Wokingham

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: 12 October 2015 – 5 November 2015

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Children's services in Wokingham require improvement to be good

1. Children who need help and protection		Requires improvement
2. Children looked after and achieving permanence		Requires improvement
	2.1 Adoption performance	Good
	2.2 Experiences and progress of care leavers	Requires improvement
3. Leadership, management and governance		Requires improvement

[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

Children's services in Wokingham require improvement to be good. The leadership and governance arrangements in Wokingham are robust and effective and demonstrate many elements of good. However, first and second line management, which are vital, are not sufficiently rigorous in challenging, monitoring and driving social work practice to ensure that all services for children and young people are good.

The senior leadership team in Wokingham has a clear vision for service improvement and many of the essential components are in place to ensure further progress. Inspectors did not find serious or widespread concerns in the experiences of children and young people. However, the quality of practice remains variable and is not consistently good. Inspectors found that weak management oversight and supervision were common features in too many cases. Ensuring robust case supervision, management oversight and decision making by first and second line managers is crucial to improving social work practice and improving outcomes for children and young people in Wokingham.

Improvements achieved since the last inspection of child protection services in 2012, and safeguarding and looked after services in 2010, include well-coordinated services that provide targeted and specialist help at an early stage, reduced caseloads, early signs of the workforce stabilising and good adoption services. Senior leaders have been instrumental in effectively pursuing opportunities to secure additional funding through government-funded innovations and collaborative working arrangements. Adopt Berkshire and Signs of Safety innovations project are two positive examples.

A robust workforce strategy has begun to reduce a previously heavy reliance on agency workers, but a legacy of high turnover among social workers and managers has impacted on the quality of social work practice, management oversight and the timely progression of care plans. Staff have good access to training and are committed and positive about working for Wokingham. Performance information and quality assurance systems are under-developed and not sufficient to provide a clear picture of practice and to identify where action needs to address shortfalls and drive up performance. Joint commissioning of children's services is under-developed, although some key areas have been agreed as strategic priorities between partners.

In the vast majority of cases, children and young people in need of help and protection receive an effective and prompt response from the duty, assessment and triage team. Thresholds for services are clear, understood and applied effectively in most cases. In a small minority of cases, delays in holding strategy discussions and instigating child protection procedures resulted in children remaining in situations of unassessed risk. When referrals do not meet the threshold for children's social care, the early help hub, overseen by a social work manager, is ensuring that appropriate services are in place to support children and their families. The domestic abuse repeat incident management group provides an effective arena for additional multi-

agency scrutiny and risk assessment.
Where the Signs of Safety model is used to assess children's needs, there is an emphasis on risk factors and children are central to the assessment. Where it is not used, assessments are too adult-focused and overly optimistic, leading to drift and delay for some children. Assessments and planning processes for unborn babies and children under the age of three years are not sufficiently robust. Most children are seen and seen alone by social workers, and benefit from direct work using a range of tools to explore their experiences and perceptions. However, children do not always know how to contact their social worker or receive a prompt response when they do. Transition planning begins too late for disabled children.

When children need to be looked after by the local authority, decisions in the majority of cases are prompt and appropriate. There are, however, delays in considering plans for children's permanence. Foster carers are well supported but do not always receive the written decisions from children looked after reviews quickly enough. Work with partner agencies is not always effectively coordinated by social workers and their managers. There are insufficient local foster carers, despite extensive efforts to recruit more. As a result, almost half of children looked after are placed more than 20 miles from home. Child and Adolescent Mental Health Services are not sufficient to support all the needs of children looked after and care leavers with direct support or intervention. Life story work for children looked after is under-developed.

The virtual school has made significant progress in improving support to children looked after, including improved personal education plans. Placement stability for children looked after is good. The local authority appropriately considers placement of children looked after within their wider family and has encouraged and enabled the use of special guardianship orders. Arrangements to enable children to live with their foster carers after their 18th birthday are established and working well. Children for whom the plan is adoption receive a good service, with adoption plans pursued for all children who would benefit from it. Fostering to adopt is considered appropriately to avoid delay. Post-adoption support services are strong.

The quality and support to care leavers varies, with some not receiving the frequency of visiting they require or the level of help they need to develop independent living skills. A good choice of accommodation is available to meet the needs of care leavers with the vast majority living in suitable accommodation. The local authority is in touch with all their care leavers. Children looked after are able to have their voice heard and are well represented through the Children in Care council, with strong involvement with corporate parents.

