Reading Borough Council

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

and

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

Inspection date: 23 May to 15 June 2016

Report published: 5 August 2016

Children's services in Reading are inadequate		
1. Children who need help and protection		Inadequate
2. Children looked after and achieving permanence		Inadequate
	2.1 Adoption performance	Requires improvement
	2.2 Experiences and progress of care leavers	Requires improvement
3. Leadership, management and governance		Inadequate

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

Executive summary

There are serious, persistent and systemic failures in the services provided to children who need help and protection by Reading Borough Council.

Important areas of children's social care services in Reading have deteriorated since previous Ofsted inspections in 2012 and 2013, particularly services for children in need and services for children at risk of and experiencing significant harm.

The safeguarding needs of children at potential risk of harm are not addressed by consistently prompt and thorough inquiries. Children are left too long in situations of unknown and acute risk. Escalating risks to children are often not recognised and acted upon urgently enough. Inspectors found too many examples where children at risk of harm had either not been seen by social workers or, if they had been seen, their experiences and the continuing risks to them were not understood and acted upon with sufficient urgency. The gravity and urgency of the level of risk were not always reliably identified or understood. Assessments were all too frequently adult-focused, omitting consideration of family histories and lacking any real understanding of children's experiences. A number of immediate concerns were referred by inspectors to senior managers. The local authority took urgent and appropriate action in response to these concerns.

Recent efforts to reduce a heavy reliance on a high number of short-term agency social workers and managers are showing signs of early progress. However, the continuing impact of a high staff turnover across the service means that children, parents and foster carers spoken to by inspectors consistently emphasised the difficulties in building positive and trusting relationships with social workers. This shortfall was particularly acute in the access and assessment teams, adversely affecting the quality of child protection inquiries and assessments and militating against careful, consistent management oversight of cases.

Service provision does feature some relative strengths in limited areas. A multi-agency safeguarding hub (MASH) supports effective joint communication and prompt information sharing across the partnership, although the understanding and application of thresholds is inconsistent. The quality of practice for children with disabilities and their families is stronger, including carefully addressing and promptly responding to any safeguarding concerns that emerge. The targeted early help service provides skilled, helpful support to children and their families. In the minority of services where service provision was better, the rate of staff turnover was considerably lower.

Services for children looked after are inadequate. In a large majority of cases seen

by inspectors, delays and drift have resulted in children starting to be looked after too late. The onset of care proceedings was frequently delayed due to poor management oversight of social work in pre-proceedings stages. Once care proceedings commenced, timeliness notably accelerated, with the judiciary reporting recently improved standards of assessments, care plans and statements of evidence.

Children mostly live in stable homes and approximately half of the children looked after who were considered by inspectors made substantial progress in their placements, assisted by comparatively high rates of stable and enduring care arrangements. Not all children who are looked after benefited from permanence planning being considered early enough, although management oversight and tracking of the early stages of permanence planning are now improving. Nearly half of the children looked after do not have an up-to-date care plan, which means that their progress may not be regularly assessed and contingency plans are not made if difficulties emerge. Planning for children who are looked after to return home is poor, with two examples seen of children returning to care under emergency police powers of protection.

The planning and provision of sufficient local placements has taken too long to develop. As a result, the majority of children who are looked after live outside Reading, and too many reside more than 20 miles from the town. This means that the provision of services to support children and their foster parents is more difficult to arrange and monitor. There is a poor understanding of children who go missing when they live outside the local authority, limiting managers' understanding and response to risks.

Permanence is not considered early enough for all children who are unable to return home to their families and for whom adoption is in their best long-term interests. Compared with elsewhere, the local authority takes too long to place children into adoptive placements, but there are emerging indications of an improvement in timeliness. The adoption service features considerable strengths, for example a relatively high number of children who are adopted, including older children and those from dual heritage and minority ethnic groups.

Too many children the local authority look after are placed in family and friends placements without a 'connected person's' assessment being completed. As a result, the local authority does not know if the arrangements are safe or suitable for children and this is a serious failure in the local authority's corporate parenting duties. More effort is required to raise awareness and reporting of children who live in private fostering arrangements. The influence and involvement of children who are looked after in reviewing and planning services provided for them is too limited.

Services to care leavers require strengthening, primarily by increasing the rates of participation in education, employment and training for young people from 16 years of age upwards. The service should ensure that young people's plans are consistently purposeful and provide clear, detailed information on their rights and care-leaving entitlements.

Instability in the senior leadership team has impeded progress in addressing identified weaknesses in services for children and families. The current director of children's services, appointed in February 2016, has very recently completed appointments to permanent senior management positions. Rigorous plans to increase permanent recruitment and retention of social workers and frontline managers have resulted in new appointments. The cross-party political commitment to improve services to children urgently is underpinned by an additional investment of £1.4 million to increase the number of social workers and frontline managers.

Senior managers are now confident that they have a realistic understanding of the scale and seriousness of practice weaknesses. Until recently, actions to address these failings have not been sufficiently urgent or thorough to prevent a decline in practice across all parts of the service. This has left children at unacceptable and unknown levels of risk and harm. Recent work is beginning to have some impact, with improvements in timeliness seen and quality standards now in place.

Performance management systems have been recently established to support managers in tackling areas of weakness more swiftly. Although signs of some positive progress are apparent since the beginning of 2016, there is much more to do before the circumstances of vulnerable children and young people are understood, supported and safeguarded by effective services.

Contents

The local authority

Information about this local authority area[2]

Previous Ofsted inspections

- The local authority operates two children's homes. Both were judged to be outstanding at their most recent inspection in 2015.
- The last inspection of Reading's arrangements for the protection of children was in March 2013. The local authority was judged to be adequate.
- The last inspection of the local authority's services for children looked after was in February 2012. The local authority was judged to be adequate.

Local leadership

- The director of children's services has been in post since February 2016 (previously, in the first half of 2015, she was the interim director for five months).
- The lead member for children's services has been in post since May 2013.
- The independent chair of the Local Safeguarding Children Board (LSCB) has been in post since 1 August 2014.

Children living in this area

- Approximately 35,850 children and young people under the age of 18 years live in Reading. This is 22.3% of the total population in the area. (Office for National Statistics, mid-year population estimates 2014).
- Approximately 18.8% of the local authority's children are living in poverty.
- The proportion of children entitled to free school meals:
  - in primary schools is 14.8% (the 2015 national proportion is 15.6%)
  - in secondary schools is 13.8% (the 2015 national proportion is 13.9%).
- Children and young people from minority ethnic groups account for 36.6% of all children living in the area, compared with 21.5% in the country as a whole.
- The largest minority ethnic groups of children and young people in the area are White Other and Pakistani.
- The proportion of children and young people who speak English as an additional language:
  - in primary schools is 33.4% (the national proportion is 19.4%)
  - in secondary schools is 24.4% (the national proportion is 15.0%).

[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.

Child protection in this area

- As at 23 May 2016, 1,724 children had been identified through assessment as being formally in need of a specialist children's service. This is an increase from 1,394 at 31 March 2015.
- As at 23 May 2016, 256 children and young people were the subject of a child protection plan. This is an increase from 204 at 31 March 2015.
- As at 23 May 2016, no children lived in a private fostering arrangement.
- Since the last inspection, five serious incident notifications have been submitted to Ofsted. No serious case reviews have been completed or were ongoing at the time of the inspection.

Children looked after in this area

- As at 23 May 2016, 236 children were being looked after by the local authority (a rate of 68 per 10,000 children). This is an increase from 205 (57 per 10,000 children) at 31 March 2015. Of this number:
  - 162 (68.8%) live outside the local authority area; 33.7% of these children live 20 miles or more outside the local authority area
  - 18 live in residential children's homes, of whom 94.4% live outside the local authority area
  - one young person lived in a residential special school outside the local authority area
  - 197 live with foster families, of whom 64.97% live outside the local authority area
  - five live with parents, of whom two live outside the local authority area
  - six children are unaccompanied asylum-seeking children.
- In the last 12 months:
  - there have been 25 adoptions
  - 22 children became the subject of a special guardianship order
  - 116 children ceased to be looked after, of whom 11 (9.4%) subsequently returned to be looked after
  - 17 children and young people ceased to be looked after and moved on to independent living
  - one young person ceased to be looked after and is now living in a house in multiple occupation.

Recommendations

1. Local authority leaders should ensure that permanent and competent social workers provide skilled, responsive and safe services to children at risk of harm, and in need of help and protection. The focus on improving practice standards for children should be urgent, determined and relentless.

2. Ensure that the timely progression of child protection inquiries are informed by clearly recorded strategy meetings with well-evaluated outcomes and recommendations that are commensurate with levels of risk and need. Inquiries and assessments should be overseen by consistent, rigorous and timely management decisions.

3. Ensure that all children in need have clear plans to support and evaluate timely improvements in their well-being and safety. Social workers and their managers should continually evaluate and review levels of risk and need, taking prompt action when children's circumstances either fail to improve or deteriorate.

4. Ensure that staff are provided with regular, high-quality supervision to support and challenge their practice.

5. Achieve a consistent understanding and application of thresholds to support more effective and timely case transfers across different levels of need.

6. Ensure that assessments consistently feature consideration of family histories and children's daily experiences, to understand and evaluate the risks and needs more accurately.

7. Provide effective management oversight to prevent delays in children being seen, and to ensure the timely progression of their assessments and plans.

8. Review all cases where children are exposed to domestic abuse and neglect, to ensure that their needs have been thoroughly assessed and that they are safeguarded, where appropriate. Particular attention should be given to children living with, or in proximity to, adults with histories of violence and abuse of other adults and children.

