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Dear Carol

Focused visit to Wokingham Borough Council children's services

This letter summarises the findings of the focused visit to Wokingham Council children's services on 17 and 18 October 2018. The visit was conducted by Tracey Scott and Tracey Metcalfe, two of Her Majesty's Inspectors.

Inspectors reviewed the local authority's arrangements for responding to contacts and referrals, including decision-making within the multi-agency safeguarding hub (MASH). They also considered transfers to and from early help services, the effectiveness of child protection enquiries and the quality of assessments for children in need of help and protection.

Inspectors considered a range of evidence, including case discussions with social workers and managers, and meetings with specialist workers and representatives from partner agencies in the MASH. They also looked at local authority performance management and quality assurance information, as well as children's case records.

Overview

Since the last inspection in 2017, there has been a marked deterioration in the quality, timeliness and delivery of services to children, with increased caseloads in children's social care and early help. This is linked to a rise in demand and instability across the workforce.

The significant pressures within the MASH and assessment service were not identified or addressed early enough to prevent the decline. In recent months, leaders have taken more assertive steps to stabilise the service. At the time of this visit, an interim director of children's services (DCS) was to be in post until 1 November 2018, at which point an assistant director, who has been promoted to the permanent DCS role, will take up her post. Additionally, an acting assistant director is in place while recruitment is underway for a permanent appointment. The current leadership team, led by the current interim DCS, has a clearer understanding of the areas for development within the service. With additional investment, such as through a new team of locum staff to reduce a substantial backlog in assessments, the management team has begun to tackle these weaknesses. This, together with a levelling off of demand, has led to a recent reduction in caseloads. New referrals are receiving a more timely response. Staff morale has begun to improve from a very low base. The situation remains fragile, the positive changes are very recent, and the ongoing impact is still to be tested.

In recent months, managers have redesigned the multi-agency safeguarding hub (MASH), creating a new team of dedicated practitioners whose role is to screen and triage new contacts and referrals. This has resulted in improvements in the effectiveness and timeliness of response, with better management oversight. Further work is needed to improve the recording and audit trail of initial decisions about contacts and referrals.

The co-location of health, police and early help professionals within the MASH enables, in most instances, helpful information-sharing. Education professionals engage remotely, but well, when information is requested of them. An over-reliance on the early help team to undertake early help assessments has resulted in pressure on this service and a delay in some children being assessed and helped.

The triaging of domestic abuse notifications is not as effective as it should be. It is coordinated by children's social care through a daily multi-agency meeting. These meetings support information-sharing and clear social care decision-making. While police provide relevant information, they do not attend the meetings and therefore do not contribute to decision-making. For some families, the process facilitates the provision of helpful support, but for others it is disproportionate to the level of concern. The need for consent is not always robustly considered.

Most initial child protection strategy discussions include police and children's social care only, and a small number do not take place quickly enough. This limits the wider information that is available about the child and their family circumstances and does not ensure the comprehensive assessment of risk and planning for all children.

As a result of the substantial and recent pressures within the service, some children who are subject to a child and family assessment have continued to experience delay in their needs being understood and receiving help.

What needs to improve in this area of social work practice

- The sustainability of arrangements to stabilise the workforce and meet ongoing demand.
- The effectiveness of arrangements for the police to play a full and active role within the MASH.
- The recording of screening and triage within the MASH, to support accountability of decision-making.
- Child protection strategy discussions, including: timeliness; the engagement of multi-agency professionals and the quality of information-sharing; threshold decision-making; and planning.
- The application of the significant harm threshold in order to ensure that children are only subject to child protection enquiries when these are necessary.

Findings

- Rising turnover of staff across the permanent and agency workforce and substantial and frequent changes in the senior leadership team have created instability and contributed to a significant deterioration in the quality of practice. After a period of decline, senior leaders in Wokingham have developed a clearer understanding of the challenges and strengths in the service and have begun to make the necessary improvements. Although a permanent DCS was due to commence her role soon after this visit and recruitment to other permanent posts in the senior leadership team is underway, a stable leadership team that is in a position to continue to make the changes that are needed is not yet in place.
- An increase in demand across all areas of the service has negatively impacted on capacity, resulting in a period of high caseloads. The MASH and assessment service have been under considerable pressure and staff morale has been low.
- The 'front door' provides an accessible single point of contact for families and professionals who are seeking help. The service provides appropriate advice and guidance and helpful signposting to services that support families. The creation of a small dedicated team of practitioners to respond to contacts and referrals has enabled recent improvements in the quality of screening and triage. The progression of the vast majority of contacts is timely, but managers have not yet ensured clear recording and a robust electronic audit trail of this initial work. The

recording of decisions and management oversight is stronger from the point at which contacts are assigned to a member of the team.