Good progress has been made to tackle child sexual exploitation, with a multi-agency operational forum ensuring that information is effectively shared and children at risk of child sexual exploitation are identified and robustly assessed. Extensive awareness-raising has taken place with children in both primary and secondary schools. However, when children return after going missing, return interviews are not completed promptly enough and information from interviews is not collated to identify pattern and trends.

Contents

The local authority

Information about this local authority area[2]

Previous Ofsted inspections

- The local authority operates one children's home. It was judged to be outstanding at its most recent Ofsted inspection.
- The previous inspection of the local authority's arrangements for the protection of children was in November 2012. The local authority was judged to be adequate.
- The previous inspection of the local authority's services for children looked after was in July 2010. The local authority was judged to be adequate.

Local leadership

- The Director of Children's Services has been in post since February 2014.
- The chair of the Local Safeguarding Children Board (LSCB) has been in post since September 2014.

Children living in this area

- Approximately 36,497 children and young people under the age of 18 years live in Wokingham. This is 23% of the total population in the area.
- Approximately 7% of the local authority's children are living in poverty.
- The proportion of children entitled to free school meals:
  - in primary schools is 5% (the national average is 17%)
  - in secondary schools is 5% (the national average is 15%).
- Children and young people from minority ethnic groups account for 18% of all children living in the area compared with 22% in the country as a whole.
- The largest minority ethnic groups of children and young people in the area are Asian/Asian British and Mixed.
- The proportion of children and young people with English as an additional language:
  - in primary schools is 14% (the national average is 19%).
  - in secondary schools is 13% (the national average is 14%).
- There is a large settled Gypsy, Roma and Traveller population, some of whom are still travelling. There is also a newer Eastern European population resident in the area.

[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

- At 12 October 2015, 523 children had been identified through assessment as being formally in need of a specialist children's service. This is a reduction from 541 at 31 March 2014.
- At 12 October 2015, 67 children and young people were the subject of a child protection plan. This is a reduction from 95 at 31 March 2014.
- At 12 October 2015, one child lived in a privately arranged fostering placement. This is an increase from none at 31 March 2014.
- Since the last inspection, one serious incident notification has 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

- At 12 October 2015, 69 children were being looked after by the local authority (a rate of 20 per 10,000 children). This is a reduction from 75 (20 per 10,000 children) at 31 March 2014. Of this number:
  - 52 (or 75.3%) live outside the local authority area
  - two live in residential children's homes, of whom 100% live out of the authority area
  - seven live in residential special schools[3], of whom 100% live out of the authority area
  - 53 live with foster families, of whom 74% live out of the authority area
  - none lives with parents
  - two children are unaccompanied asylum-seeking children.
- In the last 12 months:
  - there have been two adoptions
  - two children became subject of special guardianship orders
  - 34 children ceased to be looked after, of whom three (9%) subsequently returned to be looked after
  - two 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 of multiple occupation.
- The local authority uses Signs of Safety as their social work model for child intervention work.

[3] These are residential special schools that look after children for 295 days or fewer per year.

Recommendations

1. Monitor and improve the frequency and quality of management oversight and supervision to all staff to ensure that they are regular, reflective and challenging and focused on ensuring good outcomes for children with rationale for decisions made clearly recorded (pages 13, 31, paragraphs 19, 94).

2. Improve the quality of casework audits, practice development tools and performance management information. Ensure that it is used effectively by managers to improve the quality of social work practice (page 32, paragraph 95).

3. Accelerate the implementation of the joint local authority and clinical commissioning group emotional health strategy to ensure better and quicker access to emotional and mental health support for children and young people (page 21, paragraph 53).

4. With partners, ensure that there is an effective integrated service pathway for all children and for young people in transition (pages 15, 26, paragraphs 27, 76).

5. Improve the quality of assessments and plans by:

   - ensuring that assessments include consideration of absent significant adults (page 13, paragraph 20)
   - ensuring that assessments are of a consistently good standard, supported by good analysis of risks and protective factors (page 13, paragraph 20)
   - ensuring that they consider and reflect equality and diversity factors (page 13, paragraph 21).

6. Put in place a pre-birth protocol and improve the assessment of vulnerable unborn babies and their families (page 13, paragraph 20).