9. Ensure that all young people who go missing from home and care are offered prompt return home interviews, and that the information obtained is used to support their safety plans. Links and associations with other young people and adults of concern should be promptly identified, and preventative and disruption activities purposefully pursued.

10. Provide rigorous screening, assessment and careful multi-agency planning and follow-up at risk assessment conferences on sexual exploitation and 'missing children' for all children identified at risk of sexual exploitation.

11. Raise awareness of private fostering arrangements, and ensure that children living in such arrangements are assessed and visited within the required statutory timescales.

12. Ensure that the need for permanence for all children looked after is considered at their second review, and is regularly reviewed thereafter.

13. Comply with care-planning regulations and legislative requirements when children are looked after under voluntary arrangements or placed with family and friends.

14. Improve the sufficiency and availability of local placements for children who become looked after, reducing the trend for placing children in settings that are at a long distance from Reading.

15. Expand the membership and influence of the Children in Care Council so that it is able to communicate effectively with and represent the views of all children who are looked after.

16. Provide stronger support for care leavers in their transition to independent living through more effective support in engaging or re-engaging in education, employment and training.

17. Ensure that all care leavers have accurate, comprehensive and up-to-date information about their rights and entitlements.

18. Ensure that pathway plans are specific and detailed enough to achieve objectives and improve their outcomes for all care leavers.

Summary for children and young people

- Social workers and their managers do not always understand or take steps quickly enough to make things safer for children who are living in families where they are abused and neglected. Even when social workers are supporting and helping children, they do not always see how things are sometimes still unsafe or are becoming riskier. This is because they sometimes spend too much time talking with the adults and seeing things from their point of view, rather than carefully listening to children to understand what daily life is like for them.
- Children and young people get a poor service from the local authority. Earlier Ofsted inspections found that help and support for children needed to be better. Since then, things have become worse, and children who need protecting and help are failed by the local authority too many times.
- Children have far too many changes of social worker, because many are short-term, temporary workers. Their managers change a lot, too. This means that children and families get frustrated with the changes, having to tell their stories over and over again, and cannot trust that their social workers will stay for very long.
- Managers do not always check things properly and help social workers to think about what is going on for children who are dealing with difficult issues.
- Senior managers have changed a lot, too. This means that they don't spend enough time in the local authority to make sure that plans to improve things for children happen. A new director of children's services has been in the job for six months and is determined to stay, to make sure that her important and urgent plans improve the services for children and families.
- Children who are looked after by the council often live too far away from Reading. Managers need to do more to offer children a choice of placements that are closer to or in the town. When children who are looked after stay with their carers for a good length of time, they do well in their education.
- The council is good at making sure that those children who would benefit from being adopted are matched with adoptive parents, but this is not always early enough and it can often take too long. It sometimes takes longer for good reasons, because older children and those with very complicated problems are also given a good chance of being adopted.
- Care leavers need to be helped more to find jobs, training and education, and have the things that they are entitled to explained more clearly.

The experiences and progress of children who need help and protection	Inadequate

Summary

There are widespread and serious failings for children in need of help and protection. The local authority does not ensure that all children at potential and known risk of significant harm are adequately protected. In too many cases, children are not seen quickly enough, and child protection inquiries are not completed promptly and do not establish clear decisions to intervene to protect the child. Poor management oversight in assessment and planning for children means that children are exposed to risky situations for too long. Where children are identified at being at immediate risk of significant harm, the response to protect them is more timely. Management oversight of individual cases of child sexual exploitation and missing children is variable and often poor. Information about children who go missing and are at risk of child sexual exploitation is not routinely utilised to inform practice and action.

The understanding and application of thresholds are inconsistent and not routinely applied in accordance with the Reading Local Safeguarding Children's Board (RLSCB) multi-agency threshold document. The Reading MASH is well established. This arrangement is supporting good communication and information sharing across the partnership.

The early help service, delivered through the children's action team (CAT), ensures swift access to appropriately targeted support for families. It is child-centred and outcome-focused.

The quality of assessments and planning for children is often inadequate. There is delay in progressing the assessments of young people who are homeless and children in private fostering arrangements. There are frequent changes in workers, meaning that children do not benefit from consistent and meaningful relationships with their social workers.

The local authority's emergency duty service is effective. Inspectors found safe and competent practice within the children and young people's disability and locality teams.

Child protection plans are often also subject to drift and delay. The transfer of cases between teams is not always effective, resulting in a lack of continuity in driving plans forward to protect children better.

There are effective arrangements for tracking children who are missing education. Alternative education provision meets the needs of young people well.

Inspection findings

19. While the local authority has cohesive arrangements in place to support joint working in the multi-agency safeguarding hub (MASH), inspectors found widespread and serious failures in the assessment, planning and management of children in need of help and protection. In examples seen by inspectors, a referral concerning a child who reported a serious sexual assault had initially been lost. In another case, a strategy meeting was not held and a child protection investigation was not considered until four weeks after the referral. A number of serious concerns were fed back to the local authority in relation to its failure to identify children at risk and, in particular, to respond appropriately to escalating risks in families. This includes children left at potential risk of significant harm for too long before action was taken. These failures were particularly prominent where children were affected by domestic violence and living with, or in contact with, men who had histories and convictions of violence and sexual offending. The local authority took immediate and appropriate action in response to these individual concerns. (Recommendation)

20. In the seven help and protection cases referred back to the local authority, the failings identified by inspectors were pervasive, across all levels of need. Established and potential risks to children's welfare and safety featured the exposure to chronic neglect, domestic violence, adult mental health difficulties, drug abuse and child sexual exploitation. In some instances, concerns related to children's continuing exposure to dangerous men with extensive criminal histories of violence and convictions against children. (Recommendation)

21. A breakdown in management oversight and too many changes of managers, alongside the failure of professionals to recognise the level of risk posed to children, were all too evident in far too many cases. There was frequently a failure to assess risk effectively and recognise the seriousness of concerns. This meant that the need to take decisive and timely action to protect children was not always seen. Inspectors identified children who had been left unprotected and vulnerable to potential risks of significant harm over long periods. These are unacceptable and serious failings. (Recommendation)

22. In too many cases, there was drift and delay in progressing child protection inquiries, including holding strategy meetings or discussions. Inspectors found cases where the outcomes of inquiries failed to identify the gravity of potential risks to children. This meant that children were exposed to continuing domestic abuse, neglect and contact with dangerous men when risk assessments were not undertaken. (Recommendation)

23. The early help service delivered through the CAT ensures swift access to appropriate targeted support for families. Services are child-centred and outcome-focused. In almost all cases seen, the views of children and young people actively influenced plans and the services subsequently provided. These children benefit from having consistent, stable workers who are tenacious in providing help to vulnerable families. Inspectors identified challenge and oversight by managers, which helps to ensure that cases open to early help are allocated at an appropriate level of intervention,

providing purposeful support to improve outcomes for children and families. The council has been successful in driving forward the national Troubled Families programme. It is set to meet the target of supporting 423 families within phase two of the programme, which has so far resulted in 181 families successfully meeting outcomes.

24. The Reading MASH is well established and is co-located with Thames Valley Police and health partners. The recent increase in the capacity of frontline services means that pathways to accessing services have improved for families and professionals, and delay in responding to contacts and referrals is minimised. Appropriate consents from parents and carers are sought and the initial response rates to contacts are timely. Joint multi-agency access to the children's social care database in the MASH supports good communication and information sharing across agencies. The co-location of the domestic abuse risk assessor has significantly improved the screening and timeliness of responses to domestic abuse notifications. This was identified as an area for development in the last inspection.

25. The understanding and application of thresholds are inconsistent and are not routinely applied by partner agencies, or children's social care, in accordance with the Reading Local Safeguarding Children's Board (RLSCB) multi-agency threshold document. When children are identified as being at immediate risk of significant harm, in the majority of instances the response is appropriate and prompt. However, in a minority of cases, serious known risks had to be raised by referring agencies on several occasions before decisive action was taken by children's social care managers. Inspectors also saw one case involving complex domestic abuse which was inappropriately stepped down by children's social care and allocated to early help services. Frequent changes of managers and social workers in frontline services, compounded by high caseloads, restrict a shared, consistent multi-agency understanding of thresholds. (Recommendation)

26. The local authority's emergency duty service provides effective out-of-hours provision that benefits from an experienced and established team. Clear systems and processes support good communication between the out-of-hours service and daytime staff. This informs purposeful decision making effectively, allowing for prompt follow up of out-of-hours activity. Inspectors saw examples of appropriate and timely interventions in response to child protection concerns.

27. When allegations are made against adults working with children, there are effective processes in place for multi-agency strategy meetings with relevant partners to enable complex cases to be reviewed regularly and action taken. The local authority recognises that further work is needed to help to raise awareness and knowledge across the partnership, and has provided refresher sessions on how to respond to allegations against adults who work with children, including work with faith groups.

