13 June 2016

Mr Ian Thomas
Strategic Director of Children's Services
Rotherham Metropolitan Borough Council
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Dear Mr Thomas

Outcome of improvement work undertaken in Rotherham, August 2015-April 2016.

This letter contains the findings of the recent improvement monitoring visits undertaken in Rotherham Children's Services between August 2015 and April 2016. Her Majesty's Inspectors (HMI) have undertaken five visits over an eight month period. Each visit has involved two HMI on-site for two days. I am grateful to you and your staff for your help and the time given during the visits.

Inspectors have reviewed the progress of the improvement action plan in five areas:

- Contact and referral (MASH) August 2015
- Duty and assessment and area child protection teams October 2015 and March 2016
- Leadership and management March 2016
- Early help April 2016.

During each visit inspectors sampled practice in relation to child sexual exploitation and reviewed performance management and quality assurance arrangements. At your request inspectors did not review arrangements for children looked after or care leavers. You have been open and honest with inspectors sharing your self-assessment that these services have not developed as rapidly as other areas since your last SIF inspection. You have however shared your action plans to improve both services and have given an undertaking to seek external peer review of these services in October 2016. While we accept this undertaking it is our intention under Ofsted's new monitoring arrangements to prioritise a review of these services beginning September 2016.

During visits inspectors have considered a range of evidence, including: electronic case records; supervision files and notes, observation of social work practice, performance information, policies and strategic planning documents and meetings with key partner agencies. Inspectors also spoke to a range of staff including managers, social workers, other practitioners, agency partners and administrative staff.

You have been transparent and honest with regard to your improvement progress and where your challenges remain. The October 2015 visit identified priority action needed to be taken in respect of your duty and assessment team. You accepted these findings and took immediate action to review practice and management arrangements in these teams and invited HMI to revisit the teams in March 2016. From the evidence gathered, the improvement visits have identified where progress has been made and where areas for development continue, which are detailed below.

Key Findings

MASH August 2015

Inspectors found contact and referral arrangements were satisfactory. Management oversight and quality assurance arrangements were much improved. Rationale for decision making was clear leading to improved action planning. Child protection enquiries in cases seen were timely and formally recorded. The out of hour's arrangements had improved with effective links with day time services. The multi-agency team EVOLVE had been established in July 2015 to work specifically with Child Sexual Exploitation (CSE) cases. Recruiting to permanent posts was however a challenge for you. A Strategic head of CSE was appointed leading to greater oversight and grip of cases held in locality teams and was beginning to strengthen links between strategic and operational practice and partner agencies. Weekly risk management meetings were in evidence to review those children and young people at risk of or suffering harm through CSE. There was evidence of CSE tools being used to screen referrals and identify risk. Specific training for staff had been rolled out about the impact of CSE and risk management and staff valued this training.

Inspectors found workloads had reduced to manageable levels and staff were much clearer about their respective roles and responsibility. There was improving evidence of multi-agency partnership working in assessments and planning but this was not consistently embedded. Managers were benefiting from weekly performance information and monthly auditing by all senior managers and this was beginning to promote a collaborative learning culture.

Areas for development

The accommodation of the MASH was not fit for purpose and did not promote integrated working. You knew this and were in the process of making changes. Education partners were not represented in the MASH and Health had been slow to

get on board. High numbers of agency staff meant the workforce was not permanent or stable. The electronic recording system did not support the effective analysis and sharing of information in the MASH and indeed other parts of the service. Again you were aware of this and work was in progress to develop a new electronic case management system. High numbers of domestic abuse notifications were being sent to social care without screening or being risk assessed by police and this was adversely impacting on capacity at the front door. Thresholds for access to children's social care were not sufficiently understood, owned or implemented across the service and partnership. We found better identification of children in need of early intervention was needed.

Despite strategy meetings being recorded and chaired by a manager overall inspectors found a lack of evidence of actions, contingency planning and required timescales which was a key finding in the SIF. This had not improved sufficiently in the intervening period. Similarly, outcomes of Section 47 enquiries/investigations overall were poorly recorded and it was difficult to see how children were any safer after the strategy has been held. While there had been an improved focus on CSE assessment at the front door, there needed to be a strengthened and more focused response to children looked after. Tracking systems to monitor children and young people missing and at risk of CSE had been developed but were not embedded. Inspectors found improvements in partnership working between Children's Social Care (CSC) and South Yorkshire Police. However, there needed to be a continued effort to further strengthen partnership working, make more effective use of intelligence to identify links, patterns, locations (hot spots) and emerging threats (within and across borders/boundaries).

