

24 March 2017

Ann Marie Dodds
Acting Director of Children, Education and Early Help Services
Reading Borough Council
Bridge Street
Reading
RG1 2LU

Dear Ms Dodds

Monitoring visit of Reading Borough Council children's services

This letter summarises the findings of the monitoring visit to Reading Borough Council children's services on 21 and 22 February 2017. The visit was carried out under section 136 of the Education and Inspections Act 2006.

The visit was the second monitoring visit since the local authority was judged inadequate in August 2016. The inspectors were Nick Stacey HMI and Brenda McInerney HMI.

The local authority has made some progress in improving the rigour and effectiveness of responses to children missing from home and care, although the overall pace and scale of practice improvements for children in need are too slow. Inspectors found no cases of children at immediate risk requiring an urgent response from senior managers.

Areas covered by the visit

During the course of this visit, inspectors reviewed the progress made in help and protection, with a particular focus on the following themes:

- the rigour and quality of plans and work with children in need to support timely improvements in their circumstances, well-being and safety
- the appropriate application of thresholds of children in need 'stepped down' to early help services; the identification of increasing risks for children in need requiring a 'step up' to a child protection conference
- management oversight
- the timeliness and quality of responses to children who go missing from home and children looked after who go missing from care.

The visit considered a range of evidence, including electronic case records, supervision files and notes, observation of social workers and senior practitioners and other information provided by staff and managers. In addition, we spoke to a range of staff, including managers, social workers, other practitioners and administrative staff.

Overview

In most of the cases considered, there is a lack of clarity as to how interventions with children in need and their families will improve their circumstances over a reasonable period of time. This means that too many families do not clearly understand what steps they should take to reduce professionals' concerns. This uncertainty is increased through infrequent social work visits and a large minority of families having no plan. Improvements since the inspection have been too concerned with process compliance to the detriment of consistently better social work practice with families and children, underpinned by reflective, outcome-focused case supervision.

Findings and evaluation of progress

Progress in improving services for children in Reading since the last monitoring visit has been impeded by a further change in the Director of Children's Services (DCS). A second acting DCS was appointed internally in early December 2016. Prior to the appointment of the second DCS, there was not an agreed and consistent position from the senior management team on progressing improvements required in the children's service, particularly on how the recommendations of an extensive external audit programme would be implemented.

Senior managers understand the weaknesses in the service well and have a realistic assessment about the limited pace and scale of improvements since the inspection. They have largely relied on external auditing and quality assurance to provide them with critical information on the quality of social work with children and their families. The service does not yet have effective internal quality assurance measures. The initial phase of service improvement, following the inspection findings in August 2016, has been too concerned with process compliance to the detriment of a focus on the quality and impact of social work with children and their families. While there is a determination to redress this imbalance, it is not yet widely evident in management oversight or social workers' practice.

Attempts to implement the fundamental improvements required to provide consistently safe and effective services for children and families in Reading are taking too long. Too many children who are the subject of children in need plans are not visited within stipulated timescales. Well over a third of home visits are overdue and

a similar proportion of children have no written plan. This means that many parents and children do not understand the aim of the social worker's work or what needs to change.

Performance management arrangements, while improving, have not yet had an impact on improving key areas of performance, such as ensuring that all children have a plan in place or are visited within timescales. The absence of a permanent team manager layer is likely to further impede attempts to implement tight and accountable ownership of performance.

Lower caseloads, seen at the last monitoring visit, have largely been maintained. However, some social workers' caseloads in the safeguarding team were higher than the reported average of 22. Social workers welcome lower caseloads and this is an important factor in improving the retention of locum and permanent staff. At the time of the visit, the number of permanent social workers had increased to 62% of the workforce, which is a small improvement on the position at the first visit. The vast majority of team managers are temporary workers, indicating continuing fragility in the spine of the frontline workforce. In addition, 15 cases were unallocated to social workers and were being overseen by managers. This indicates that ongoing turnover of social workers continues to have a detrimental impact on the consistency of work with a small number of children and families.

Most social workers seen during the visit were agency staff, but the majority had been in the local authority for many months, and in some cases for over a year. Social workers told inspectors that their caseloads were largely manageable and their line managers helpful and available. Most spoke of a welcome 'culture change' in recent months where their views were both listened to and valued, and senior managers were trying hard to create a climate where social work could flourish. Inspectors judged that social workers did not regard audits of their practice with children and their families as threatening, but as an attempt to help them improve and develop. This trend was apparent in the recommendations of local authority audits being implemented in cases tracked during the visit. The local authority is revising its quality assurance framework in April 2017 to strengthen internal auditing arrangements.