28. The percentage of assessments completed within timescales has improved from a low rate of 55% in January 2015 to 81% in April 2016. Not all assessments are completed within timeframes that are commensurate with children's needs and circumstances. In the large majority of assessments seen during the inspection, the timeliness, recording and the overall quality of work were weak. Assessments are

not child-centred, and analysis of family histories when evaluating children's needs, including their need for protection, is poor. An over-focus on adults' concerns within assessments and plans, particularly in neglect and domestic abuse cases, resulted in failure to consider the impact on children's development and day-to-day lived experiences. In too many cases, drift and delay featured and managers' instructions to undertake assessments were either not complied with or significantly delayed. Consequently, children and young people's experiences and voices were lost or unheard, leaving them exposed to further harm. (Recommendation)

29. Social work tools and research are not routinely used in assessments. Either an absence of chronologies or their ineffective use means that histories of known risks do not routinely inform current assessments and planning. Insufficient partner agency contributions to assessments result in a lack of integrated, holistic approaches to planning and the management of risk. Inspectors found little evidence of attention to diversity. (Recommendation)

30. Inspectors found unacceptable delays in progressing assessments when young people presented as homeless. There is a lack of understanding and inconsistent application of the Southwark judgement. The threshold for the accommodation of young people under section 20 of the Children Act 1989 is not sufficiently considered or discussed with young people. Delays in understanding and responding to young people's needs resulted in young people being left in situations of known or unassessed risk for too long. (Recommendation)

31. There are currently no children known to be living in private fostering arrangements. Inspectors found that in two of four recent private fostering assessments the children were not seen following their assessments and there were delays in commencing assessments of their carers. This means that when the local authority is notified of children living in such arrangements, children are not sufficiently supported and safeguarded during their period of residency with private foster carers. The local authority has taken steps to raise the profile of private fostering arrangements through workshops, mailshots to agencies and leaflets to schools. (Recommendation)

32. Frequent changes in social workers and managers have resulted in children not benefiting from good relationships with professionals whom they know and who know them. For children with communication difficulties, changes in workers have led to children's development and experiences not being observed and evaluated over time. These changes often lead to a 'start again' syndrome, causing delays in implementing plans. They also leave children vulnerable when their circumstances deteriorate, which frequently goes unrecognised. (Recommendation)

33. Inspectors found some good practice within the children and young people's disability and locality teams, demonstrating sensitive and positive individual work with children and their families. These children and their families benefited from having a consistent social worker alongside effective, continuous management oversight. This work led to some good outcomes for individual children and improved their lives. However, this positive practice was comparatively rare. In two cases, the work presented by the local authority as an example of appropriate and

current good practice also featured recent instances of missed opportunities and serious failures.

34. There is an improving picture in the timeliness of initial child protection conferences, which are held within 15 days. However, the number of children subject to second or subsequent plans is high, at 23%, and above that of statistical neighbours and the England average. Advocacy arrangements, while established, do not effectively support and encourage children's participation in child protection conferences where appropriate. The local authority is currently considering increasing the capacity of the independent advocacy service to these children and young people.

35. Inspectors found that in an overwhelming majority of the cases that were tracked and audited the quality of plans for children was poor. Child protection plans were subject to significant drift and delay and, in a few cases, consideration of legal intervention was too slow. In a minority of cases, children on plans were left exposed to known or potential risks of significant harm for far too long, particularly in neglect and domestic abuse cases. These serious failings were referred by inspectors to the local authority, who responded promptly and appropriately. Inspectors did observe limited examples of more positive practice that successfully captured the progress made against plans. (Recommendation)

36. Core group meetings are not always held within timescales, and the transfer of cases from the access and assessment team to locality teams is not consistently well organised, resulting in gaps in addressing plans and delays in assessing the progress that children are making. Records of progress and discussions at core group meetings are not consistently apparent. An absence of effective contingency plans or the failure to implement plans within specified timescales has led to drift and delay in taking decisive actions. In a minority of cases, visits to children on child protection plans resulted in children not being seen on their own or not being seen at all, and the recording of home visits was generally poor. In more recent plans, inspectors saw a few examples of more positive work where discussions in core groups and the measurement of progress were much clearer.

37. Local authority performance reports highlighted that 40% of children in need do not have plans. In cases without plans, there is no effective method for the local authority to determine whether children have been seen, what progress has been made or whether risks are escalating. For parents, the absence of plans means that it is not clear what needs to happen and what support will be provided to help them to make the necessary changes. Delays in implementing decisions to step down child in need cases lead to some children not receiving ongoing support quickly enough from early help services. The local authority acknowledged that cases are held for short periods of up to two weeks by assistant team managers when social workers leave. During such periods no planned work is completed, although duty social workers respond to any emerging safeguarding concerns. (Recommendation)

38. Children's safeguarding needs are carefully considered at multi-agency risk assessment conferences (MARAC) and multi-agency public protection arrangement meetings. Inspectors' observation of practice noted well-organised MARAC meetings, with discussions clearly focusing on victims and the impact on children. There is

good attendance at these meetings across the partnership. Inspectors found that some complex domestic abuse cases discussed at MARAC meetings were inappropriately allocated to the early help service. It is not always clear how action plans that are recorded in the minutes of MARAC meetings influence more positive outcomes for children. This is recognised as an area for development. (Recommendation)

39. Responses to risk arising from child sexual exploitation seen by inspectors were variable, and in some cases weak. The local authority recognises that the child sexual exploitation screening tool is not consistently used, and information from return home interviews does not reliably inform planning and assessments of children at risk of child sexual exploitation. The follow-through and coordination of plans discussed at sexual exploitation and going 'missing' assessment conferences are inconsistent. Inspectors found overly optimistic views among professionals of recent changes in children's circumstances, a failure to progress plans adequately and, in some instances, a failure to actively engage and see children at risk of sexual exploitation. (Recommendation)

40. The director of children's services (DCS) has made responding to child sexual exploitation a priority. She chairs the LSCB sexual exploitation and missing sub-group. A child sexual exploitation coordinator, appointed in September 2015, has helped to improve the performance mapping and tracking of children who are missing and at risk of child sexual exploitation. Alerts are appropriately placed on children's files. However, frequent changes in workers impede the effectiveness of this work. Inspectors saw some recent effective joint working and communication with the police that resulted in some children and young people at risk of sexual exploitation being appropriately protected. (Recommendation)

41. Upon the return of children who have been missing, there are marked delays in conducting return home interviews for too many children. These children are less likely to share important details about what happened while they were away. Observations relating to their mood and physical presentation on their return cannot be made to inform the understanding of their vulnerability and any risk that they may have been exposed to. Where return home interviews are held, the quality of information and analysis within case records is poor in most cases. This weakens opportunities to reduce further 'missing' episodes. In a few cases seen by inspectors, return home interviews resulted in concerns being appropriately escalated, with support provided to children to reduce risks. (Recommendation).

42. There are effective arrangements for tracking children who are missing education. Of the 97 children missing education (CME), 59 were level one high-priority cases. Most had very poor attendance at school, at less than 50%. A CME manager tracks these cases well, supported by a commissioned provider who is immediately notified of school absences and pursues immediate inquiries. Close work is undertaken with partners to improve attendance or return children to school. Tracking data is shared well across safeguarding meetings. A small proportion of children are on a reduced timetable, and the virtual head closely monitors plans to move them towards full-time education.

43. Alternative education provision meets the needs of 58 young people effectively. These children have been excluded from school and either attend, or have their education managed by, a pupil referral unit. Half of the children are on individual plans and half attend the unit. These include five children looked after. The advisory teacher for children who are electively home-educated maintains comprehensive records and undertakes appropriate safeguarding checks with relevant agencies to establish whether children are known and whether there are any relevant concerns. The advisory teacher contacts every family, and the majority respond very positively, and have received good advice and support through home visits.

44. Mature partnerships support the 'Prevent' duty in Reading. Partners understand the profile of the community and are alert to the need to remain aware of changing patterns, profiles and trends. Four young people are currently receiving interventions through the 'Channel' panel, and partners described effective interventions that meet different needs arising from a range of vulnerabilities.

The experiences and progress of children looked after and achieving permanence	Inadequate

Summary

Too many children known to children's social care become looked after when their circumstances have deteriorated to unacceptably poor levels. Although decisions to look after children are appropriate, many of these children should have become looked after sooner. Support and help for children on the edge of care are insufficiently developed. As a consequence, some children are living in risky or neglectful situations for far too long before decisions are made to safeguard them.

Agency checks and 'connected person's' assessments for children placed with family and friends are either not completed, or significantly delayed, meaning that some children are living with carers whose suitability and safety have not been assessed.

Permanence planning is not rigorously considered or addressed at an early enough stage, leading to drift and delay in achieving long-term secure arrangements for some children and young people.

The number of local foster carers is insufficient. As a result, many children are placed a considerable distance from their home, which impacts on their ability to remain in contact with their extended families.

Placement stability is good, and the large majority of children and young people live in homes that meet their needs. Overall, the educational outcomes for children looked after are improving, with the virtual school increasing the level of support and challenge to schools. The school attendance of a significant minority of children looked after is poor.

Healthcare needs for children looked after have not been promptly assessed or reviewed regularly until very recently. Provision for meeting the emotional and mental health needs of children looked after is becoming increasingly effective.

There is increasing evidence of independent reviewing officers (IROs) challenging weaker care planning arrangements, particularly when there are delays in progressing timely permanent placements. Too many children looked after do not have up-to-date care plans.

When children looked after go missing, return home interviews are not undertaken quickly enough. Not enough information is collected to understand the risks that children have been exposed to, and to enable social workers to plan interventions to protect them more effectively.

The Children in Care Council is underdeveloped, with too few children involved.

Adoption is appropriately considered for all children who cannot live with their birth family, but not early enough in children's care pathways.

The quality of pathway planning for too many care leavers is not good enough.

