

8 May 2019

Ms E Ioannides
Brighter Futures for Children
Civic Offices
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Dear Ms Ioannides

Eighth monitoring visit of Reading local authority children's services

This letter summarises the findings of the monitoring visit to Reading local authority children's services on 12 and 13 March 2019. The visit was the eighth monitoring visit since the local authority was judged inadequate in June 2016. The inspectors were Tracey Scott and Nick Stacey, Her Majesty's Inspectors.

The improvements in the specific area of practice scrutinised during the visit have been sustained since an earlier monitoring visit in October 2017. The wider, overall pace of improvement has not been sufficient.

Areas covered by the visit

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

- the effectiveness of the children's single point of access (CSPoA) in responding to concerns about children
- the early response to risk, particularly strategy discussions and child protection enquiries
- the effectiveness of the arrangements for 'stepping up' or 'stepping down' between different levels of intervention.

Inspectors considered a range of evidence, including electronic case files, meetings with social workers and managers, discussions with senior leaders and analysis of relevant documentation and data.

Overview

On 3 December 2018, responsibility for delivering children's social care and early help services in Reading transferred to Brighter Futures for Children (BFfC). This followed Reading Borough Council using its powers under Part 1 of the Children and

Young Persons Act 2008 to delegate its children's social care statutory functions to BFFC. BFFC is a new community interest company, wholly owned by Reading borough council.

Frequent changes in senior managers and a high turnover of frontline staff continue to adversely impact on managers' ability to bring about improvement. A new interim director of children's services has been in post since the beginning of March 2019 and a permanent deputy director started in November 2018. The recent recruitment of permanent team managers is a positive step, but the instability and interim status of large parts of the workforce indicate ongoing fragility. Caseloads remain too high in some access and assessment teams.

While demand across Reading local authority children's services remains high and well above that of comparable authorities, it has recently started to reduce. The quality of performance data is unreliable. It does not allow managers to gain a consistently clear understanding of performance across all areas of the service. This hampers managers' ability to accurately measure compliance with basic practice requirements. Some aspects of performance are more reliably reported and are beginning to show signs of improvement. Senior leaders are now concentrating on improving the quality of social work practice.

The CSPoA has broadly sustained the improvements seen in the 2017 monitoring visit. However, weaknesses in some areas of practice seen at that time remain, and the quality of social work practice in child protection enquiries and assessments remains inconsistent. Despite this, the inspectors saw no cases where children were at immediate risk of harm.

Findings and evaluation of progress

The CSPoA includes a wide range of co-located and virtual partner agencies. Daily meetings are well attended and are effective in sharing information and making decisions about new contacts to the service. Practitioners within the CSPoA have a shared understanding and application of thresholds. Timescales for initial screening and enquiries are mostly met. The requirement to seek parental consent to share information is understood and appropriately sought or overridden if required.

Contact screening and referral decisions are undertaken by qualified social workers and are carefully overseen by assistant team managers. Information about the previous involvement of children's services with children and information from other agencies are promptly gathered and succinctly summarised to inform management decisions. Decisions about next steps are mostly appropriate and proportionate and are signed off by social workers and endorsed by team managers.

Thresholds are not always well understood by partner agencies. Partners are too reliant on children's services to determine the level of intervention. Too many referrals are made to children's services that do not meet the threshold for

intervention. This increases the work of the CSPoA and contributes to the comparatively high level of referrals. In a small number of cases sampled, the response to the initial contact or referral was not proportionate. The referrals did not meet the threshold for intervention, but comprehensive information gathering was still undertaken by the CSPoA. This is resource intensive and is unnecessarily intrusive for the families concerned.

The CSPoA provides a consultation service for professionals to talk through concerns with a qualified social worker. These exchanges are not recorded, resulting in the absence of an audit trail of decision-making that could then inform future decisions. Repeated and accumulating concerns are not captured, and decisions are therefore made in isolation.