7. Ensure that when a child goes missing from home or care, a timely return visit is completed and information from interviews is collated and analysed to inform service delivery (pages 15, 21, paragraphs 28, 51).

8. Ensure that strategy discussions include all relevant agencies (page 13, paragraph 18).

9. Ensure that children looked after can contact their social workers and that they receive prompt response to contacts (page 20, paragraph 46).

10. Ensure that early permanence planning is in place for all children (page 19, paragraph 38).

11. Ensure that care plans and actions agreed at reviews for children looked after are promptly disseminated and carried out and that work with partner agencies is effectively coordinated by social workers and their managers (page 23, paragraph 62).

12. Improve the quality of services to care leavers by ensuring that:

- visits to care leavers are purposeful and visiting frequency is according to their individual needs (page 26, paragraph 76)
- care leavers have access to opportunities to gain good quality independence skills (page 26, paragraph 75).

Summary for children and young people

- Inspectors found that services for children and young people in Wokingham require improvement to be good. Managers know what they need to do and plans are already in place to make most of the improvements that are needed.
- Social workers act quickly when children and young people need help and protection.
- Managers do not always make decisions quickly enough or pay attention to the progress or what needs to happen next for all children. This means that some social workers are not sure what they have to do and some children wait too long for support.
- Children and young people are listened to and the majority meet with their social workers regularly, but not all know how to contact them when they need to.
- Some children and young people have had too many different social workers. This makes it hard for them to get to know and trust their social workers.
- Families, children and young people are able to get the support they need when they are facing difficult problems. This helps them to make positive changes that improve their lives.
- Wokingham does not have enough local foster carers. This means children and young people live too far away, which makes seeing their family and friends difficult.
- Plans for children and young people who are in care or are care leavers vary. Some children and young people are not clear about what should happen, who is going to do it and by when. Planning for the future, especially for disabled children, does not take place soon enough or include what would happen if things do not work out.
- Most care leavers report that they feel well supported by their personal advisers. Opportunities for care leavers to remain living with their foster carers until they are ready to leave are successfully encouraged.
- Nearly all children looked after go to good schools and most attend well. Schools are well supported by the virtual school team to do their best for children looked after.
- Permanent families are not always found quickly enough for some children who cannot continue to live with their own families.
- When children need help to understand their life stories, this has not happened quickly enough.
- When children need to be adopted, this happens quickly. Children and their adoptive parents are well supported.

The experiences and progress of children who need help and protection	Requires improvement

Summary

The local authority knows that it needs to improve and develop frontline management oversight in order to effectively challenge the variability of social work practice. Nevertheless, children and young people who are in need of help and protection are identified and swift action is taken to make sure they are safe. Strategy discussions mean that correct decisions are made when there are concerns about risks to children, but they do not always involve all the appropriate people.

Children and young people benefit from effective early help and specialist services. Staff across the partnership are trained in Signs of Safety. This is ensuring that children across all age groups and their families benefit from appropriate help at the right time to reduce escalation of concerns. Skilled multi-disciplinary staff in the family resource team provide interventions that are making a difference to children's lives and preventing family breakdown.

The quality of assessments varies greatly, with particular weaknesses in the assessments of unborn and younger children. Where the Signs of Safety model is used, assessments are robust, identify risks and include safety plans.

Social workers use a range of tools to understand children's experiences. This helps social workers to build relationships with children. However, multiple changes in social workers and managers has contributed to drift and delay in implementing plans to support some children and has affected children's ability to sustain positive relationships with adults.

Effective multi-agency arrangements are in place for identifying and monitoring children and young people missing from home and care and those at risk of sexual exploitation. However, return interviews for children who go missing are not completed quickly enough and information from interviews is not analysed to form a picture of patterns and trends.

A specialist team works with disabled children and provides appropriate child-focused work from skilled practitioners. Co-located services enable timely access to early help. Transition arrangements to adult services need to be strengthened to ensure collaborative early planning.

Effective arrangements are in place for young people aged 16 to 17 years who become homeless.

Inspection findings

13. Children and young people in Wokingham benefit from a range of well-coordinated services that provide targeted and specialist help, underpinned by a coherent multi-agency 'early help innovation' strategy. There is good partnership working and full commitment to developing the Signs of Safety model. Appropriate training is in place for all partners who are involved in supporting children and young people who need early help.