Inspection findings

45. At the time of the inspection, the local authority was looking after 236 children. In a minority of cases, decisions that children should become looked after were not made within timescales that met children's needs. Decisions are often based on an overly optimistic determination that children should remain with their families, often in circumstances of ongoing neglect and risk. This was particularly apparent where risks were escalating, with slow responses to children's changing circumstances by workers. When children became looked after, inspectors saw examples of their circumstances improving, such as reductions in the number of times that they went missing. (Recommendation)

46. Inspectors saw some cases where legal planning meeting recommendations to initiate care proceedings for children had been delayed for many months. The rationale for not complying with recommendations was not apparent, reflecting poor management oversight. These children were left in circumstances of unacceptable risk, with their needs unmet. (Recommendation)

47. Consent from parents and carers when their children become voluntarily looked after under section 20 of the Children Act 1989 was neither consistently evident nor clearly recorded. Assessments of family and friends were either not undertaken, or completed too slowly in some cases seen. This meant that these carers were not offered financial and social work support. The local authority did not know if the arrangements were suitable or safe for children whom they had a responsibility to safeguard. (Recommendation)

48. Work to prevent children becoming looked after is underdeveloped. The edge of care service is often commissioned too late, when children's difficulties in their families are too deeply entrenched to effect change and to prevent them becoming looked after. Family group conferences are not used early enough to consult extended family networks about alternative care arrangements.

49. Some children who return home have become looked after again within a short period of time, in two cases as a result of the use of police powers of protection. In cases seen, a lack of effective safety planning, rigorous assessments and support plans developed prior to their return home contributed to these children becoming looked after again.

50. The use of pre-care proceedings agreements through the Public Law Outline (PLO) is poor. The use of letters before proceedings is not taking place early enough for families to be clear about the areas of concern and the potential consequences of their actions if the required changes do not take place. Inspectors saw recent cases

where the PLO had been initiated, and children and families benefited from a more timely process. However, frequent delays in initiating the process mean that the PLO is not consistently successful in reducing identified concerns for children. It is more typically a pathway to subsequent court proceedings.

51. The Children and Family Court Advisory and Support Service (Cafcass) and the local judiciary highlighted that the quality of court work undertaken by the local authority had recently improved significantly. The recent appointment by the local authority of two court managers is an important element in improving the quality and timeliness of assessments and evidence produced. There is less delay caused by the late filing of evidence, and better quality assessments are increasingly received by the court, thereby reducing setbacks caused by the need for independent assessments to be completed. While the current average time of completion for care proceedings is about 29 weeks, longer than the national requirement of 26 weeks, the timeliness of proceedings has been adversely affected by the length of proceedings in addressing a backlog of historical cases. Timeliness in recent cases is improving markedly.

52. Delays in considering permanence planning have negatively impacted on children and young people, particularly their formation of a clear understanding of what is likely to happen to them. Permanence planning meetings are not routinely taking place prior to children's second looked after reviews, or before subsequent reviews when permanence has still not been achieved. This means that care plans are not as effective as they should be in securing permanence for all relevant children who are looked after. This has been recognised by the local authority, and improved tracking of permanence plans has recently been introduced both for children who are the subjects of legal proceedings and for voluntary care arrangements, supported by the establishment of a permanence panel. However, in a minority of cases seen, delays in implementing actions adversely affected the timeliness of permanence planning. (Recommendation)

53. The local authority actively considers placements of children looked after within their wider family, and has encouraged and enabled the use of special guardianship orders (SGOs) and placements with family and friends. Of 63 children who ceased to be looked after in the six months prior to the inspection, 14 were the subject of an SGO. At 22%, this is well above both the local authority's number for the previous year and the national average. Twenty-four of the current 236 children looked after are placed in family and friends arrangements.

54. Consideration of children's identities is weak in assessments and plans. It is limited to a record of their ethnicity, unless the child's identity needs are a critical, central feature of the case. Inspectors did see some good examples of sensitive analysis, such as the exploration of issues concerning sexual identity, but this was in a minority of cases.

55. Overall, social workers visit children looked after sufficiently often and see them alone where appropriate. In a minority of cases seen by inspectors, the purpose of the visit was primarily to meet minimum visiting requirements, with little evidence of purposeful direct work. In most cases seen, the views of children were well recorded. Examples were noted of effective interactions helping them to understand

their circumstances. The high turnover of social workers and managers has adversely affected the consistency and quality of practice, management oversight and the timely progression of care plans. Nearly half of children looked after did not have an up-to-date care plan, meaning that there was no recent assessment of their progress or contingency planning if difficulties emerged. Frequent changes of workers hinder the opportunity for children, their carers and families to establish meaningful relationships with social workers. (Recommendation)

56. Social work caseloads are too high, with average caseloads of 35 children, and this limits the capacity of social workers to undertake direct work with children, including life-story work. The local authority is aware of the impact of changes in social workers and heavy caseloads, and recent measures are beginning to address this.

57. Advocacy arrangements for children who are looked after are satisfactory. They are provided through a commissioned service, and 26 children and young people benefited from ongoing support at the end of March 2016. Advocates made contact with children and young people in a timely manner to help to resolve complaints and representations.

58. The majority of children looked after reviews, but not all, are held in time and are well attended by an appropriate range of agencies. The meetings are well structured and chaired to ensure that information is considered in all important areas. Overall, the views of children are well evidenced and the chairs record the reviews in a child-friendly style to help children to understand their care plans and the outcome of their reviews. However, not all reviews had recorded actions which were specific and measurable, with some lacking sufficient clarity and detail.

59. The positive impact of IROs is gaining momentum, although they have yet to demonstrate a sustained impact in ensuring up-to-date care plans and effective early permanence plans. They meet regularly with social workers and children prior to reviews. The same officer is maintained, where possible, to provide continuity and familiarity for children. While not yet fully established, the use of midway reviews is enabling IROs to perform an increasingly influential role in improving the quality of care planning. In a minority of cases seen, the IRO challenge was not sufficiently prominent to address ongoing situations of drift. However, the number of IRO challenges during the year April 2015 to March 2016 was 58, an increase from 29 in the preceding year.

60. The response to children and young people looked after who have been missing is poor. The majority of return home interviews are not completed within 72 hours of their return and, when interviews are conducted, the information recorded is not comprehensive enough to understand the circumstances relating to them going missing. Following the interviews, there are further delays in information being sent to allocated social workers. The content is not routinely used to inform subsequent care planning and the development of risk reduction strategies. When children looked after are placed more than 10 miles from the local authority, they are not offered a return interview by the local authority, with the quality of response, if any, dependent on variable local arrangements. There is an absence of tracking and oversight of children who are placed out of area. This means that the database does

not accurately reflect the scale of missing episodes for all children looked after. This also inhibits the collection and analysis of intelligence to plan disruption activities to help to keep children safer. (Recommendation)

61. Health arrangements for children looked after are improving. The local authority has made successful efforts to improve the timeliness of health assessments, in the light of considerable delays in 2015. As at April 2016, 96% of children looked after for 12 months or more had an up-to-date health assessment and 81% of initial health assessments were completed within timescales.

62. Placement plans in the cases seen do not always record the healthcare arrangements for children, including immunisation histories, meaning that carers do not have all the information relating to children's health to help them to ensure that the children's needs are understood and met.

63. Arrangements to meet the emotional and mental health needs of children looked after are improving, with the development of a clear emotional health pathway. The introduction of the 'Options' team has significantly increased the range of provision available. Individual work is undertaken with children, consultations are offered with social workers and support is provided to carers. Social workers spoken to during the inspection spoke positively about the impact of this provision on improving children's emotional well-being and in assisting enduring, stable placements. Strengths and difficulties questionnaires are completed in most cases, but are not routinely used to inform subsequent planning for children.

64. Commissioning arrangements to assess and provide support for the emotional and mental health needs of children looked after who are placed outside the local authority area are too variable, with only a minority of children receiving services. This variability is largely due to the differing quality and accessibility of arrangements with the local authorities for where children looked after are placed. This makes it difficult for managers to assess the prevalence, quality and suitability of such provision.

65. If they are remanded in custody, young people are well supported and visited regularly by their social workers.

66. Children looked after are helped to keep themselves safe from bullying and discrimination. Managers support schools well through a wide range of safeguarding training, which has a good focus on preventing bullying and e-safety within a framework of clear anti-bullying policies.

67. The virtual school is making progress in improving the support to children looked after. Recent improvements include the imminent introduction of an electronic personal education plan (PEP). Although the training provided for social workers and designated teachers is improving, the content of plans and the quality of PEPs is not yet consistently good enough. In plans of poorer quality, targets are not specific or measurable, and do not enable accurate monitoring of progress in reviews.

68. The vast majority of children looked after attend good or outstanding schools. The virtual school monitors the progress of children attending schools that are judged by Ofsted to be less than good, where broader permanence and well-being factors are carefully balanced with the potential benefits of moving to a good school. The pupil premium is used effectively to provide additional support, where necessary.

69. Educational outcomes are improving for older children looked after. In 2015, key stage 2 results remained constant with the previous year, with 33% of children achieving the Level 4 benchmark in reading, writing and mathematics. This was below the national average of 48%, but the cohort of children was very small, comprising six children. Four of these had special educational needs. The key stage 4 attainment gap is closing, with over 20% of this relatively small group of 15 children achieving at least five GCSEs at grades A to C, including English and mathematics, in the past year. This is an improvement on the previous year's figures, and is well above the low national average figure for children looked after.

70. The number of fixed-term exclusions for children looked after from September 2014 to the time of the inspection was three in Reading schools and nine for children living outside the town. There were no permanent exclusions during this period. This is in line with national averages.

71. The accuracy of information held by the virtual school has improved significantly with the commissioning of a service specifically to track attendance. The attendance levels of children looked after are not good enough, with 29% of children looked after who are of school age having school attendance of under 90% for the past year. Too many children are not benefiting from regular school attendance that could further improve their educational attainment.

