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25 January 2017

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West Berkshire Council
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Dear Ms Wardell

Monitoring visit of West Berkshire local authority children's services

This letter summarises the findings of the monitoring visit to West Berkshire local authority children's services on 5 and 6 December 2016. This was the first visit, under the current arrangements for monitoring local authorities, judged to be inadequate since the local authority was judged inadequate in March 2015. The inspectors were Janet Fraser HMI and Donna Marriott HMI.

Based on the evidence and cases seen by inspectors during this monitoring visit, the local authority has made positive improvements to services for children. Further work is needed to ensure these improvements result in consistent practice across the service.

Areas covered by the visit

During the course of this visit, inspectors reviewed progress made in the areas of:

- the stability of the social care workforce
- the understanding and application of thresholds and quality of decision making in the children's advice and assessment service (CAAS) and multi-agency safeguarding hub (MASH)
- the quality of social work assessment in the CAAS and locality teams
- the response to children who go missing and/or are at risk of child sexual exploitation
- the effectiveness of management oversight and supervision.

The visit considered a range of evidence, including electronic case records, supervision files and notes, data and documents provided by the local authority. In

addition, we spoke to managers and social workers in CAAS, MASH and the locality teams.

Summary of findings

- The recruitment and retention campaign has reduced the number of temporary managers and social workers. Fewer children are experiencing changes of social worker as a result.

- Thresholds for statutory intervention are understood by partners and social care staff.

- Effective arrangements in CAAS mean that decisions about contacts and referrals are made promptly, are overseen by managers and are, in the large majority, appropriate.

- For some children there could be delays in decisions being made when agency checks are made by the MASH. Strategy discussions continue, predominantly, to only include social care and the police. Strategy meetings include a range of appropriate agencies.

- The majority of assessments are thorough, include relevant information and consider the risks to, and individual needs of, all children in the family.

- Social workers visit children and, where appropriate, see them alone. Social workers are knowledgeable about the children they work with and use direct work to understand the children's experience.

- Not all children at risk of sexual exploitation receive robust intervention that reduces risk quickly enough. Case records of children who go missing do not always record what steps have been taken in response to the missing episode or how they have been kept safe.

- Management oversight is evident on case notes and through supervision. It is not yet sufficiently rigorous in driving case planning for all children.

- Social workers are positive about working in West Berkshire. They feel supported and challenged by their managers.

Evaluation of progress

The current leadership team has been effective in improving the quality of services in most of the areas considered during this visit. The increasing stability of the workforce is supporting practice improvement. The reduction in turnover of managers means that management grip is improving and, in cases seen, the regularity and quality of supervision is mostly effective in driving case planning.

There is further work needed to streamline decision making in the MASH, to ensure that quality of practice and management oversight is consistent across the service and that there is a consistent response to all children who go missing from care or home. Practitioners find negotiating the electronic case record system cumbersome and time consuming.

Since the last inspection, senior leaders have properly focused on recruiting and retaining permanent social workers and managers. As a result, the local authority's reliance on agency staff has reduced steadily, from 50% at the time of the last inspection, to 17% in October 2016. Members of the senior leadership team, and all middle managers, are now permanent appointees. Some key teams, such as the child protection chairs and independent reviewing officers, now consist of 100% permanent staff where previously 70% of the team were agency workers. Consequently, turnover in social work teams is reducing, and in the past 12 months there has been a significant increase in the number of children who have had only one social worker, rising from 34% to 64% in the year to September 2016.

In cases seen by inspectors, thresholds are understood by partner agencies. The 'front door' arrangements are effective, managers in CAAS oversee all contact and referral decision making and almost all threshold decisions seen by inspectors are appropriate. Managers oversee decisions and utilise performance information and manual spreadsheets to drive decision making. Management oversight is evident on children's case records and through supervision. Social workers spoken to in CAAS say that they are well supported and report that their managers are accessible and visible.

Social workers in CAAS consistently seek parental consent, obtain background history and carry out comprehensive agency checks to inform decision making. Children are visited regularly and are seen alone by their social worker when appropriate. There is evidence of purposeful engagement with children and families, with clear planning to drive intervention, including safety planning. When the threshold for statutory intervention is not met, consent is not always sought when the decision is made to step down children's cases too early help.

The newly established MASH has strengthened decision-making arrangements. Delay in some agencies providing information, combined with the broad timescales applied for such enquiries, mean that some children's cases could remain too long in the MASH before a decision is made about threshold and next steps.

Deficits in the current integrated children's IT system mean that it is not an effective tool to support managers in tracking and driving work and results in unnecessary duplication. The local authority has already identified this shortfall and is taking action to respond, commissioning a new IT system, but this is not yet in place.

When children's needs do not meet the threshold for social care intervention, pathways for early help are in place. However, these do not always result in timely

support for families to prevent needs escalating. The impact of this is that some children and families wait too long to have their needs met.

Strategy discussions are held promptly in response to identified risks. In more complex matters, when strategy meetings are held, relevant partners attend and the information shared underpins well-informed decision making. Partner agency engagement in strategy discussions remains an area for development. Predominantly, they only include police and social care. The decisions made during the large majority of strategy discussions are appropriate and clearly record actions needed. In a small minority, actions for timescales are not recorded and in one case seen it was not clear how risk would be addressed while child protection enquiries were carried out. Decisions to progress to Section 47 enquiries were appropriate in cases seen by inspectors and led to timely action to safeguard. Assessments conducted as part of this process are thorough and effectively focus on risk.

Social workers in the locality teams who spoke to inspectors were knowledgeable about the children they worked with. Children are visited and mostly seen alone. Inspectors saw good examples of the individual needs of children in large sibling groups being properly considered and some direct work with children informing assessment and planning.

The quality of assessment has improved since the last inspection. The majority of assessments seen are strong and include relevant information from other agencies, family history and children's and parents' views. Research is evident in some assessments. Risk is appropriately analysed and used to plan appropriate next steps. Risk is reducing for most children as a result of interventions. Those assessments that are less good are overly descriptive, which dilutes focus.

The local authority, with its partners, has effective strategic arrangements to share intelligence about children who go missing or who are at risk of sexual exploitation.

Responses to children who go missing from home or care are inconsistent. In some instances this was in relation to child centred decision making, however records did not properly reflect this. Notification reports from the police following a missing incident are routinely recorded on the child's electronic case file and return home interviews are attached to the record when they take place. However, when return home interviews have not taken place there are gaps in recording. This means that there is not a coherent understanding of the child's experience, or what action has been taken to ensure that the child has been safeguarded effectively.

Child sexual exploitation screening tools are used to measure potential risk. However, escalating risk is not always promptly recognised and responded to. For example, for one young person, where risks were not reducing, there was delay in moving to child protection procedures. In contrast, inspectors saw examples when planning for children displaying extremely risky behaviours received significant management oversight and monitoring.

Social workers consistently report feeling well supported by managers and are positive about working in West Berkshire. Caseloads seen by inspectors ranged from nine to the mid-twenties. Social workers consider that their caseloads are manageable. Supervision for most social workers is now regular and reflective. Social workers describe feeling both challenged and supported through the supervision process. The standard of supervision, however, is not yet consistently good enough and an example was seen where management oversight was insufficiently rigorous to ensure that all potential risks were sufficiently understood, or that plans were reducing them effectively.

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

Yours sincerely

Janet Fraser
Her Majesty's Inspector