14. The local authority has continued to invest in a good range of effective and targeted youth support services as part of its early help offer. Skilled multi-disciplinary staff in the family resource team (FRT), children's centres and youth workers provide interventions that are making a positive difference to children's lives. Youth workers provide effective support for young people who need targeted short-term support to help them develop positive skills and behaviours. For example, some well-focused work with young people in danger of exclusion from school through misuse of drugs has helped them to remain in mainstream education.

15. A recently refreshed threshold of need document is understood and effectively applied by agencies and practitioners. The early help triage provides a clear pathway to early help services. The early help hub, established in August 2014, provides robust multi-agency consideration of the most appropriate early help support for children and their families. A well-coordinated weekly multi-agency meeting gives timely consideration to all requests and promptly identifies the most relevant agency to support the family. Good oversight from the referral coordinator helps to determine progress for children and young people from the time of the referral. Between June 2014 and June 2015, 1,412 children and young people received early help services, delivered directly with either the child or young person or through family-based interventions designed to improve outcomes for those children. The local authority's own data show that 61% children had improved outcomes as a result of this intervention.

16. The majority of early help assessments sampled during the inspection were good. Recent assessments, which used a new format developed as part of the work to introduce the Signs of Safety, were particularly good. In a small number of cases, assessments required improvement due to poor recording of the voice of the child, delay from initial contact to assessment and delayed provision of parenting courses. Step-up and step-down processes are effectively ensuring that children and their families get help at the right time and right level.

17. 'Troubled families' work in Wokingham has been positive in achieving results. By May 2015, 110 (100%) troubled families identified had been worked with and their circumstances improved. Phase two has been launched and the target of identifying 60 families out of a group of 350 has been achieved.

18. Children and young people who are at risk of actual or likely harm are appropriately identified and responded to by the duty assessment and triage team. The response to concerns and the provision of services is timely and

appropriate. In most cases, risk is reduced effectively. Efficient arrangements are in place to respond to requests to children's services for information and advice. Referral coordinators receive contacts and referrals overseen by experienced and suitably qualified social work staff. An experienced, qualified manager undertakes all decisions in the team effectively. Parental consent is appropriately sought before carrying out agency checks. In most cases seen by inspectors, the use of the Signs of Safety model has resulted in a greater clarity of risk and need, ensuring that the right interventions are in place.

19. When child protection referrals lead to strategy discussions, they generally take place between police and social care only. This means that information from other agencies is not always available to inform decision-making. The local authority, in partnership with police and other partners, has started to address this. Quality standards have been agreed and the associated training days secured, although it is too early to evidence impact of these changes. The recording of strategy discussions is variable, with some lacking historical information. This compromises opportunities to fully understand risks to children and young people. In a small number of cases referred to the local authority, delays in holding strategy discussions resulted in children being left in situations of unassessed risk. By contrast, strategy meetings observed by inspectors were prompt, with appropriate agencies present. Managers chaired the meetings well. They resulted in good-quality decisions and subsequent work that was focused on risk and the needs of children.

20. While management decision-making and oversight of casework is evident in the majority of cases seen in the duty assessment and triage team, practice in the long-term neighbourhood teams is weak. Management oversight is documented on children's case files. However, the frequency, quality and rationale for decisions made is insufficient, with some having significant gaps in case records. This means that previous actions are not robustly reviewed for their completion or effectiveness and management direction is not available to social workers when risks to children increase.

21. Chronologies are available and maintained in most cases, although the quality is variable. More recent chronologies are good and have been used effectively to inform assessments. The quality of assessments varies greatly. In nearly all assessments, the voice of the child was present and their wishes known. However, the majority required improvement, as they failed to assess the impact of fathers and other significant males in children's lives, and were overly optimistic in parental motivation to change. In particular, the assessments of unborn and younger children lacked sufficient analysis of risk to inform effective planning.

22. Issues of equality and diversity such as ethnicity, sexual orientation and faith are commented on but the impact is not sufficiently considered within assessments and plans.

23. Social workers are knowledgeable about the children they are working with. Children are visited and seen alone frequently. Social workers use a range of tools to understand children's experiences. This helps social workers to build

relationships with children. However, frequent changes of social workers hamper this work and have contributed to drift in meeting the needs of some children promptly.

