent support, due to significant staffing changes, both within the fostering service and the childcare teams. They do, however, have access to a wide range of training, which was acknowledged by foster carers spoken with, along with the value of the child and adolescent

mental health services (CAMHS) support, which assists them in caring for children. Foster carers also describe good support in assisting children to return to family members or other permanent homes. Foster carers are aware of delegated authority arrangements and their responsibilities to children placed. The majority of foster carer annual reviews are within timescales, and most carers have completed the Training, Support and Development (TSD) standards. The attention paid to a wide range of training, completion of TSD standards and up-to-date reviews ensures that foster carers are assisted in their learning and development to meet a range of children's needs.

53. The local authority recognises that too many children and young people live too far away from immediate family and friends, and 55% reside over 20 miles from their home. This is as a result of insufficient carers being available for teenagers and those who have more complex needs. The local authority's recruitment plan does not suitably address this shortfall. Rutland places high importance on placing children with connected persons and in familiar settings. Recent viability assessments of connected persons are thorough and of good quality. At the time of the inspection, over a quarter of children lived with connected carers, and some children and young people have secured permanence with family members through special guardianship orders. This has enabled children to live with people whom they know well and retain links to their birth families and origins.

54. Placement stability is a strength. Children benefit from stable placements, which enable them to develop strong relationships with their carers. At the time of the inspection, 73% of children looked after had lived in the same home for over two years. The commitment of foster carers ensures that children are nurtured, encouraged and supported with their schoolwork and that they develop social interests.

55. Management oversight and decision-making lack consistency. Inspectors identified gaps in social workers' supervision records and a lack of reflection. When management oversight is recorded, there is a lack of rationale for decisions taken. This means that when professionals or young people view these records, they will have little understanding of why actions were taken. (Recommendation)

56. The large majority of children looked after attend a good school. When they do not, this is because they remain in the school they attended before becoming looked after, and their needs continue to be met well. When a placement move results in a school move, staff quickly find children looked after places in schools that are able to meet their needs. School attendance is high, and there have been very few fixed-term exclusions and no recent permanent exclusions.

57. School staff and the virtual school headteacher know children well and take appropriate actions to support their progress and attainment. Consequently, the large majority of children looked after make good progress at all key

stages, including post-16. However, workers often fail to document this well in personal education plans, which are characterised by cursory assessment of the child's needs and a lack of corresponding actions, weak target setting, poor reviews of targets and a lack of evaluation of pupil premium plus spending. In a few cases, personal education plans are not completed at all. (Recommendation)

58. The local authority engages in a number of activities to prevent bullying and discrimination and to help young people to keep themselves safe online. This includes work at youth groups to promote anti-bullying week, one-to-one mentoring for victims of bullying, including homophobic bullying, and provision of the 'Health for teens' and 'Kooth' counselling websites.

59. When health needs are identified, these are appropriately met. However, the timeliness of initial health assessments and reviews for children who live outside the local authority area continue to be an area requiring improvement since the 2011 inspection. Initial and review health assessments for Rutland children placed within the county or in Leicestershire are timely, but at the time of inspection approximately 11 children living further afield had assessments out of timescales. Strengths and difficulties questionnaire information does not inform health assessments, which means that emotional and mental well-being are not considered as part of children's overall health assessment. Therapy and counselling, for children and young people who require additional support with their emotional and mental health needs, are spot purchased. However, access is not always timely, and a lack of fast tracking arrangements with health providers means that children looked after do not always receive support when they need this. Inspectors saw a small number of examples of children having waited too long for therapy, which had contributed to a delay in securing permanence. (Recommendation)

60. Partnership working is a strength, and there is good attendance and cooperation at meetings and reviews to improve the lives of children. However, reviews of children looked after do not sufficiently focus on meeting needs, and IROs do not challenge delays or the lack of progress against plans. Although children and young people are encouraged to attend their reviews, their views and wishes are not always considered, nor do they inform decisions made about them. (Recommendation)

61. Children's contact with significant people in their lives is reviewed and detailed in care plans. A dedicated and well-resourced contact service ensures that good-quality supervised contact takes place between children and their families. Families are appropriately supported to attend, and workers actively encourage meaningful sessions through appropriate coaching and guidance. However, inspectors saw a small number of children for whom social workers have not actively pursued contact between the children and people important to them, including brothers, sisters and grandparents. IROs do not challenge this in review meetings.