A small number of children who need early help experience delays in receiving a service. This is due to a duplication of work within the CSPoA, repeated management decisions and further consent from parents being sought for early help enquiries. Leaders have already recognised this and are taking steps to streamline this part of the service. Comprehensive early help assessments capture children's voices well and feature well-balanced analysis to inform subsequent plans. Direct work with children is promoting an early engagement and understanding of the child's experience. However, this work is not always targeted or purposeful in meeting the needs identified in assessments. Effective systems are in place to step children up from early help to children's services when their needs increase. Work to better align early help services across partners and provide earlier support to children and families in universal services is progressing but not yet having an impact.

Children at risk are identified quickly in CSPoA and are allocated to a social worker without delay within the advice and assessment service. The process of access and assessment managers chairing strategy discussions is unhelpful. It leads to a duplication of work as the receiving assessment manager needs to appraise themselves of all necessary information to effectively chair the meeting. The threshold for holding strategy discussions and initiating subsequent child protection enquiries is appropriate in most cases. However, a small number of children's cases seen did not warrant this level of intervention, and a MASH enquiry and single assessment would have been a more proportionate approach.

Not all relevant partners contribute to strategy discussions. This practice was noted in the 2017 monitoring visit and has not improved. Given the co-location of partners in the CSPoA, this is a missed opportunity and potentially leads to gaps in the understanding of the child's circumstances, the early understanding of risks and initial safety planning. Very recently, police capacity has been increased and consideration is also being given to increasing health partner capacity in the CSPoA.

On occasions, police investigations take place without a strategy discussion to consider all available information or decide whether a joint investigation is needed. This reduces the quality of investigation and planning for children. The quality of recording of strategy discussions is variable. Most documents detail clear interim

safety and contingency plans for children, but others do not provide sufficient detail to understand decision-making and plans to progress a child protection enquiry. An absence of records of strategy meetings in a small number of cases and delays in promptly updating the child's electronic case record mean that important information may not be available to inform decisions if further incidents occur.

Most strategy discussions and child protection enquiries take place promptly, but a small number are delayed due to a lack of police or social work availability, potentially leaving children at risk. Most records of child protection enquiries are generally well written, providing a comprehensive analysis and leading to an early understanding and reduction of risk for children. However, a small number of records gave insufficient consideration to the level of parental engagement and family history when making recommendations.

The response to children who go missing is rigorously overseen through effective weekly multi-agency 'missing' meetings. Actions from these meetings successfully reduce risk to children. There are some delays in initial police notifications, but once they are received they are progressed quickly by the missing co-ordinator. Most return home interviews are timely and of a good quality. Strategy meetings take place when risks to young people are identified, and are effective in reducing risks. This reflects the positive findings of an earlier monitoring visit.

Caseloads in some teams are too high. A recent focus on the timely completion of assessments and transfer out of cases from the access and assessment teams is slowly beginning to have an impact.

The quality of performance management information is variable and sometimes poor. Data provided to inspectors identified 191 children who had not been seen by a social worker. Exploration of this during the visit indicated that this was a data and recording issue and that children had been seen. Discrepancies in information recording make it difficult for leaders to gain real insight into and understanding of the quality of social work practice.

The children's improvement plan is currently being revised and updated to reflect the six priorities of 'Brighter Futures for Children'. Senior leaders recognise that, while some limited progress has been made, the rate of improvement has been erratic and too slow. Some compliance-based performance indicators have improved, but the quality of social work is still inconsistent. A quality assurance framework and workforce development strategy has recently been developed and a principal social worker has recently been appointed. Previous monitoring visits have highlighted a recurring pattern of permanent staff being recruited, strategies being developed, plans being implemented, and improvements started but not sustained. Recently arrived leaders are rightly focusing their energies on trying to build stability within the workforce and improving the quality of practice.

Thank you and your staff for your positive engagement with this monitoring visit. I am copying this letter to the Department for Education. It will be published on the Ofsted website.

Yours sincerely

Tracey Scott
Her Majesty's Inspector