72. Better sufficiency of local placements is a priority for the authority at the time of the inspection, with 162 children, comprising 68.2% of children looked after, living out of area, with 33.7% of these children living 20 miles or more outside the local authority area. A clear sufficiency strategy is in place, with targets set for increasing the number of local in-house foster placements. Recruitment strategies have neither significantly increased the supply of local foster placements nor correspondingly reduced the number of children who are placed outside the local authority area. This means that there is a restricted choice available when matching the needs of children to potential placements. (Recommendation)

73. Placement stability is good, and the large majority of children and young people who are looked after live in foster or residential placements that meet their needs. Placement stability figures are either consistent with or significantly above those of statistical neighbours or the national averages. Of 193 children looked after in fostering households at the time of the inspection, 87 had been in the same placement for over a year. Arrangements to enable children looked after to remain in their foster placements beyond their 18th birthdays are well established.

74. The fostering panel is well chaired by two experienced, independent chairs, with a central list of members who bring a range of experience and knowledge, providing challenges to raising practice standards for children. Family and friends assessments

are not always brought to panel in a timely manner, with three placements reported as overdue for consideration and approval at the time of the inspection.

75. Foster carers report largely constructive, purposeful relationships with their supervising social workers, and are positive about the wider levels of support that they receive though support groups, training and the after-hours telephone service. Foster carers expressed frustration at the frequent changes of social workers that the children in their care experience, with consequent negative effects on care planning and young people's willingness to trust or engage with other social workers. (Recommendation)

76. The number of children and young people who have an independent visitor is low, with only three new referrals in the past year. This means that very few children and young people who are looked after benefit from the support of an independent visitor. This is particularly relevant in Reading, where a majority of children looked after are placed outside of the area, with many over 20 miles away from their extended families. (Recommendation)

77. The Children in Care Council's group, 'Your Destiny, Your Choice', is underdeveloped. It is attended by a very small group of dedicated and enthusiastic children, and its influence and communication with the larger set of children looked after is limited. Most children and young people, therefore, are not aware of the group's activities or how to influence its work and priorities, particularly those placed outside the local authority. (Recommendation)

The graded judgement for adoption performance is that it requires improvement

78. The local authority is demonstrating an increasing sense of renewed focus and urgency in its adoption work. An improvement plan designed in 2015 to address delay has introduced tracking arrangements and earlier involvement by the adoption team. This is having a positive impact on the time taken to place children who are currently in the system. However, adoption is still not considered and progressed early enough for all children who are unable to return home to their families of origin and for whom adoption would be in their best interests. The average time taken between a child entering care and a decision to adopt is seven months. It takes an average of seven to eight months to match children with adopters once a placement order has been granted. (Recommendation)

79. Better performance is evident in the recently published Department for Education (DfE) adoption scorecard (2012 to 2015). This shows that 23% of children left care through adoption, which is higher than both the England and the statistical neighbour average, at 16% each. This means that suitability for adoption is considered for a wide spectrum of children looked after in Reading.

80. The average number of days between a child entering care and moving in with their adopted family, from 2012 to 2015, at 635 days, was shorter than the average time

for the 2011 to 2014 three-year period (669 days). There has been a year-on-year decrease from 681 days in 2013–14 to 568 days in 2014–15. This demonstrates that the process is becoming quicker, but it is still considerably longer than the DfE target of 426 days. (Recommendation)

81. Performance in placing a diverse range of children, including older children, brother and sister groups, and children of mixed or Black and minority ethnic heritage, is strong. Of all children who left care through adoption between 2012 and 2015, 8% (15 children) were over the age of five, which is above both the England and statistical neighbour averages of 5% and 6% respectively. In the same period, 17% of children adopted were from Black or minority ethnic groups, which is also above both the England and statistical neighbour averages of 9% and 10% respectively.

82. 'Foster to adopt' is established in the process of adopter recruitment, preparation and approval, and is actively considered for children who would benefit from this arrangement. Five 'fostering for adoption' placements were made in the past year. The use of 'Link Maker' is strongly promoted, facilitating adopter-led matches with children.

83. Therapeutic support to help children to address difficult pre-care experiences that can lead to attachment difficulties and challenging behaviours is available from the 'Options' service. This resource positively assists the transition of children to their prospective adopters and better enables children with significant complex needs to be afforded permanence through adoption. It also contributes to the stability of placements. There have been no placement disruptions for children placed for adoption over the past two years.

84. Since 2014, the local authority has been part of the Adoption South Central consortium, comprising 11 local authorities and two voluntary agencies. This has introduced benefits of scale through an increased pool of available adopters, improved management of long-distance placements and readily accessible support to adopters. Additionally, the adoption service is in a partnership with the Berkshire Adoption Advisory Service (BAAS), which provides a joint adoption panel, prospective adopter preparation groups, profile sharing of children available for adoption, birth parent support, post-adoption contact and joint staff training.

85. The timeliness of the recruitment and assessment of adopters is slower than the national target of six months from application to approval. At stage one of the assessment process, the considerable delays in obtaining timely returns from disclosure and barring checks have been reduced. Prospective adopters are made aware of this potential delay at the outset, and good use is made of the unintended additional time available. A recent positive innovation for potential adopters has been the partnership between the adoption service and a DfE-funded social enterprise, 'Cornerstone'. This organisation provides mentoring and training for prospective adopters, and continues to support them post-approval. There have been 12 mentoring matches made to date, and this offer has been well received.

86. The quality of prospective adopters' assessments is good. They are clear and concise, carefully evaluating potential adopters' life experiences and their suitability

to adopt. Adopters spoken to during the inspection reported that their preparation, training and approval had been challenging, but that they were well supported during these stages by knowledgeable, reliable and sensitive staff. The continuity and stability of social workers from the adoption service was appreciated by prospective adopters in building and sustaining trusting professional relationships.

87. Sufficiency of adopters available to meet the needs of children with an adoption plan is met through internal recruitment, consortia arrangements and non-consortia local authority adoption agencies. The adoption service recruited 14 adopters in 2015–16, which was below its sufficiency target of 22. Considerable efforts are made to recruit carers who reflect the diversity of the children needing to be placed.

88. The BAAS provides an adoption panel which meets twice monthly, to avoid delays. The panel has effective oversight of the approval of adopters and matching recommendations. The chair is appropriately qualified and has significant relevant experience. The chair and panel members receive regular appraisals, and have access to a wide variety of development and training opportunities. The panel is administratively well supported, with panel minutes reflecting careful and thorough scrutiny of approvals and matches. The adoption panel chair and adviser provide the agency decision maker (ADM) with six-monthly performance reports on the standard and quality of reports and presentations to panel. The majority seen by inspectors were of a high quality.

89. The ADM responsibilities are discharged by the head of service for children's safeguarding. Monthly ADM meetings are in place to oversee and review the decision-making process. This is effective and efficient, and provides better timescale certainties for all parties.

90. Post-adoption support is strongly promoted and provided, consistent with the priority that the adoption service places on ensuring that adopters have the confidence, knowledge and assistance to ensure that children are successfully adopted and that disruption is avoided. Adoption support plans (ASPs) form part of a comprehensive adoption placement report, completed by the adoption service and presented to adoption panel for every child matched. ASPs sampled by inspectors reflected detailed consideration of children's health, education, development, identity, family and social relationships, self-care, contact and birth parents' views.

91. At the time of the inspection, 62 carers were in receipt of adoption allowances for 76 children. To date, 12 applications have been made to the adoption support fund. In the cases sampled during the inspection, it was evident that the local authority provides specific packages of support to meet children's needs and to ensure that adoptions are successful.

92. BAAS supports adopters and birth parents effectively to engage in and maintain 'letterbox' contact arrangements, to the benefit of approximately 226 adopted children. Fifteen referrals were made to this service in 2015–16, but inspectors heard that there are occasions when referrals to the service are not always sufficiently timely. Support is also available to birth parents through the BAAS birth relative support service, with 11 referrals made in 2015–16.

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

93. The care-leaving service is currently working with 136 care leavers. The service benefits from a more stable workforce. Care-leaving advisers have heavy caseloads of an average of 30 young people. Despite this, advisers work closely and effectively with the large majority of care leavers to support them towards independent living. For a minority of care leavers, the level of support that they receive is insufficient to meet their needs. As a result, these young people are less well prepared to become successful, independent adults.

94. Care-leaving advisers meet with most young people every three to four weeks. For the large majority of young people this provides sufficient support, but a minority with more complex needs would benefit from more frequent visits. The Reading team is in touch with almost all care leavers. Managers identified four care leavers with whom they were no longer in contact. Case records showed that the last contact with each of these young people, all aged over 18, was very recent, and the continuing efforts to re-establish contact were clearly evident.

95. Transitional arrangements begin shortly after young people looked after reach the age of 16. Care-leaving advisers attend the looked after reviews and start pathway planning with the young person and their carers. They work hard to gain the trust of the young person. This work is important and largely successful. Care leavers said that they were disillusioned during the period that they were looked after by the local authority, largely because of frequent changes in their social workers. In some cases, this entailed multiple changes of social worker in a very short period. Most reported that their trust had been re-established and that they are well supported by their care-leaving advisers and get on well with them. (Recommendation)

96. Leaders and managers have placed a high priority on removing the need to use unsuitable accommodation for care leavers, even in emergencies. One care leaver is occupying bed and breakfast accommodation, which is a significant improvement on the 30 young people who were in such accommodation a year before this inspection. Plans are well advanced to contract a commissioned partner to provide higher-quality independent living units. Managers are undertaking further urgent commissioning work to ensure that this new supply of temporary and permanent accommodation becomes available as soon as possible. The objective is to reduce the current pattern of spot purchasing semi-independent accommodation, introducing improved quality and market management to this unregulated area of housing provision. (Recommendation)

97. Care leavers told inspectors that they feel safe in their accommodation and that they are helped by their care-leaving advisers to improve their independent living skills, such as budgeting and cooking. In addition, key workers help those young people living in supported accommodation to develop these essential skills.