62. During the past year, only one child looked after has been missing, on one occasion, and there are currently none involved in offending behaviour. Workers identify, assess and deliver effective interventions for young people at risk of child sexual exploitation, including mentoring and group-work on identifying grooming behaviour, e-safety and healthy relationships. However, this work is not always well recorded in children's case records, and interventions delivered by early help professionals run parallel to, rather than informing, care plans.

63. Children and young people are actively encouraged by their social workers and their carers to participate in a wide range of leisure activities. Children are supported to develop positive relationships with their peers to address broader issues of diversity, such as social isolation. However, diversity is not consistently considered to inform assessment or plans for children and young people. In addition, a lack of life-story work means that children are not always helped to understand their lives, sense of identity or experiences while living away from their parents. (Recommendation)

The graded judgement for adoption performance is that it requires improvement

64. Adoption is considered for all children who cannot return home to their families, including older children, those from minority ethnic communities, and brothers and sisters. However, parallel planning is not well established, and there has been no consideration of foster-to-adopt placements. That, coupled, in some cases, with delays in initiating care proceedings, means that adoption is not pursued with the urgency required for early permanence. Consequently, children have not had the opportunity to benefit from being placed with an adoptive family at the earliest opportunity. (Recommendation)

65. The local authority has a service level agreement with a neighbouring local authority to undertake a significant part of its adoption work. This includes the recruitment, preparation, assessment and approval of adopters; family finding for children; and three years' post-order support. Active family finding does not take place, however, until the local authority has legal authority to place a child, which means that plans are not progressed as swiftly as they could be. The local authority does not have its own tracking systems to monitor the progress of children waiting for an adoptive placement and is reliant on the other local authority to progress the plans in a timely way. (Recommendation)

66. In the last 12 months, one child has been adopted and seven children have had a decision made that they should be adopted. In one case, the adoption decision has appropriately been changed. As this local authority places only

small numbers of children for adoption every year, year-on-year comparisons, in terms of numbers of adoption plans, make drawing any meaningful conclusions difficult. Currently, no children are waiting for an adoptive family.

67. The timeliness with which children are placed for adoption after becoming looked after is improving. The average time in the three years 2013–16 is 496 days. While this does not meet the national threshold of 426 days, this performance is better than the three-year average for 2012–15, which was 591 days, when the national threshold stood at 487 days. The average time from when the court makes the order enabling the local authority to place a child with adopters until the child is placed is consistently better than the national threshold. The three-year average for 2013−16 in Rutland is 90 days. This is an improvement on the three-year average for 2012–15, which was 103 days. Both are better than the national threshold of 121 days.

68. A neighbouring local authority undertakes to recruit, prepare, assess and approve prospective adopters on behalf of Rutland, as part of its service level agreement. Prospective adopters are assessed in line with national regulations, and, if there is delay, this is minor and for a good reason. Adopters spoken to by inspectors were positive about the preparation and assessment process, including the flexibility of social workers when undertaking assessment visits. They value the preparation training, which assists them to understand the needs of adopted children and the impact of abuse and trauma. The quality of prospective adopter reports ranges from adequate to good. They provide an assessment of the strengths and vulnerabilities, but some would benefit from further analysis to provide a more robust tool to inform the adopters' approval and subsequent matching considerations. The number of Rutland residents applying to adopt through this arrangement has been very small.

69. Children are benefiting from secure, stable placements, which meet their needs. The number of locally approved adoptive families, provided as part of the service level agreement, is currently low. However, when suitable local adopters are not identified, regional and national processes are used in a timely way to identify families. This ensures that children do not wait for a suitable placement. Matching is well considered and leads to placements which last. Children's social workers and family-finding social workers consider the prospective adopter reports of families who seem most likely to meet the needs of the child, shortlist and visit families to reach a recommendation about the best match. This is then validated in a formal meeting before it is placed before the adoption panel for its consideration. Children and their adoptive parents are supported well up until an adoption order is granted, and there have been no pre-order disruptions in the last year.

70. The evaluation of the extent and effectiveness of the adoption service provided to Rutland by the neighbouring local authority is limited and prevents robust managerial monitoring. There is a joint adoption panel with the neighbouring local authority. The adoption panel produces a bi-annual report

about its work, but this is not presented to Rutland. There are currently no formal arrangements for the agency decision-maker to meet with the agency adviser and adoption panel chair to share information, concerns or themes. This limits the development and improvement of the service.

71. The adoption panel functions effectively. The independent panel chair is experienced and he is supported by panel members who have a wide range of personal and professional experience of adoption. The minutes demonstrate that panel members are well prepared, ask relevant and child-focused questions and provide suitable challenge. This contributes to effective consideration of the issues, to inform the agency decision-maker.