Duty and Assessment Improvement visit October 2015

Inspectors raised concern with regard to the quality of assessment, planning, management oversight and decision making when cases were transferred from MASH to duty and assessment teams. The evidence gathered found practice improved when cases transferred from duty and assessment teams to Area Chid Protection Teams (ACPS). Across the duty and assessment teams there was a lack of understanding of thresholds both for step down to early help and for escalation to Initial Child Protection Conference (ICPC).

In the vast majority of cases seen the quality of assessment was poor. Risk was not sufficiently explored or understood and there was a lack of use of chronologies and assessment tools to assist social workers understand the child's history and the impact of their experiences. Assessments were narrowly focused and did not consider the needs of all children within the household. There was a lack of evidence of multi-agency partner's contribution to assessments and plans or social workers triangulating parental self-report with other professionals. Direct work with children was mostly absent and the child's voice was not sufficiently considered in assessments and plans which concerned them. Children's plans were unfocused and it was difficult to see what was expected of parents and professionals in order to

improve the child's circumstances. There was a lack of management oversight and a lack of clear rationale for decision making. There was a lack of interim safety planning between transition points for children. The case loads of Child Protection chairs were too high, reducing their capacity to monitor in between reviews.

In stark contrast when cases transferred into Area Child Protection Teams (ACPS) practice was significantly improved. Teams were more stable and caseloads had significantly reduced enabling social workers to undertake direct work and more qualitative assessments. Supervision was regular, management rationale was in evidence on most records and social workers were receiving support and challenge from managers. Social workers told inspectors they felt safe. Newly qualified social workers social workers were well supported. Team managers were using performance information to positive effect and this was evidenced in improving team performance and the overall experience for children, young people and their families. Improvements could be seen in responses to children at risk of and suffering CSE. Assessments seen were robust, risk was well understood, and there was evidence risks were reducing for some children. Multi-agency partnerships were strong, strategies were robust and well-coordinated actions followed with wrap around services for children and young people. Staff were clear about their roles and responsibilities.

Duty and Assessment March 2016

Inspectors returned in March 2016 to re-visit the duty and assessment teams. There continued to be appropriate and robust screening of contacts and referrals in the MASH. Newly introduced early help panels were beginning to support step down. You had begun work with the Local Safeguarding Children Board (LSCB) to explore the issue of the understanding of and the application of thresholds across the partnership.

All cases looked at by inspectors had an assessment with evidence the child had been seen. This was a significant improvement. Assessments had been completed in a timely way for the child. Improvement could be seen in assessment quality in some but not all cases looked at by inspectors. Analysis of risks had slightly improved and there was evidence that strengths and the family's history were being considered. In some cases the child's experience was being captured well and the impact on the child could be understood. Almost all cases seen had a plan with evidence of review. Recording of strategy meetings had improved slightly and strategy meetings were compliant with statutory guidance which was a significant improvement.

Areas for development

While there was increased evidence children were being seen there was limited indication of the purpose or outcome of the visit. Recording was descriptive, did not link to concern or risk, and there was limited evidence of how visits linked to the child's plan. There was limited evidence of actions to be undertaken for next the visit

or what was required of parents. Where a father was involved, even if estranged or living in the same household they were not being consulted. The individual needs of siblings within assessments were also not being considered. While you were beginning to develop chronologies these were not being used to identify significant events in children's lives and inform analysis of risk and research was not being used to assist the analysis of risk. There was no evidence of contingency planning. When cases stepped down to early help or closed, assessments were not robust enough. There was very little evidence in any files seen of consultation with adult services. Management grip was only evident at the allocation of cases.