Given the scale and breadth of inadequate practice identified at the inspection, the introduction of a revised internal quality assurance system has been too slow. Social workers lack confidence and a clear purpose in their direct work with children in need. Most child in need plans list the proposed services and agencies intended to help children and families, but do not clearly set out the overarching changes and improvements required. The measurement of progress is largely concerned with the extent to which services are taken up, rather than a confident analysis of children's experiences and the quality of parenting provided to them. This results in some plans becoming aimless when services offered are either not, or are partially, engaged with. There is restricted evidence of professional curiosity and respectful challenge of parents.

The Signs of Safety model is used extensively in children in need plans to document risks, needs, strengths and professional concerns. While this approach helps evaluative thinking, lengthy column lists are rarely distilled into succinct danger statements, or sharply defined primary risks and needs that shape well-designed, outcome-led plans. Plans are not regularly reviewed to assess progress, and when they are, the process relies too heavily on social workers to organise, chair and minute the meetings. Managers and case supervisors do not attend reviews. As a result, they miss opportunities to contribute directly to discussions of the impact of multi-agency work on improving children's outcomes.

Regular management oversight was evident in most cases seen during the visit. Aside from a few notable exceptions, it was predominantly concerned with process compliance and task completion. Supervision rarely includes an exploration of the impact of direct social work with children and parents. Consequently, social workers are not offered reflective help and guidance on how to engage older children and teenagers who may be reluctant to share their experiences. Similarly, managers rarely advise social workers on how to involve parents who avoid, or are ambivalent about, social workers' involvement in their lives.

Strategy meetings concerning children at risk of significant harm seen during the visit continue to be predominantly telephone discussions between social workers and the police. This excludes the important information and views of other agencies working with children and their families. Social workers' records of home visits are often discursive, narrative accounts unaligned to important objectives of children in need plans. In some cases, there were significant gaps in home visits of up to three months. In one case, only a single home visit occurred during a four-month period before the case was closed.

Assessments conducted in the advice and assessment teams lack clarity on the purpose and objectives of the recommended work with children in need and their families. Sharper, incisive rationales, describing the primary outcomes sought for children in subsequent child in need interventions, would help receiving social workers to shape and form clearer plans at the outset.

Decisions to close children's plans or to step them down to early intervention services are largely appropriate. However, the rationale for the manager's decision was often absent. It was not evident to inspectors that all children's circumstances had significantly improved before their cases were closed. Cases stepped up for a strategy meeting, and consideration of a child protection response, were appropriate. The volume of children who are not seen regularly, alongside an absence of plans, or effective review of them, means that there may be continuing unidentified risks for some children designated as in need of statutory social work services.

All children who go missing from home or care are offered return home interviews with youth workers experienced in direct work with young people. The majority of interviews accepted by young people are completed within three working days,

although nearly a third take longer. However, only 57% of children agree to a return home interview.

A recently introduced new format for return home interviews is helping to improve the quality of content and recording in return home interviews, distinguishing the young person's account from professional opinion and analysis of risks. Staff are tenacious and creative in engaging young people, and the majority of examples seen gathered rich, detailed information about missing episodes. The local authority is aware that it needs to do more to assess risks and needs from other involved agencies when children decline interviews, as these can be the most vulnerable children.

The local authority continues to deploy effective disruption activity with the police and other partners, such as trading standards, to disperse young people from locations of concern. A dedicated local authority Missing Coordinator screens all missing notifications from the police each day. Return interviews are allocated quickly, and intelligence on associations and patterns are recognised. However, there is a lack of police analyst input to intelligence mapping. If this took place, it would strengthen the quality and quantity of information to inform prevention, disruption and safeguarding activities.

Safeguarding strategy meetings are held at appropriate stages when there is evidence of risk or exposure to child sexual exploitation, substance misuse, individuals of known concern and other risks. Meetings are carefully recorded and a wide range of involved agencies attend. All children who go repeatedly missing, three times or more over a three-month period, are evaluated at monthly sexual exploitation and missing risk assessment conference meetings. Records of meetings seen identify known risks to children effectively. Action plans are often too imprecise in detailing how chronic non-engagement could be tackled, or how risks had been demonstrably reduced when young people are no longer reviewed. Overall, the operational management of children who go missing has improved markedly since the inspection in the summer of 2016.

I am copying this letter to the Department for Education. This letter will be published on the Ofsted website

Yours sincerely,

Nick Stacey
Her Majesty's Inspector