72. Introductions between children and adopters are well considered, and there are opportunities for birth parents to have a one-off meeting with the adopters. Adoptive families have regular visits from the child's social worker and the adoption social worker to provide support and advice for any emerging challenges. In contrast, birth parents do not receive support from a worker independent of the child's social worker once adoption has been identified as a plan. Consequently, they are not given effective help and support in dealing with, and understanding, separation and loss. Additionally, they may be less likely to engage with the local authority to provide information to promote their children's heritage. (Recommendation)

73. The quality of information available for children to access now and in the future is variable. Child permanence reports tend to be written in a way most suitable for the court arena, rather than as a tool that can be used for effective matching and for the child to read in the future to understand their history. Adoption placement reports do not always give a clear reason why particular adopters are the best match for the child and how they will meet their specific needs. Later-life letters are also variable in quality. They provide limited information and are not always as clear as they could be about the information that they provide. Consequently, a child's understanding of their history and experience may not be enhanced by these records, should they choose to access them in the future. Life-story books are better. They start positively from where the child is now placed and then explain, using simple language and good-quality photographs, the journey taken to reach their adoptive family. Life-story books and later-life letters are provided to adopters in a timely way. (Recommendation)

74. Post-adoption support is an area which requires development for adopted children, birth families and adopters. It is not well planned, proactive or wide ranging. Training is ad hoc, there are no support groups for adopters or children and there are a limited number of social events. Adult service users experience delay in accessing their records and receiving birth records counselling. There are, however, robust and appropriate arrangements for indirect contact to ensure that these are safe and secure and enable children to maintain their heritage. These include arrangements post 18. (Recommendation)

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

75. Local authority staff make strenuous efforts to maintain frequent contact with all of its care leavers, and have remained in touch with all of them for the last two years. Care leavers are safe, and none is judged to be at risk of significant harm from, for example, sexual exploitation or substance abuse.

76. All current care leavers reside in suitable and safe accommodation, either with their former foster carers or independently in their own flats. Local authority staff prioritise the accommodation needs of care leavers, and most are accommodated, when appropriate, within three months of their making it known that they desire to live independently. No care leavers live in houses of multiple occupancy.

77. The rural nature of the county and the small number of care leavers limit the ability of the local authority to provide transitional, semi-independent accommodation. However, workers provide young people with bespoke support that helps them to develop the skills that they need to live independently. Workers tackle swiftly and well any emerging problems, such as rent arrears or antisocial behaviour. As a result, care leavers successfully make the transition to independent living, and there have been no tenancy breakdowns for care leavers in the last two years.

78. Young people aged 16 or 17 are encouraged to remain looked after and, consequently, all four of the current young people of this age live with their foster carers. There are clear arrangements in place to support 16- and 17-year-old young people who find themselves homeless, and there have been no recent cases of homelessness for this age group or any use of bed and breakfast accommodation.

79. Only three current care leavers aged over 18 have remained with their former foster carers. Although plans for staying put are not considered early enough, when placing children looked after, all moves to independent living take account of the young person's needs and in many cases allow them to access education provision. (Recommendation)

80. Workers have high aspirations for care leavers and place great emphasis on the importance of their education. Additionally, the early intervention service provides support to help young people to remain engaged in education and training. Consequently, the proportion of care leavers who continue to participate in education, training and employment is high, with 19 of 24 care leavers (79%) currently undertaking full-time study or training, including a small number at university. These young people make good progress, partly because of the excellent relationships with local colleges and the responsiveness of local authority staff to any concerns raised by providers.

81. Staff do not give enough consideration to apprenticeships as a possible route into employment, and the local authority does not give care leavers priority access to its own apprenticeships. However, the early intervention service provides care leavers with access to work experience and additional support that helps them to secure employment. A high proportion of young people who have left the care leavers' service in the last two years remain in employment.

82. Care leavers feel positive about themselves. A key reason for this is the care and attention given to them by the leaving care worker, who attends their parents' evenings and award ceremonies. These young people feel that the interest and care demonstrated helps them to aspire to future success.

83. The leaving care worker and other local authority staff understand the needs of individual care leavers and take appropriate actions to support them. However, they do not record this well. Pathway plans are often not completed in a timely manner and do not document clearly the needs of care leavers. Few have clear, specific actions that can be used effectively to support their welfare and development. Professionals cannot, therefore, use pathway plans to share information, and the effectiveness of support for care leavers depends on the skills and knowledge of particular individuals, leaving the quality of service vulnerable. (Recommendation)

84. Planning is thorough for those care leavers who need the support of adult services beyond their 18th birthdays. Staff maintain a register of those young people who may need ongoing support, starting when they enter Year 8 at school, and continuing until they are 25 years old. There are frequent reviews of each young person's progress, and this helps to ensure a seamless transition to adult services.