- Early help referrals are appropriately reviewed and prioritised within the MASH. However, practitioners within universal services do not complete early help assessments; these are undertaken by the early help team. The resultant demand on the early help team has led to a delay in some children's needs being fully assessed and met. When making decisions to close children's cases, the early help team does not always consider the impact of parents not accepting or engaging in support, resulting in repeat referrals for some children. The local authority recognises that there is further work to do to address this and leaders plan to evaluate this group of children further to understand the reasons for re-referral and to improve the rigour and effectiveness of closure decision-making.

- Police domestic abuse notifications are not triaged or prioritised before being passed to the MASH. This results in a high volume of police contacts being received by the service. These notifications are subsequently subject to a domestic violence triage meeting. All relevant agencies, including the police, provide information to these meetings to support decision-making, but police do not attend in person so are unable to contribute to the discussion or plans. Although inspectors saw examples of helpful and proportionate decisions and actions from these meetings, a number of the cases considered do not meet the threshold for children's social care and the discussions are resource-intensive for those who are involved. In addition to this, the meetings do not always take sufficient account of the need for consent in the sharing of multi-agency information.

- Thresholds for child protection enquiries are sometimes too low, resulting in a small number of families being drawn into child protection processes when this is not required. In most cases, social workers and managers engage only the police in initial strategy discussions. Other partners are not routinely involved in these discussions about the risk of significant harm to children, so wider information about family circumstances is not fully considered. Processes to involve the police in strategy discussions and in subsequent actions are overly complex. For example, where police information is requested, or when police attendance is required at a strategy meeting or to undertake a joint visit, social workers either call 101 or the regional police number to log a strategy meeting, request information and arrange police attendance. Not all strategy discussions take place at the point of referral, with some taking up to two days to convene. This means that the assessment of risk and planning for a small number of children is delayed. When strategy discussions are followed up with a face-to-face meeting, these are comprehensive, and include the helpful sharing of information, the appropriate consideration of risk and proportionate plans to reduce risk for children.

- A prolonged period of pressure on the service has resulted in a significant backlog of child and family assessments, with some taking more than six or even nine months to complete. As a result, some children have waited for much too long to receive the support that they need. Leaders have recently created additional managerial and social work posts, and have commissioned a discrete, temporary team of locum staff to undertake assessments. This has enabled practitioners to clear the build-up of assessment work. At the time of this visit, caseloads in the team were manageable and most new assessments were progressing in good time, in line with children's individual circumstances. In most recent cases seen by inspectors, assessments were of a good quality. They provide strong evidence of purposeful direct work with children, careful consideration of family history, clear analysis and an appropriate initial plan.

- While the response at the 'front door' has been strengthened, some children still experience delay in being seen in accordance with their needs. Inspectors identified delays for a small number of children at all points from assessment through to initial child protection conferences, as well as in transfers between teams. Leaders are in the process of increasing capacity in the long-term teams in order to address this.

- In cases seen by inspectors, processes for daytime services to receive work from the emergency duty team (EDT) were working appropriately. However, the EDT manager told inspectors that frontline teams do not provide them with sufficient information and that strategic arrangements are not robust enough, negatively affecting the quality of service they can provide. The DCS is taking this forward to review arrangements and to ensure clarity and effective communication.

- The review and coordination of new contacts when children go missing is managed by the MASH early help assistant team manager. This works well in the identification of levels of vulnerability and in the offer of early help services. Through return home interviews, practitioners appropriately seek to understand the reasons for and context of the missing episode. Where needed, a plan of intervention is offered to children and families. Not all children's records evidence that an interview has been offered or has taken place, and a number of these conversations take place outside of defined timescales. For some children, this leads to a delay in understanding and acting on their situation.

- Senior and quality assurance managers have implemented an extensive audit programme, including themed audits and observations of practice. Leaders recognise that the audit tool needs to be improved and recent training of managers who audit cases has taken place to support a more consistent approach. The process of learning and practice change in response to audit findings is not always rigorous and there are some missed opportunities to promote learning through audit discussion and supervision.

- Although supervision of frontline staff is mostly regular, and staff feel well supported by these meetings with their managers, it does not always address practice or performance or rigorously progress plans for children.

Ofsted will take the findings from this focused visit into account when planning your next inspection or visit.

Yours sincerely

Tracey Scott
Her Majesty's Inspector