98. The quality of pathway planning is too variable. Better pathway plans include detailed information about young people, reflect their views well and outline plans to provide the support that they need to make good progress towards successful independent lives. They also include clear, detailed targets, which are reviewed regularly by care-leaving advisers, to prevent drift and delay. Weaker plans contain less detail and poorer targets that do not readily identify who needs to take what action and by when. These plans typically do not reflect the views of young people well. Care leavers interviewed during the inspection said that they did not feel fully involved in either their children looked after reviews or their later pathway planning meetings. A minority said that they saw little value in the plans and that they included out-of-date information that was not updated prior to or during reviews. (Recommendation)

99. Assistant team managers do not review cases with care-leaving advisers frequently enough. In one tracked case, there was a supervision gap of 18 months that managers agreed was unacceptable. Managers have recognised that the managerial structure to support care leavers requires improvement. The care-leaving service is being restructured to create a separate team to provide greater managerial capacity and oversight, improving the frequency and quality of supervision. Apart from continued support from a nurse for sexual health, there is no specific, dedicated healthcare provision for care leavers beyond their 18th birthdays. The children looked after health team directs care leavers to universal services when specifically asked to do so, but this is not routinely established practice. The health team provides young people with a health passport when they reach the age of 17. The passports contain information relating to young people's health histories and provide useful details of local health provision. For young people who need it, there is an explicit child and adult mental health services (CAMHS) transfer protocol at age 17 years and six months to adult mental health provision. Five young people benefited from this in the past year. (Recommendation)

100. Leaders and managers celebrate the achievements of care leavers through an annual awards event. Care leavers are able to influence the work of the authority through presentations at whole-service events which occur throughout the year. However, the care leavers' pledge is not supported by clear, written information and materials for care leavers. As a result, too many care leavers lack a clear understanding of their entitlements. (Recommendation)

101. A good proportion of young people living with foster carers remain with them after the age of 18. Five of the six young people who turned 18 during 2015 benefited from these 'staying put' arrangements. This is significantly above the rates achieved nationally.

102. The proportion of care leavers aged 16 to 18 who are not in education, employment or training (NEET) is similar to national rates, at 23%. Despite being comparable to other authorities, this is not yet good, particularly in the context of a buoyant local economy with high employment levels. All young people up to the age of 18 should be in education, employment or training, and the proportion of Reading care leavers who are thus engaged should be increased. (Recommendation)

103. The proportion of young people age 19 to 21 who are NEET has increased to 44%, which is significantly above statistical neighbours and national figures. However, this headline figure masks a more complex picture. Of 22 care leavers who are NEET, seven are young parents, five have poor health and are claiming employment support allowance and five are in custody. Care-leaving advisers support the five young people in custody well. Through regular visits and strong advocacy with prison staff, care leavers are encouraged to gain the most from employment and education opportunities within prison. Support continues for all care leavers until they reach the age of 21, and includes monthly visits by care-leaving advisers. (Recommendation)

104. In its work to help greater numbers of care leavers to find employment and training, local authority managers recognise that they could do more to provide access to apprenticeships and traineeships for care leavers at the council. They could also positively influence local employers to consider care leavers as a priority group. However, managers have used City Deal funding effectively to implement the 'Elevate' programme, which provides enhanced support to all young people seeking education, employment or training. (Recommendation)

105. A good proportion of care leavers gain places on university courses. At the time of the inspection there were 10 young people undertaking degree courses. These young people continue to benefit from valuable support provided by their care-leaving advisers. This support extends to helping them to find appropriate accommodation during summer breaks, if they want to return to Reading.

Leadership, management and governance	Inadequate

Summary

The managing director of the local authority, senior managers and political leaders have presided over a significant deterioration in services for children and young people over the last three years, and have failed to identify and safeguard many of the most vulnerable children.

Significant weaknesses in the quality of services for children and young people were identified by senior managers in 2015. Relevant plans developed to address these have stalled as a result of continual turnover during the last 12 months within the senior leadership team. As a result, insufficient improvements have been made. Inspectors saw during this inspection that, for many children and young people in need of help and protection, risks are not always properly identified and responded to promptly.

Too many children become looked after following a continued decline in their circumstances at home, which has left them exposed to significant harm. Inspectors saw some cases where legal advice to instigate care proceedings had been delayed. Permanence plans for children who need to be looked after for longer periods are not made quickly enough, and a large proportion live too far from their families. The local authority does not effectively safeguard children looked after who live more than 10 miles from Reading and go missing.

High staff turnover has led to children and young people having too many changes of social worker, contributing to children experiencing drift and delay. Caseloads in frontline social work teams are too high. Management oversight and supervision is inconsistent and, in some teams, poor.

Commissioning arrangements are underdeveloped and not underpinned by a detailed needs assessment.

Senior managers understand the weaknesses in the service. However, many plans to address them are at a very early stage and have not yet led to improvements for children and young people. In some areas, there is evidence that improvement work is properly targeted and is having an impact on achieving better outcomes for children, young people and their families. For the majority of children and young people, the failures in service provision are widespread and serious. Substantial financial investment is supporting a review of the workforce and a redesign of children's services

Inspection findings

106. Services for children and young people requiring help and protection have deteriorated since the last child protection inspection in 2013, when services were judged to be adequate. Instability in the senior leadership team has contributed to the significant delay in addressing substantial weaknesses in service delivery. The local authority's improvement plan, underpinned by audit and service reviews and overseen by an independently chaired improvement board, has identified priority areas for development. However, progress has been impeded by the break in continuity at senior management level and the absence of a stable permanent senior management team. The DCS has made it a priority to secure a senior management team and permanent appointments are now in place. Having undertaken an earlier interim period in the role of DCS from February to June 2015 the DCS has, since her reappointment in February 2016, picked up and driven forward interrupted improvement plans. Although some positive progress can be seen, it is very recent and, for too many children and young people, circumstances have not yet improved.

107. Workforce instability across social work teams has presented a serious challenge to the local authority over the past 12 months, with a significantly deteriorating picture in late 2015. Staff turnover is high and children, social workers and managers told inspectors about the negative impact that this has had on the ability of children to form meaningful relationships with their social workers. The high turnover of social workers and managers, sometimes caused by positive and necessary action taken by the local authority to address poor performance, has also contributed to children and young people experiencing drift, delay and exposure to risky situations for longer than they should. Management oversight is insufficient in too many cases, and does not mitigate the impact of the high staff turnover. Senior leaders understand the pressures in the service, and the local authority's self-assessment recognises that services for children and young people who require help and protection are inadequate. (Recommendation)

108. The local authority has rightly prioritised the establishment of a skilled, stable workforce to reduce the authority's high reliance on agency staff, currently at 42%. The complement of social workers in the access and assessment team has been increased by five. This has reduced caseloads from a peak in December 2015 when social workers were working with up to 60 children. Caseloads at the time of the inspection had been reduced to an average of 35, but inspectors saw some social workers with caseloads still exceeding 40, which is unacceptable. The local authority recognises that caseloads are still too high and knows that there is more to do. It aspires to reduce caseloads to between 18 and 22 within the next six months, as the capacity within the workforce is increased. (Recommendation)

109. The local authority now has a comprehensive recruitment and retention programme, illustrating a clear, cross-party political intent to improve services for children and young people. This is supported by an additional investment of £1.4 million to increase the number of social work and management posts to populate a specialist children's service structure, due to be introduced in autumn 2016. Eight current members of staff have been seconded to social work degree courses and the council

is involved with the Step Up to Social Work programme. Significant progress has been made in recruiting staff in recent months, with 29 social work posts in the process of being filled. Eight are from within the United Kingdom and 21 from overseas. Although this is a positive step, most of this cohort of new staff will not be in post and having an impact until October 2016. A positive indication of recent progress made is the application and appointment of six agency staff, who are employed in the borough, to permanent social worker positions. (Recommendation)

110. The quality and regularity of supervision seen by inspectors is inconsistent and often poor. It is notably better in those teams where there is greater stability, such as the fostering team. The local authority's own audit identifies that compliance with the department's expectations in relation to supervision is low. As a result, training on supervision for managers and staff has been commissioned, with the first sessions beginning during this inspection. (Recommendation)

111. Senior leaders understand the weaknesses of the service. The local authority audit programme demonstrates a realistic appraisal of the quality of practice. Judgements reached by the local authority in the cases audited as part of this inspection were generally in line with those reached by inspectors. Plans to improve the quality of practice are in place, but have not yet had a sufficiently positive impact. In some instances, improvement work completed last year needs to be repeated, for example in relation to 16- to 17-year-old young people who are homeless. A joint protocol with housing that was established last year is not being consistently applied in the cases seen during this inspection.

112. There are clear and regular lines of communication between elected members and senior strategic leaders. Both the lead member and the chair of the Adult, Children and Education (ACE) Committee, which also acts as the Scrutiny Committee, show a focused and clear understanding of the challenges and performance of children's services, underpinned by regular, comprehensive performance management reports. The committee has increased the number of meetings held each year to provide additional focus on children's issues and to ensure that officers are held to account.