85. When young people leave care, staff supply them with documents about their own and their family's health histories. However, staff do not prepare a clear summary of this information that is comprehensible to the young people. Workers do not generally discuss this information with them during pathway plan reviews and, consequently, young people do not have the information they need to make informed choices about their health.

86. When young people leave care, workers provide them with other documents that they are likely to need in their transition to adulthood, such as their birth certificate, passport and national insurance number. They also explain their financial entitlements, and the leaving care worker provides further information as appropriate. However, there is no care leavers' pledge, leaflet or web resource that signposts their entitlements, and care leavers are not always able to recall specific details. They do know how to access their personal records, but, when they request such access, this meets with a swift response.

Leadership, management and governance	Requires improvement

Summary

Children in Rutland are not yet receiving a consistently good service. Senior managers and leaders have taken action to address workforce stability and competence. They have made considerable progress in developing the infrastructure and putting in place the systems and processes necessary for Rutland to be able to deliver against its full range of statutory responsibilities, but there is still some way to go.

The local authority has a clear vision and sense of purpose. Elected members are visible and active. Reporting arrangements between the Children's Trust Board, the Health and Wellbeing Board and the LSCB are well developed. The scrutiny panel provides robust critical challenge.

The local authority has strengthened its capacity to commission and contract manage services and is making judicious use of regional partnerships to achieve efficiencies of scale while ensuring that services are responsive to the needs of Rutland's residents. Engagement with children and young people, including the youth council, is good.

However, the local authority's sufficiency strategy is not fit for purpose. The high proportion of children who are being looked after out of area is largely a product of the local authority's inability to recruit and retain foster carers who have the right level of skills, knowledge and experience. Additionally, the service level agreement that the local authority has with a neighbouring authority to deliver adoption services on behalf of Rutland County Council, has received very little management oversight.

While the quality assurance framework is starting to deliver better outcomes for children and young people, and the workforce development strategy is having an impact on workforce quality and stability, the progress made in children's social care services has not kept pace with the progress made in early help.

The quality of performance management information is not sufficiently robust. A failure by some frontline managers and IROs to provide effective management oversight has had a demonstrable impact on the quality and consistency of practice in children's social care.

The corporate parenting board is not as effective as it needs to be in driving improvements and monitoring outcomes for children looked after and care leavers.

Inspection findings

87. With clear lines of accountability and governance, senior managers and leaders share a common commitment to modernising and improving services in order to ensure that the people of Rutland, including children and young people, are well served. The chief executive exercises an appropriate level of influence and control. Elected members are visible and active. The people (children) scrutiny panel challenges senior managers appropriately. For example, they have recently questioned the timeliness of assessments, whether bed and breakfast is ever used for children and the number and nature of referrals to early help. As well as investing in a new electronic case management system, elected members have sanctioned the creation of a new business intelligence manager post.

88. However, the quarterly performance management reports, which are available to senior managers and leaders, include very few examples of targets and no comparator information against which to measure progress. The reports have little in the way of commentary or analysis and no data on, for example, the no-further-action rates of contacts, referrals or assessments, the number of cases stepped down from children's social care to early help and children missing from home or care and/or at risk of child sexual exploitation. Thus, the reports do not provide a comprehensive picture of the child's journey or how well children and young people are being helped, cared for and protected. (Recommendation)

89. Reporting arrangements between the Children's Trust Board, the Health and Wellbeing Board and the LSCB are well developed. The Children's Trust Board has been influential in gaining support for, and harnessing multi-agency commitment to, the development of an effective range of early help services. With its focus on prevention and integration, the Health and Wellbeing Board has been a driving force behind the council's decision to move its existing children's centre to a central location, alongside the library in Oakham, in order to extend its reach and impact.

90. Refreshed as an electronic repository of information about the needs and characteristics of the local population, the joint strategic needs assessment (JSNA) has evolved from being a single document to a series of rolling assessments, which are responsive to changing circumstances. An arrangement, whereby the director of public health for Leicestershire and Rutland is seconded to Rutland one day a week, ensures that the JSNA takes fully into account the distinctive needs and demographics of Rutland's population. As a result, children and families are being supported effectively by a wide range of services.