24. Child protection conferences and reviews of child protection plans are timely and attended by an appropriate range of agencies. Most social work reports for initial child protection conferences provide a good assessment of risk and protective factors, leading to appropriate decisions. However, reports prepared for review child protection conferences are not always timely and vary in quality, resulting in poor planning for a small number of children. Where practice falls below standards required by the local authority, child protection chairs take effective action to compensate or escalate to responsible managers.

25. Wokingham independent reviewing officers (IROs) also chair child protection conferences. They have manageable caseloads that include both children looked after and those subject to child protection plans. Inspectors observed effectively and sensitively chaired conferences, with participants' views sought and good engagement with parents. Parents and young people report that they are clear why professionals are worried and what they need to change. Overall, child protection plans identify the appropriate action that is needed to reduce risk and meet children's identified needs, but not all actions are specific and measurable.

26. A commissioned service provides advocacy support to 28 children and young people to attend conferences and ensure that their views are captured. Core groups and children in need meetings are held within or close to timescales set by child protection plans, and reviewed regularly. They measure progress against actions effectively. Business support staff comprehensively record the minutes from meetings. This is a valuable resource and ensures that actions and plans arising from meetings are readily available to social workers, children and young people, parents and professionals involved.

27. Children's social care and police have a good, shared understanding of the risks to children from domestic abuse. This understanding is set out with a clear range of actions in an up-to-date domestic abuse strategy, sponsored by the Community Safety Partnership and the Local Safeguarding Children Board. Robust arrangements for the screening of domestic abuse notifications are in place. The domestic abuse triage – involving staff from children's social care, a voluntary organisation working with women who suffer from domestic abuse, and the police – meet daily to effectively prioritise referrals. Multi-agency risk assessment conferences (MARAC) enable an effective coordinated multi-agency response and approach to risk in relation to children living in households where there is domestic abuse. The domestic abuse repeat incident management (DARIM) group adds additional multi-agency scrutiny and risk assessment. This proactive approach provides earlier coordinated intervention to lower-level repeat domestic abuse cases that do not meet the MARAC threshold. Cases are escalated effectively and access to a good range of services is available. Case sampling demonstrated good information-sharing, shared analysis and

robust action to secure the safety and well-being of children. The domestic abuse strategy is comprehensive and includes female genital mutilation as a form of abuse, although Wokingham's known prevalence rates are low.

28. A specialist team works with disabled children and provides appropriate child-focused work from skilled practitioners. Co-located services enable timely access to early help. For example, the 'Bridges' team provides a range of short breaks and outreach services to young people with learning difficulties. However, transition planning to adult services begins too late for disabled young people, with some not being assessed by adult services until they are almost 18. These arrangements need to be stronger to ensure collaborative early planning with adult services for young people with complex needs.

29. The arrangements for responding to the needs of children and young people who go missing have been strengthened, with an operational panel in place and a commissioned service providing independent return interviews. Staff make contact with all children and young people who go missing to offer a return interview. The team received 22 referrals between July and September 2015. Of these, only one young person was visited within 72 hours. A further 14 children declined an interview despite persistent efforts to engage them. In cases sampled by inspectors, interviews included the views of young people and an analysis of risk. Return interviews completed by individual social workers were timelier. The local authority is now taking effective action to improve the timeliness of return interviews for all young people.

30. Children missing education are carefully monitored and tracked. Of the 66 children who have been missing from education over the last academic year, only 27 have periods of missed education during the current term which is a significant improvement. Managers are notified by schools when a child misses education and timely checks are made with appropriate agencies. Plans are in place to improve the links between children missing education and children missing from home panels, which has the potential to improve the scrutiny of those absent from school.

31. The multi-agency child sexual exploitation and missing persons operational group meets monthly. Management oversight and assurance is secured through a child sexual exploitation strategic and operational governance structure shared jointly and co-chaired between children's social care and the police with regular reporting to the Local Children's Safeguarding Board. There is effective alignment to the early help hub and the children missing from education panel. Panel members routinely review individual children's circumstances and the levels of risk they are exposed to. Rigorous scrutiny of information is used to plan and to provide services designed to reduce risks.

32. At the time of the inspection, the child sexual exploitation panel was monitoring six children. Cases reviewed by inspectors demonstrated interventions were proportionate to the assessed risk. The numbers have remained low and are in keeping with the profile of the local authority. The

prevalence of risk is predominantly from lone offenders targeting adolescent girls through social media and through friendship groups. Child sexual exploitation champions are actively disseminating good practice and available to social workers for consultation. Members of the champions group are piloting a revised assessment tool to assist in the assessment, analysis and planning for young people deemed to be at risk.