113. In the past six months performance management systems have been revised and re-established. Managers at all levels have access to a suite of information, including weekly as well as quarterly performance reports, that is reviewed by a performance board and the improvement board. The lead member also receives copies of these reports. There is evidence of clear improvement in some indicators. These include timeliness of assessments, at 54.9% in January 2016, which improved to 81% in April 2016. This improvement was achieved despite an increase in the volume of assessments undertaken. Similarly, the timeliness of initial child protection conferences held within 15 days has improved to 86% in April 2016. However, the quality of practice identified in the local authority audits and during the inspection remains largely poor across the spectrum of assessment, planning and reviewing. (Recommendation)

114. The quality of practice is stronger in some services and teams, especially where there is a more stable workforce, such as the early help service and children's disability team. Across all teams, inspectors saw some limited examples of good

work making a positive difference to children and young people. In some service areas, improvement work has had a noticeable impact. In the last year, the number of care leavers living in bed and breakfast has been significantly reduced, and the number of children being adopted has been increased. Very recent improvement can be seen in the application of the Public Law Outline process and a significant surge in better timeliness in the completion of care proceedings.

115. An experienced, knowledgeable and enthusiastic principal social worker, appointed in February 2016, has been proactive in identifying areas for improvement, planning improvement work and measuring baseline performance. This includes the consolidation of practice standards, the development of induction programmes, and quality-assurance activity and training. A realistic appraisal of practice and challenges faced in Reading is supporting progress. It is too soon for much of this work to demonstrate an effect on performance.

116. Arrangements are in place for learning from complaints, audit and case reviews. This is disseminated to staff through newsletters and briefings. The impact of learning from this work has been reduced by the high level of staff turnover.

117. A web-based joint strategic needs assessment includes consideration of important aspects of services for children. These include the issues of female genital mutilation, children's emotional well-being, young people not in education, employment or training, and an insufficient number of local foster carers. Some unmet needs are identified concerning care leavers and children looked after however, the data requires updating as in many areas it is often two or three years old.

118. Commissioning arrangements are underdeveloped. The current commissioning strategy is recognised as a holding document that is not informed by a comprehensive needs assessment. The local authority is not meeting its duty in relation to the sufficiency of local foster placements and, as a consequence, too many children looked after live outside Reading. As a consequence, the provision of services to them is too variable and not adequately organised or monitored by the local authority. The local authority knows that this is a key area for development, but the pace of implementing these plans needs to be much swifter to support the improvement programme. (Recommendation)

119. Established links are in place between relevant strategic bodies. The lead member sits on the children's services improvement board and the Local Safeguarding Children's Board, and chairs the Children's Trust. She is vice-chair of the corporate parenting panel. Relevant attention is given to children's matters by the Health and Wellbeing Board, with regular reports received in relation to child and adolescent mental health services and the autism strategy. The board also coordinates the work to respond to the issue of female genital mutilation in Reading.

120. The chair of the corporate parenting panel has a clear plan of work with a focus on key areas of weaker performance for children looked after. There is increasing evidence of challenge from the panel, for example in relation to the completion of health assessments having a positive effect. The participation and influence of

children looked after and care leavers on the panel are insufficient and require strengthening in order that children are contributing to its priorities and work plans.

121. Strategic partnerships in relation to children and young people who go missing and are at risk of sexual exploitation have slowly developed from a low base in 2014. The child sexual exploitation strategy was launched in June 2015. All schools, including academies, put on a drama production to raise awareness of sexual exploitation among young people. Work is aligned with services for vulnerable adults, in recognition of the continued vulnerability of some young people in their transition to adulthood. Police, in conjunction with the licensing authority, have undertaken awareness raising with hotels. Strategic oversight, for example in relation to the number of return home interviews completed, has recently increased the number now undertaken. However, the timeliness and quality of these interviews require further improvement. There is still work to be done to improve the quality of work in frontline teams in relation to the recognition of risk and to provide consistently effective responses to it. (Recommendation)

122. The local authority has appropriately notified Ofsted of five serious incidents in the past three years. Until recently, the process for referring these cases to the Reading Local Safeguarding Children Board (RLSCB) case review sub-group worked well to consider whether a serious case review was needed. However, in recent months the process has not been sufficiently clear. This has resulted in confusion about whether two serious incidents should be considered by the sub-group. The DCS and the RLSCB chair have undertaken to implement a formal, transparent process and to revisit the decision-making process for these two cases.

123. Six months ago, key partners such as the judiciary and the Children and Family Court Advisory and Support Service described the service as failing. They report significant improvements since then in an increasing number of care proceedings, with the application of thresholds for initiating court proceedings considered to be more appropriate. Both the quality of social work evidence presented to the courts and the timeliness of the proceedings are improving. The appointment of two court case managers is pivotal in achieving these improvements.

The Local Safeguarding Children Board (LSCB)

The Local Safeguarding Children Board requires improvement

Executive summary

Despite positive change in the past 18 months, the Reading Local Safeguarding Children's Board (RLSCB) requires further improvement before it can be judged good. The board was previously unaware of the extent of concerns about the poor performance of children's services. Through greater scrutiny, it has gained an accurate view of practice, appropriately escalating concerns where deficits are highlighted. Almost all key partners are well engaged. However, its influence has been hindered by frequent changes in the children's social care senior leadership team.

Partners and young people have shaped the board's priorities. The majority of sub-groups are shared with other Berkshire local authorities. They have been reviewed with refreshed terms of reference and membership to ensure that they are aligned to these priorities. Some sub-groups are more advanced than others. For example, the sub-group to counter child sexual exploitation and missing children has ensured that appropriate strategic arrangements are in place to oversee this work. A comprehensive safeguarding training programme is in place, but the learning and development sub-group has yet to achieve a sharp focus on Reading professionals. Work is underway to strengthen the sub-groups, but they do not yet routinely link with each other to follow up issues, actions and practice improvements.

A strong independent chair has led the board's restructure. Changes, including the disbanding of the executive group, have enabled the board to fulfil its statutory functions consistently and to exert its influence better. The challenge and concern log facilitates active challenge, and has led to practice improvements.

Comprehensive performance information enables the board to identify potential strengths and weaknesses in local safeguarding practice. A cycle of audits and section 11 safeguarding audits is in place. However, the board lacks a systematic approach to learning and improvement. An improvement cycle is evident, but it is overly reliant on individuals and is not consistently driven. A learning and improvement framework was agreed in May and is now in place.

The case review sub-group makes sound decisions about whether serious incidents should be scrutinised through a serious case review. Learning is appropriately disseminated. The process for deciding whether a case should be considered by this group has not been sufficiently formalised in recent months.

The board has developed and published a comprehensive threshold of need document. Although the board has analysed some aspects of early help practice, an up-to-date detailed analysis of the application of thresholds and of the effectiveness

of the early help pathway is yet to be completed.

The board has engaged well with young people in some areas, for example in producing a vibrant young people's version of the annual safeguarding report. It has not yet made arrangements routinely to involve young people in all areas of its work.

The 2014–15 annual report is comprehensive and well written.

Recommendations

124. Develop an overarching process to ensure that learning from quality assurance activity is properly shared, tracked and reviewed. This should include clear and relevant actions from single and multi-agency case audits.

125. Implement a clear and transparent process for referring serious incidents to the case review sub-group for detailed consideration of whether a serious case review is needed.

126. Ensure that the work of the learning and development sub-group has a sharper focus on the particular learning and training needs of Reading professionals, including overseeing and, where appropriate, influencing the provision of single agency training.

127. Undertake a review of local safeguarding thresholds, including the effectiveness of the early help pathway, and the understanding and application of thresholds at all the key points in a child's journey.

128. Secure regular and consistent attendance and engagement at the board and sub-groups by children's social care, to increase the board's ability to contribute to improvements in core social work practice.

Inspection findings – the Local Safeguarding Children Board

129. Soon after the independent chair was appointed in December 2014, she began a comprehensive reorganisation of the board. All of the board's sub-groups have been reviewed and some have been substantially restructured. The executive group, which, according to the chair and key partners, had been overly focused on administrative processes with little influence over local safeguarding practice, was disbanded in 2015. This resulted in a large number of issues, challenges, updates and work streams being considered at full board meetings. This centralised oversight has been necessary to increase the board's accountability and drive change, but the volume of work has led to protracted board meetings and a risk that these become less productive. The chair has introduced high expectations, a culture of continual improvement and an intolerance of complacency. She expects partners to prepare well, to engage fully in discussions and to demonstrate their understanding through their challenge of each other. This is uncomfortable at times, but all partners spoken to by inspectors said this cultural shift has enabled them to

tackle successfully some longstanding areas for development, for example poor performance in health assessments for children looked after.

130. The board benefits from the involvement of two lay members and from consistent representation from the voluntary sector. The lead member is a committed board observer. For almost all partner agencies, senior managers at the right level are well engaged. This is illustrated by the willingness of key partner agencies such as the police, the clinical commissioning group and a local head teacher to act as champions for the board's priorities. The one exception is children's services, where the high turnover of senior managers has led to fragmented attendance and frequent changes in membership. This has not prevented the board from closely scrutinising some areas of social care practice, such as the response to children who go missing or who are at risk of child sexual exploitation, the experiences of children looked after who are placed out of area, social work caseloads and the impact of social care staff turnover. However, it has limited its ability to influence effectively the frontline services for children who need help and protection. (Recommendation)

131. Board members acknowledge that they have not always fully understood their roles and responsibilities in relation to the work of the board. A board compact and induction pack, developed by members themselves, provides a straightforward summary of key expectations, duties and responsibilities. This has been welcomed, particularly by new members, but it has only recently been rolled out and it is therefore too early to judge the difference that it has made.