91. Although the local authority's sufficiency statement describes the needs of the current children looked after population and the level of existing provision to meet those needs, it fails to offer an analysis of the mismatch between supply and demand or explain how this is going to be addressed. Aside from general

statements about the need for more placements for teenagers and the importance of succession planning, given the ageing profile of its in-house foster carers, there are no recruitment targets. In the last three years, the local authority has only managed to recruit four foster carers: two in 2014, two in 2015 and none in 2016. This is contributing to the high proportion of children looked after who are living out of area. (Recommendation)

92. The local authority has strengthened its capacity to commission and contract manage services, and there is a much greater focus on outcomes. The design, development, commissioning and procurement of services are increasingly responsive to the needs of Rutland's residents. However, until recently, the service level agreement that the local authority has with a neighbouring authority to deliver adoption services on behalf of Rutland County Council, has received very little time or attention. Action to address shortfalls identified in this inspection has yet to be taken. (Recommendation)

93. The lead member is not afraid to question or challenge, and has made a significant difference, both in the lives of individual children looked after and through his work with the youth council to enhance the emotional well-being and mental health support available to school-aged children and young people. For example, he has helped to organise extra tuition for some children and ensured that a mental health nurse is available in schools for one day each week for children to access. However, progress in extending the reach and influence of the corporate parenting board has been slow. Although there is a process for making their views known, and the lead member attends every third meeting of the Children in Care Council (CiCC), children looked after and care leavers do not have any direct involvement with the board. The pledge, which is in the process of being revised and updated, has yet to be signed off and re-launched. Discussions about how best to acknowledge and celebrate the achievements of children looked after, other than their academic achievements, have yet to reach a conclusion. (Recommendation)

94. The chair of the LSCB regularly attends the Children's Trust. The chief executive also meets with the chair of the LSCB at periodic intervals, sometimes with and sometimes without the DCS, and is in close contact with her counterpart in Leicestershire with whom she monitors the work and progress of the LSCB. A lack of consistent representation in the LSCB sub-group, which is responsible for scrutinising performance in key areas of safeguarding, has now been addressed.

95. Senior managers and leaders have been slow in developing effective performance management in some important areas. A performance management culture is starting to grow, which is making effective use of business intelligence in order to drive continuous improvement and deliver better outcomes for children. The local authority has invested heavily in a new electronic case management system and appointed a business intelligence manager. However, work to realise the full functionality of the new case management system, which went live in June 2016, is ongoing. Although the

early help scorecard is well developed, the performance scorecard for children's social care is still a work in progress. Currently, the local authority is heavily reliant on a number of different tracker tools, and on the manual generation of data, to populate reports.

96. During the course of this inspection, it became apparent that there were a number of inaccuracies in the local authority's child-level data, including, for example, the number of assessments that had been completed without children being seen and the number of children who were subject to a second or subsequent child protection plan. Additionally, the way in which data is being entered on the spreadsheets, which senior managers use to track children at risk of child sexual exploitation and those missing from home and care, undermines their effectiveness and means that the information has to be manually analysed. While recognising that these are precisely the kind of problems that the new electronic case management system is designed to address, it means that, currently, senior managers cannot be confident that they know precisely what is happening at the frontline.

97. The quality and effectiveness of management oversight and control at the frontline have been problematic, as evidenced by the findings of the local authority's internal audits and the case tracking exercise completed by inspectors. Senior managers have taken decisive action to address performance issues. Since coming into post in September, the new head of safeguarding has had a demonstrable impact. As well as strengthening arrangements at the front door, by developing a more effective triage service and improving the timeliness of assessments, she has revitalised the 'LAC and ARC' (looked after children and at risk of care panel) and introduced a permanence flowchart. Although rightly proud of the progress that has been made to date, she recognises that children's social care is not yet where it needs to be.

98. Despite the limitations of the tool that managers are using to track children missing from home or care, senior managers maintain regular oversight of the local authority's response to missing children, including children looked after who have been placed in Rutland by other local authorities. Reports of children who are missing from school are cross-checked weekly against those who are reported as being missing from home or care, and the head of safeguarding chairs a monthly meeting which reviews the position of all children who are at risk of child sexual exploitation and, or as a result of, going missing. Since the start of the year, 20 children have been reported as missing. During that time, only one Rutland child has been reported as missing from care and that was a single episode.

99. Senior managers have adopted a systematic approach to strengthening performance and improving the quality of practice. Measures taken, which include the introduction of agreed practice standards, a robust supervision policy and a quality assurance framework, and the adoption of a recognised social work model, are underpinned by a strong focus on recruitment,

retention and workforce development. While the stability of the workforce has improved, and the new head of service has introduced a greater level of scrutiny of practice and performance, there is still some way to go to attain a consistently good service for children and families.