Leadership and Management March 2016

Considerably strengthened and robust relationships were fully established between the DCS, lead member and Chief Executive with the promise of this being added to by the new independent chair of the Rotherham Safeguarding Children Board (RSCB). It was particularly positive that the governance arrangements through Commissioners have not inhibited the functionality of these relationships. Careful consideration has been given to provide support for the current shadow executive arrangements. At the time of the visit there remained some key appointments that had either only just been made or were very recent. However, the thread of high level of motivation, clear direction of travel and determined challenge was evident. Specific operational and tactical arrangements between the council and South Yorkshire police have shown evidence of improved cooperation and collaboration. This is noted in the examination and investigation of possible individual and organised exploitation of children. The specialist joint arrangements for this are fully functional, with recent evidence of impact. The effectiveness of the Evolve team however is yet to be evaluated in detail.

The impact of many of the strategic developments is yet to be seen with the strategic and governance arrangements at the early stages of being reviewed. Efforts are clear to achieve a more 'open-architecture' of governance where challenge is seen as support. The stabilisation and functional effectiveness of the workforce has begun to be established. Turnover continues but not at a damaging level and almost all of those spoken with express positive morale and confidence in the direction of travel of children's social care services. While it is recognised there is much yet to be achieved it is clear that many of the foundations toward a stable, able workforce are in place, albeit recently achieved.

First line management casework oversight and direction was much improved. Managers recorded clear and risk-focused direction. Management rationale for decision making was clearly recorded in cases seen. It was clear that there is managerial ownership and efforts to drive improved performance in social care. There was evidence of shared ownership and responsibility amongst managers seen. Managers welcome the current "no hiding place" style of management with support being as robust as challenge. Independent Reviewing Offices (IRO) arrangements however have not been well supported by the four changes in manager of the

service in a short space of time. They remain clear that they are still seeing too much delay in implementing plans, with limited progress in the focus, of plans, quality of assessments and appropriate preparation of children in care. They feel they are beginning to be listened to but are yet to confidently find their professional 'voice' on behalf of children in care.

Areas for development

The voice of the child was not consistently evidenced on an individual casework basis or sufficiently influential at all levels in children's services. You are working hard to secure a competent and stable workforce and demonstrate active and purposeful planning. This is yet to impact sufficiently on the 'front of house' practitioner base with just three permanent SW appointments in the last round of recruitment. You continue to have difficulty meeting your sufficiency duty and it is clear that it is likely to take a further 12-18 months before substantial improvement is achieved. You are at the early stages of developing and delivering effective early help and edge of care services. This is not yet having a clear impact on reducing crises and demand for statutory interventions.

Sound quality assurance and performance management frameworks are now in place and there is clear capacity and commitment from both children's services and partners to drive these forward. You are now ready to move from the compliance phase of your improvement plan to focus on the quality of practice. The current suite of audit tools and framework are an emerging strength, with further links being pursued with the RSCB quality functions. This is however yet to evidence practice improvement. Your electronic case record system has had some interim updates, is unlikely to support this work until the implementation of liquid logic from 31 October 2016. Lines of internal communication across the local authority and within children's services have improved considerably, but are yet to ensure a full 360 degree communication, including the valued practitioner forum, to ensure effective engagement with, and of, staff at all levels.

There has been an understandable and considerable focus on child sexual exploitation safeguarding practice. It was evident at the time of the visit that the separate specialist teams were exhibiting significant tensions and pressures. There were specific issues regarding staff relationships within the Evolve team that required your further consideration.

Early help April 2016

The pace of improvement in relation to development of the early help programme over the past six months has been positive and rapid. This is integral to the successful development of the children and young people's transformation programme 2015-2021. The vision and priorities of the council are clearly set out in the new early help and engagement service plan. These are appropriately aligned with wider strategic planning to increase preventative and early help services

through a variety of established, recent and planned services. The early help strategy is currently in draft form with a planned implementation in July 2016.

Refreshed governance arrangements are in evidence. There is a clear commitment from senior managers and elected members to improve the quality of services and to improve outcomes for children and young people through a robust focus on early intervention and prevention. The commissioner made early help a top service priority. A member led early help review board and early help sub group of the children and young people's strategic partnership is in place to oversee the development. The council and its partners we have seen share an ambition regarding the increased offer of early help to prevent the escalation of family difficulties through integrated and locality working. There is strategic buy in from all major stakeholders and this has the potential to provide valuable services and resources which are aligned to the views and needs of local communities.