132. Established working relationships and communication between key groups and strategic bodies are in place. For example, the independent chair of the RLSCB regularly attends the Health and Wellbeing Board (HWB) and also regularly attends the Children's Trust Board. The chair has championed greater understanding and action to tackle the issue of female genital mutilation in Reading by chairing a task and finish group. This has resulted in a clearer view of prevalence, clarity regarding governance arrangements and the development of a multi-agency protocol and pathway. These will be rolled out alongside a multi-agency training programme in June 2016. The independent chair also provides regular updates to the children's services improvement board, and to the council's children and education scrutiny committee.

133. The board has identified a need to formalise relationships with key strategic bodies and, as a result, has recently refreshed the 2014 joint working protocol between the RLSCB, the HWB, the community safety partnership and the safeguarding adults board. This protocol has been signed by all relevant strategic group chairs. It includes a requirement for chairs to meet biannually to review priorities and discuss prioritised challenges, agendas and actions. Although this has yet to take effect, it has laid the foundation for a more meaningful partnership approach to tackling the board's priorities, in particular domestic abuse and the emotional well-being of children and young people.

134. The board undertakes a range of activities to maintain oversight of local safeguarding practice. The quality assurance sub-group was merged with the performance sub-group early in 2015. It now appropriately focuses only on Reading

safeguarding practice. This group has overseen a programme of single and multi-agency audits, with themes such as child sexual exploitation, multi-agency risk assessment conferences, core groups, neglect and missing children. The 2016–17 audit programme reflects the board's priorities well.

135. Audits result in individual action plans which include appropriate learning activity and strategic changes, such as the development of the neglect strategy that is soon to be published. However, children's social care has only very recently joined the sub-group, and this has been a crucial gap. Further, not all audits have taken place as planned, and not all action plans sufficiently address the findings from audit activity. For instance, the actions from the 2016 missing children audit tackle the inequity in experiences of children looked after who live more than 10 miles from Reading and the quality of their return home interviews, but they do not include the need to improve the timeliness of these interviews. Although the 'voice of the child' is included in some audits, for instance through the 2015 'lived experiences of children subject to plans' audit, where children were spoken to directly about their experiences, this is not a sufficiently consistent feature of single or multi-agency audits. (Recommendation)

136. The board's ability to review and satisfy itself that practice changes are sustained is hampered by the absence of an established process for overseeing and checking actions, or a clear and consistent cycle of scrutiny, action planning, communication, learning and review. A learning and improvement framework was formally adopted by the board in May 2016 and is in now being implemented. (Recommendation)

137. In the last three-year cycle, all agencies completed a section 11 audit. This is an assessment undertaken by local agencies to analyse how they safeguard children through their day-to-day business. The section 11 sub-group is pan-Berkshire, and enables partners to complete just one audit rather than repeating this for each local board. The new cycle, which began in September 2015, includes a face-to-face meeting with agency leads. This has increased the board's scrutiny of its strengths and areas for development. The multi-agency dataset has been regularly reviewed over the past 12 months, and now contains the right breadth and depth of information. For example, it includes data regarding numbers of missing children, the proportion who received a return home interview and the timeliness of these interviews. Commentary is helpful to partners in understanding what the data means.

138. The board has ensured that the local threshold of need document is up to date and comprehensive. It was launched through well-received multi-agency workshops to 350 professionals in 2015. The application of thresholds at all stages of the Reading child's journey, and the effectiveness of the early help pathway now need to be comprehensively scrutinised by the board. (Recommendation)

139. The case review sub-group has applied the right threshold when considering whether serious incidents should be addressed through a serious case review. The sub-group uses the national case review panel appropriately as a source of advice when making difficult decisions. Partners are provided with sufficient notice to be able to share useful information, and this aids the decision-making process. National

serious case reviews are discussed and learning is appropriately disseminated. The reconfiguration of the group to include all Berkshire West cases has helped partners to manage the pressures of attending a number of meetings for various local boards. It has also enabled the group to learn from serious incidents in other local areas. However, the current process for referring serious incidents to the sub-group is not sufficiently formalised. Recently, this has resulted in confusion about whether two serious incidents should be discussed in this forum. The chair of the board, the chair of the sub-group and the DCS have recognised that a clearer and more formalised process is needed and have already begun to address this. Both cases will now be considered. (Recommendation)

140. The RLSCB has provided a range of multi-agency safeguarding training opportunities for its partners. Core training is provided, along with specific workshops to address safeguarding issues such as child sexual exploitation, 'Prevent' and female genital mutilation. So far this year, 57 newly appointed children's social care staff have attended training on how to complete domestic abuse risk assessments, Specific workshops are arranged to communicate lessons learned from case reviews, although the board has not yet established a reliable way of checking whether these workshops have made a difference to frontline practice. Training methods are increasingly flexible to the needs of learners. For instance, take-up of e-learning courses in 2015–16 increased by 132% from the previous year. The joint Berkshire West training sub-group has very recently been reconfigured and now has a stronger Reading focus. This is in recognition of the need for it to oversee more closely local single agency training and to be more responsive to the needs of Reading frontline staff.

141. The board has been instrumental in establishing a comprehensive child sexual exploitation strategy. Appropriate strategic and operational processes are in place to oversee and track these children, and regular reports are received by the board. In March 2016, steady progress was reported on the action plan to counter child sexual exploitation. For example, the board has committed partnership money to continue to fund the missing children coordinator post. Through its analysis of data and audit activity, the board has highlighted concerns about the consistency and quality of responses to children who go missing and the use of risk assessment tools concerning child sexual exploitation. It is critical that the board continues to oversee and closely analyse these areas of practice.

142. One of the key areas for development for the board is the need for a systematic interlinking of the sub-groups with each other in the progression and oversight of actions against the board's priorities. This gap is contributing to the large amount of work being overseen and progressed via board meetings. The chair has established a process for sub-group chairs to report on a quarterly basis. This is strengthening their role and increasing their accountability. She has also introduced a bi-annual sub-group chairs' forum in order to strengthen sub-group arrangements further. It is too early to judge whether this will bring about the required improvements. (Recommendation)

143. The board knows itself well. A recent self-assessment of its strengths and weaknesses, undertaken by board members themselves, is largely accurate. It seeks the views of local partners and agencies on its ongoing development. For example, during summer 2015 the board undertook a survey of its effectiveness, sending questionnaires to 269 individuals and obtaining 103 responses. The findings have informed the board's work programme. For instance, the need to improve communication led to the development of a virtual communications sub-group.

144. The board has established an effective approach to multi-agency challenge through its risk and concern log. This enables partners formally to highlight issues of concern and track actions to address them. Over the past 12 months, the oversight of this log and the accompanying action plan has become a core aspect of the board's business. Progress in tackling these issues is evident, for example through the increased engagement of Thames Valley Police at child protection conferences, the review of the rapid response protocol and additional financial contributions from key partners. The culture of transparency and challenge has been further strengthened by themed challenge sessions.

145. The 2014–15 RLSCB annual report is a well-written document. Almost all areas of local safeguarding practice are critiqued, with equal weight given to children receiving early help, children in need, children at risk of harm and children looked after. Data is presented in an easy to understand way and with relevance. RLSCB priorities are explained well, alongside achievements, challenges and impact. However, the work of the designated officer is not sufficiently scrutinised and private fostering is not given sufficient attention. The 2014–15 business plan has been used well to track and drive actions, evidenced by 46 of the 55 actions showing as green and complete at the end of the year.

146. The board has engaged well with young people in deciding on its priorities, and in the creation and publication of a children's and young person's version of the annual report. However, it has not yet found a way routinely to involve young people in its work.

Information about this inspection

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

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

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

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

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

The inspection team consisted of eight of Her Majesty's Inspectors (HMIs) from Ofsted.

The inspection team

Lead inspector: Nick Stacey

Deputy lead inspector: Janet Fraser

Team inspectors: Mary Candlin, Andy Whippey, Michael McCracken (seconded inspector), Mark Shackleton, Stephanie Murray, Caroline Walsh, Natalie Trentham

Shadow inspectors: Christy Wannop

Senior data analyst: Donna Neill

Quality assurance manager: Helen Cawston, Senior HMI

Any complaints about the inspection or the report should be made following the procedures set out in the guidance 'Raising concerns and making complaints about Ofsted', which is available from Ofsted's website: www.gov.uk/government/publications/complaints-about-ofsted. If you would like Ofsted to send you a copy of the guidance, please telephone 0300 123 4234, or email enquiries@ofsted.gov.uk.

The Office for Standards in Education, Children's Services and Skills (Ofsted) regulates and inspects to achieve excellence in the care of children and young people, and in education and skills for learners of all ages. It regulates and inspects childcare and children's social care, and inspects the Children and Family Court Advisory and Support Service (Cafcass), schools, colleges, initial teacher training, further education and skills, adult and community learning, and education and training in prisons and other secure establishments. It assesses council children's services, and inspects services for looked after children, safeguarding and child protection.

If you would like a copy of this document in a different format, such as large print or Braille, please telephone 0300 123 1231, or email enquiries@ofsted.gov.uk.

This publication is available at www.gov.uk/government/organisations/ofsted.

Interested in our work? You can subscribe to our monthly newsletter for more information and updates: http://eepurl.com/iTrDn.

Piccadilly Gate
Store Street
Manchester
M1 2WD
T: 0300 123 4234
Textphone: 0161 618 8524
E: enquiries@ofsted.gov.uk
W: www.ofsted.gov.uk