100. The quality assurance framework is starting to deliver better outcomes for children and young people, although not consistently across all parts of the service. The lessons from monthly case audits, dip samples and children's and families' feedback are shared with staff regularly, through a combination of monthly quality assurance clinics with managers, monthly children's conferences with the entire staff group and supervision with individual members of staff. Children are increasingly being seen alone and are benefiting from good-quality direct work done by social workers and family support workers who know the children well. This followed auditing, which considered how well the child's voice was being considered in casework. The quality and timeliness of assessments have also improved as a result of action taken in response to an audit of assessments. However, managers recognise that there is a need for greater consistency and that the service that children and young people receive is still too variable.

101. The CiCC 'Speak up, speak out' (SUSO), is under-developed. At the time of this inspection, it only had two members. The local authority is taking action to address this by, for example, making better use of social media to increase SUSO's membership, engage more children looked after and increase their opportunities to participate in decisions that have an impact on their lives. Work is in progress to refresh the pledge, relaunch the 'Welcome to the family' booklet for children in foster care and produce and disseminate information for children looked after and their carers about youth services. It is, however, too early to evaluate the impact of this work, which is being led by a senior youth and community development worker.

102. Good working relationships with Cafcass mean that important legal decisions, which have a significant impact on children's lives, are made without unnecessary delay. The appointment of the new head of safeguarding provides an opportunity to strengthen the relationships with the Local Family Justice Board (LFJB) through active participation in the LFJB's performance and training sub-groups.

103. Unlike early help, where staff receive regular, good-quality supervision, the quality and consistency of supervision in children's social care have been very variable. However, inspectors found increasing evidence of reflective supervision and clear case direction, and heard from social workers that the level of support that they now receive from managers who are active and visible has improved. (Recommendation)

104. The recruitment and retention of a settled and suitably qualified workforce have been problematic. This has had a significant impact on the quality of practice experienced by children and the effectiveness of management

oversight. The workforce development strategy, which is comprehensive and inclusive, is starting to bear fruit. Having introduced market supplements to ensure that its packages of pay and remuneration for social worker and team manager posts are more competitive, the local authority has been creative and imaginative in using a range of different methods to attract and recruit staff. From a previous position, when there were twice as many agency social workers as there were permanent members of staff, the position has been reversed. A new service manager is due to take up her post in January. This will increase management capacity in children's social care. Additional investment in social work posts is reducing social work caseloads.

105. Attended by the lead member and by senior managers, monthly half-day conferences involving the whole staff group are used effectively to share information and learning, engage and motivate staff and promote continuous improvement. Morale is good.

The Local Safeguarding Children Board (LSCB)

The Local Safeguarding Children Board is good

Executive summary

This Local Safeguarding Children Board is well run and effective. Rutland and Leicestershire share the children and adult boards, which are chaired by the same individual. Visible leadership by the chair and the engagement of leaders across the partnership are helping to keep safeguarding high on the agenda in Rutland. The board has developed an ethos of constructive challenge and support. It works closely with the Safeguarding Adults Board and Leicester City LSCB on areas of common concern, such as multi-agency training and safeguarding procedures. A single business unit supports the board and the leads for its six strategic and three joint priorities.

Drawing on a comprehensive, multi-agency dataset, regular thematic audits and learning from case reviews, the board has established a wide-ranging evaluation of the effectiveness of safeguarding, focusing clearly on children's needs. However, its section 11 audits are not sufficiently probing.

The board's scrutiny and influence have facilitated a better understanding of the threshold into children's social care, more timely identification of the health needs of children looked after and the improving response which inspectors have seen when children are at risk of sexual exploitation. Although it monitors completion rates for return-home interviews for children going missing, it does not give sufficient attention to the quality and effectiveness of these interviews in improving risk management.

Its child death overview process is highly effective. A comprehensive analysis of long-term patterns enables the board to influence wider health priorities and to promote initiatives, which are improving children's safety.

The board has developed an effective approach to evaluating safeguarding training, demonstrating a positive and sustained impact for practitioners.

The LSCB has rightly emphasised the importance of children's participation in the work of the member agencies. There are ad hoc examples of the board and partners reaching out to children. However, children are not directly influencing the board's own direction and priorities.

Recommendations

106. Evaluate the quality and effectiveness of return-home interviews and risk management when children are going missing from home or care.