33. The local authority maintains a list of children and young people who are electively home educated (EHE). Currently, 77 young people are EHE. Appropriate agencies checks are completed to identify any concerns. To date, 57 children and young people have been visited at home to ensure the appropriateness of their education. There are plans in place to visit the remaining 20 children. A very small minority of EHE children are known to children's social care. Nine children have started or resumed mainstream education because of the constructive support provided by the local authority. Only one child out of 29 who are in alternative educational provision is looked after. The majority of children who are in alternative provision are there because of medical issues. Plans are in place for all to return to full-time education.

34. The emergency duty service (EDS) is effective and shared with six neighbouring unitary authorities across Berkshire. It has sufficient capacity to respond to all children who need help and protection out of hours. In the cases seen by inspectors, the EDS had responded well, with appropriate direct intervention with families, clear and timely decision-making and prompt two-way communication with daytime services.

35. Arrangements for responding to allegations about risk presented by adults in a position of trust in relation to children are satisfactory. The recently appointed designated officer initiates action appropriately in respect of such allegations, in accordance with established systems. Cases seen by inspectors demonstrate a good response, with prompt and appropriate steps taken to protect children and active follow-up to ensure that outcomes for children are good.

36. The local authority received no notifications of known or suspected private fostering arrangements between 2011 and 2014. In the last year, considerable efforts have been made to sharpen inter-agency awareness of children and young people who are privately fostered. At the time of the inspection, a small number of children were living in a private fostering arrangement, having had an assessment that was thorough and culturally sensitive, with a plan of support to both child and carer. Robust arrangements are in place to review private fostering arrangements. Children living under private fostering arrangements are reviewed every six months by an IRO. This provides additional scrutiny to such arrangements.

37. Effective arrangements are in place for young people aged 16 to 17 years who become homeless. Good collaborative arrangements with the Wokingham housing service mean that assessments take place swiftly and appropriately. When necessary, young people become looked after or appropriate accommodation is provided.

The experiences and progress of children looked after and achieving permanence	Requires improvement

Summary

Outcomes for children looked after in Wokingham are not yet good because services are not consistently meeting the needs of all children.

Effective action is taken to ensure that children and young people looked after are promptly supported and there is no delay in progressing matters through the courts. However, permanence planning has not been considered at an early enough stage. This has led to drift and delay for some children and young people.

Some children looked after and care leavers seen by inspectors reported poor experiences with their social workers. Overall, they did not feel that social workers respected or listened to their views. They felt that social workers often did not keep their word or keep appointments made with them. The legacy of difficulties in recruiting and retaining social workers and managers for children looked after has adversely impacted on the consistency and quality of work, the progression of care plans and the ability of children looked after to form trusting relationships with social workers. The local authority has worked hard to stabilise the workforce, which is beginning to reduce the number of changes of social workers children experience.

Overall, the educational needs of children looked after are well supported. However, until recently, their health needs have not been promptly assessed or reviewed and they do not always receive prompt support for their emotional health.

The local authority's foster carers are well supported. However, the number of local carers is insufficient, despite extensive efforts to recruit more. As a result, almost half of children looked after are placed more than 20 miles from home. This adversely impacts on their contact, relationships and travel time.

When children go missing from care, return home interviews are not completed quickly enough to understand the child's experience and to reduce the risk of further missing incidents.

Children looked after are able to have their voice heard, and are well represented through the Children in Care council, with strong involvement of corporate parents.

Adoption is appropriately considered as a permanent option for all children who cannot live with their birth family. There is a good range of post-adoption support to meet children's needs.

The quality of pathway planning for care leavers is too variable, with some plans not sufficiently outcome-focused or providing enough detail about who will do what, and by when. Care leavers would benefit from greater levels of support through more frequent visiting from their personal advisers.

Inspection findings

38. At the time of the inspection, the local authority was looking after 69 children. Thresholds for entry to care are applied appropriately in almost all cases. There were no cases seen where children had been put into care inappropriately. In most cases where children were looked after on a voluntary basis, this was appropriate. However, during this inspection, the local authority had to take legal advice to ensure that the care status of two children was secure.