Partnerships with the Police and Youth Engagement Service are particularly strong and well aligned with the troubled families' programme which you call "Families for Change". Significant work has been undertaken to improve operational buy in from partners and this has improved significantly with schools and learning communities. There is still some way to go to secure full engagement and some operational challenges remain to engage health visiting, school nurses and CAMHS. More work needs to be done to increase and improve education and health partners confidence not only in the early help offer but in their capacity to deliver early help assessments and support.

Threshold descriptors are clear and align with early help pathways to services which outline a virtual pathway to and signpost professionals, practitioners and families to early help services. However, thresholds for access to children's social care are still not sufficiently understood by partners and cases referred to early help are not always being coordinated effectively. The interface between early help and the front door needs to be clearer. There are additional issues around the analysis of risk and decision making. The newly established early help triage team is starting to impact on the timely coordination of services through to nine early help multi-disciplinary locality teams integrating disciplines. Positively the early help triage team ends the previous 30 different routes to early help through one front door. It is too early to see the impact on whether this is effective in diverting some children and young people with a lower threshold of need from statutory services, however the early indications are encouraging.

There is evidence of robust management oversight of the team and decisions, appropriate and educative advice and challenge back to referrers, including the MASH and locality teams. New and quality assurance and performance monitoring arrangements in place for early help live from 1 April 2016. Routine Department for Education performance reporting systems are in place enhanced with bespoke success measures which intend to capture for example; contact timeliness, track step up and step down timeliness and allocation, assessment timeliness and outcomes,

deep dive audits and more. These new arrangements bring all of these systems into one electronic data base.

Areas for development

The integration of the early help workforce into locality teams is a positive and necessary change. Not all staff are however sufficiently trained, confident or competent to undertake early help assessment (EHA). There needs to be an impetus to develop staff training, skills, knowledge and confidence. Some staff have articulated to inspectors that they feel overwhelmed, under skilled and not being clear about what they are doing and why. Some Manager's lack of knowledge and skill in this area of work is impacting on their ability to understand the complexity and challenges and quality assure the work to a satisfactory level. Managers are not giving clear direction at the allocation of cases, not setting timescales for completion, they are not evidencing review and challenge of decisions and they are not evidencing that remedial actions from pervious supervisions are actioned.

The current early help assessment form is not fit for purpose. It does not have a section for the worker to analyse their findings, to record the child's wishes and feelings or the views of parents or carers. It does not have a section for management oversight and next steps or to record the completion date. Early help assessment quality overall was poor in the cases seen. Children are not always seen as part of an early help assessment and it is difficult to see what direct work if any is undertaken as workers do not always record these interventions. As a result plans are insufficiently focused on areas of risk and need. The intended outcomes are not always clear and few have realistic or even set timescales of when change/ progress is required. Team around the child meetings are taking place but in those seen are not all robustly monitoring or driving children's plans.

Child sexual exploitation April 2016

Inspectors have found continued improvement in practice. There is evidence of significant learning arising from the review of high profile cases in Rotherham. What started as reactive approaches to children suffering CSE has developed into proactive, sensitive and robust investigative practice between police and social care.

Considerable efforts are made to identify children and young people at risk of CSE and when identified receive bespoke wrap around multi-agency risk assessment and responses. Assessments seen in the Evolve team during the visit in March 2016 were thorough and timely. Risk and need were clearly identified. Care plans were robust, addressed risk and were regularly monitored, reviewed and updated by managers. Where young people were perpetrators, a unique approach by police in particular, influenced by CSC, seeks where appropriate and proportionate to risk not to criminalise but educate, support and monitor through whole family and multi-agency systems approaches. Where charges are brought and where convictions occur, young people are supported, reassessed and monitored up to sentencing and beyond

which is good practice and child centred. Where victims are suspected or identified, in some cases months and months of proactive and tenacious work is resulting in victims developing trusting relationships with police and social workers. The impact is in many cases young people making disclosures and identifying other victims.

Future arrangements

As you will be aware, as set out in the letter from Eleanor Schooling, National Director, Social Care, dated 26 May, we are introducing new monitoring arrangements for inadequate local authorities. The letter sets out the activities and general timescales.

As we have already been engaged with Rotherham, with your agreement, we will move to a monitoring arrangement. I and the regional Senior HMI, Bob Morton, would be happy to meet with you to discuss. I am currently on another inspection but will contact you shortly to take forward.

Yours sincerely
Tracey Metcalfe
Her Majesty's Inspector