107. Review the section 11 audit process, to ensure that these audits are sufficiently probing.

108. Enable children to more fully influence the LSCB's priorities.

109. Improve awareness raising of private fostering across the partnership and wider community.

Inspection findings – the Local Safeguarding Children Board

110. Visible and proactive leadership from the independent chair is keeping safeguarding high on the agenda in Rutland. The board has successfully engaged statutory partners and proactively reached out to voluntary and community organisations to identify their safeguarding awareness and needs. During 2016, staff changes in Rutland affected the availability of relevant managers for sub-group meetings. However, attendance by board members was consistent and this, along with the chair-attending meetings in Rutland, ensured that key work streams remained on track.

111. The board structure is efficient and streamlined, with work streams shared with Leicester City LSCB and the Safeguarding Adults Board in areas of common concern. This proactive and thoughtful approach provides regular opportunities for members of these boards to meet together and supports shared knowledge and a shared agenda.

112. The board uses a wide range of intelligence to inform and adjust its priorities, drawing on regular audit and quality assurance activity, an extensive multi-agency dataset and practitioners' views.

113. Lay members of the board are well supported. This has made them feel confident about asking questions and challenging the professionals around the table.

114. Rutland County Council has confirmed its financial contribution at the same rate for 2017–18 as the current year.

115. The chair brings an extensive knowledge base, helping members to ask questions and challenge each other while maintaining constructive working relationships. Board members regularly scrutinise monitoring reports, assessing improvement and challenging each other when performance is not good enough.

116. Multi-agency audits are well planned, regular and delivered on time. Multi-agency case audits have consistently included Rutland cases, despite a gap in attendance from the local authority's representative at the relevant sub-group. The sub-group did not allow this gap to delay the completion of multi-agency audits, and the gap in attendance was addressed effectively. The audit themes chosen link clearly to the LSCB's business priorities and learning from serious case reviews. They direct attention to aspects of help and protection, such as thresholds and child protection plans, in which the local authority inspection findings demonstrate the need for scrutiny. Audit findings inform practice guidance and training for practitioners, with a focus in the last year on disguised compliance, a neglect toolkit and effective supervision.

117. Rather than commissioning a multi-agency audit of early help work, the board has scrutinised practice through a joint report from the two local authorities and monitors a wide range of relevant measures in the multi-agency dataset. It has focused multi-agency auditing in this area on the experience of children when intervention is stepping up from early help to children's social care, or stepping down from children's social care to early help. This selective approach makes sense and, given inspectors' positive findings about early help in Rutland, an additional audit is not an immediate priority.

118. The board has begun to evaluate safeguarding practice in relation to children who have disabilities. It has made good progress in recent months, analysing data and preparing an audit tool ready for a multi-agency audit in 2017–18.

119. Effective scrutiny and challenge by the LSCB has also helped to ensure that the health needs of children looked after are identified and addressed more quickly.

120. The LSCB is identifying learning effectively from serious case reviews. Reviews are undertaken and published when the criteria are met. Decisions to delay the recent publication of reports from serious cases from 2012 and 2014, pending completion of criminal investigations, were appropriate. The board provides regular learning events and bulletins to highlight lessons from audits and serious case reviews. Such learning is disseminated, and action is taken, prior to the publication of serious case reviews when required. Attendance at these learning events has been generally good, including professionals from both statutory and independent services. Inspectors found that Rutland social workers whom they spoke to were aware of key messages disseminated by the LSCB. These have been highlighted through monthly staff conferences and meetings.

121. Member agencies have not waited for publication to act on lessons emerging from serious case reviews. For example, in response to the recent child murder case in Leicestershire, a powerful 'Kayleigh's love story' film is being used proactively by early help workers, schools, police officers and social workers to warn children of the dangers of online grooming.

122. The LSCB regularly reviews its multi-agency safeguarding procedures, refining these in response to local and national developments. This work is undertaken jointly with Leicester City LSCB, an example of joint working arrangements, which both independent chairs have keenly promoted. Recent examples include strengthening guidance on bruising in pre-mobile babies, in the light of serious case review findings, and updating the threshold document to cover breast ironing, in response to emerging awareness of this issue.

123. The board has updated its procedures on female genital mutilation and has implemented a communication plan, which includes a YouTube video and engagement activities to raise awareness.

124. The board has facilitated an increasingly comprehensive approach to safeguarding children at risk of sexual exploitation, reflected in the well-structured multi-agency work that inspectors found in Rutland. It has exercised repeated scrutiny and challenge in relation to practice here. The independent chair is proactively holding agencies to account and monitoring the establishment of the multi-agency specialist child sexual exploitation hub. A data analyst is bringing together information on hotspots and profiles of offenders and victims. Training and guidance have been informed by regular multi-agency auditing, and a further audit occurred at the time of the inspection.

125. Analysis of LSCB multi-agency data indicates a positive impact on professionals' awareness and understanding of child sexual exploitation, with a sustained increase in the last year in child sexual exploitation-related referrals to children's social care. Professionals are also making greater use of a risk assessment toolkit, which has been introduced to improve protection for children at risk of child sexual exploitation.

126. The board regularly monitors the completion rate for return-home interviews but does not gather information on the quality of these interviews or on how they are being used to reduce risk. (Recommendation)

127. The escalation process is being used, and the independent chair is proactive in challenging partners when improvements are needed. The LSCB sets targets for improvement and has a clear auditing and monitoring process to assess whether these are met.

128. Section 11 audits are not sufficiently probing. While the LSCB uses a wide range of other intelligence to evaluate the quality of help and protection and does not rely solely on these audits, there is a mismatch between the high level of compliance with standards as reported by member agencies in their section 11 returns and the more comprehensive and accurate picture of practice revealed when all of the board's audit and scrutiny activities are taken into account. (Recommendation)

129. The board has used its audit findings and performance data well to influence and challenge other strategic partnerships in their priority setting, for example prompting discussions about early help and thresholds at the local authority's scrutiny committee. The LSCB and the local authority have worked with schools and other partners to improve understanding of thresholds. The LSCB annual report and inspectors' findings show that referrals come from a range of agencies, with the majority from education, along with increased conversion rates from contact to referral year on year.

130. The child death overview panel is highly effective. Careful analysis of findings over the longer term has enabled the panel to identify patterns that might otherwise be missed. It uses this intelligence well to raise awareness of safety risks for children, inform improvements and influence wider health and well-being priorities. This is a particularly strong element of the LSCB's work.

131. The board has put in place a sophisticated approach to evaluating the impact of safeguarding training. This is also a significant strength. Post-training survey data shows a consistent picture of safeguarding training having a sustained impact on trainees' skills, knowledge and confidence. The training offer links clearly to LSCB priorities, reflecting themes from serious case reviews and audit activity.

132. It is also using a range of other means to provide information on safeguarding to professionals, in an effort to reduce the impact of the drop in practitioners attending face-to-face training. A very informative 'Safeguarding matters' newsletter highlights learning from case reviews and audits and provides practical guidance to promote improvement. Rutland County Council is using the monthly conferences, which managers run with frontline staff, to help to highlight these key messages. Voluntary sector representatives are promoting training to local voluntary sector and community organisations.

133. The LSCB has rightly emphasised the importance of children's participation in the work of the member agencies. The board has agreed to make this an integral feature across the work programme, although business plan progress reports do not demonstrate that it is happening consistently, and a subgroup established specifically to promote children's influence proved unsuccessful. There are individual examples of the board and partners reaching out to children. For example, the chair meets with the youth council and CiCC. However, overall, current arrangements have not been successful in enabling the board's direction and priorities to be directly influenced and informed by the views and experiences of children. (Recommendation)

134. The board's annual report provides a comprehensive evaluation of the effectiveness of safeguarding. Importantly for an LSCB covering two local authority areas, it provides distinct findings about practice and performance in each. For example, it assesses the impact of improvements in Rutland that the board and member agencies are making with improving conversion of contacts to referrals to children's social care. This reflects the better quality of

referrals in recent months, which inspectors noted during the inspection. The report notes future priorities, which were also identified by inspectors, such as the need for more consistent managerial oversight, recognition and analysis of risk, and ability to write SMART plans. This is transferred into the business development plan, with actions such as the need for an improvement in understanding, identification, risk assessment and management of neglect.

135. The board is honest and open in its analysis of areas where the impact of its scrutiny and challenge has not had the desired impact. In particular, no cases of children being privately fostered have been identified in Rutland despite regular scrutiny through the board's quarterly performance data reports. (Recommendation)

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 that 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 whom 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 seven of Her Majesty's Inspectors (HMI) and one social care regulatory inspector from Ofsted.

The inspection team

Lead inspector: Karen Wareing (HMI)

Deputy lead inspector: Nigel Parkes HMI

Team inspectors: Susan Myers (HMI), Lisa Summers (HMI), Pauline Higham HMI designate), Russ Henry (HMI), Rosemary Chapman, John Mitchell (Senior HMI)

Senior data analyst: Neil Powling

Quality assurance managers: Sarah Urding (Senior HMI), Nick McMullen (Senior HMI)

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Piccadilly Gate
Store St
Manchester
M1 2WD
T: 0300 123 4234
Textphone: 0161 618 8524
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