39. Undue delay in considering permanence planning has negatively impacted on too many children and young people looked after and their ability to have a clear understanding of what is likely to happen to them. It also means that care plans are not as effective as they should be in securing permanence as soon as possible. This has been recognised by the local authority, which in June 2015 established a permanence planning panel. The panel is systematically reviewing children looked after cases to ensure that the permanence planning is robust. This focus has ensured that permanence planning for those children received into care in recent months is now more robust.

40. In the few cases where children were looked after with plans to return home from care, all demonstrated careful planning supported by assessments, with review arrangements in place and appropriate continuation of plans after care.

41. Children's cases that are subject to letters before action, the pre-proceedings phase of the public law outline (PLO), are regularly reviewed. Letters before action are clear, stipulating the concerns and the actions required by parents/carers and by when. Tracking meetings between managers and the local authority's legal services provide robust oversight. The local authority engages effectively with the local courts and is an active participant in the work of the Local Family Justice Board. This has enabled cases to progress through the courts without undue delay, with an average for the area of 30 weeks in 2015. However, this does not meet the national requirement of 26 weeks. The local authority with advice from the legal team has reviewed all children who are looked after on a voluntary basis to ensure that these do not warrant intervention through the courts; all were assessed to be appropriately accommodated under section 20 of the Children Act 1989. While aware of the changes in social workers in some cases, the courts had not experienced any negative impact of this on timetabling or the quality of social work in the courts.

42. The local authority considers placement of children looked after within the wider family appropriately, and has encouraged and enabled the use of special guardianship orders. During 2013–14, 10 special guardianship orders were achieved, but in 2014–15, only two were achieved. The local authority is reviewing relevant children, through the permanence panel, to ensure that special guardianship orders are consistently considered.

43. Assessments of children looked after are regularly updated in almost all cases and contain a clear analysis of issues affecting them and their needs. However, some assessments lacked detail or were insufficiently focused on the immediate needs of that young person. Assessments did not consistently consider diversity issues for children looked after. This was stronger where diversity issues were prominent, such as for disabled children, where those needs were thoroughly assessed and taken into account in case planning.

44. Work with children looked after between reviews was not consistently well coordinated. Those cases that were good had effective joint working to further the care plan, but others showed a lack of coordination and failure to share information or fully involve all relevant agencies, which impacted negatively on how plans were progressed. This was exacerbated where there had been changes in social workers.

45. Overall, social workers visit children looked after regularly and see them alone where appropriate. However, in some cases, the purpose of the visit was primarily to meet minimum visiting requirements, with little evidence of purposeful direct work. Children and foster carers who met with inspectors confirmed this. In a small number of cases, where children had moved placement, minimum visiting standards set by the local authority had not been met. This was because of social workers not being clear about the required frequency of visits. This was identified and addressed by managers.

46. Social work caseloads for children looked after are manageable. This enables them to undertake direct work including life story work. However, a number of children looked after, foster carers and IROs have voiced the need for life story work for children and young people who have not received it. Despite being well resourced, with manageable caseloads, high turnover among social workers and managers for children looked after has impacted adversely on the consistency and quality of practice, management oversight and the timely progression of care plans. This also negatively impacted on the relationships that social workers were able to establish with young people, their carers and families.

47. Children looked after and care leavers seen by inspectors said they did not feel that social workers always respected or listened to their views. They felt that social workers often did not keep their word or keep appointments made with them. They gave many examples of trying to contact their social workers, but not receiving a response. They expressed particular concern about frequent changes of social worker and that often social workers did not inform them directly or say goodbye to them when they left or changed roles. The local authority has made significant progress in stabilising the workforce and has more recently successfully reduced the number of changes of social workers for children looked after. However, some children looked after are still affected by the legacy of previous workforce instability.

48. Young people value the support from advocates, with 42 children and young people looked after being supported by this arrangement.

49. Reviews for children looked after are timely and are well attended by the appropriate range of agencies. The meetings are well structured and chaired to ensure that information is considered in all key areas affecting the young person. Overall, plans are clear, with updated measurable outcomes, and they include the views of young people. However, not all had actions that were specific and measurable. Some showed drift in permanence planning or contingency planning, with not all actions completed in a timely way. Some plans were too vague or lacked clarity or detail.

50. Contact arrangements between children looked after and their families were clear, with due consideration of safeguarding issues. However, young people seen by inspectors reported that they seldom understood the reasons for their contact arrangements. 'Strengths and difficulties' questionnaires are completed in most cases but are not consistently used to maximise planning for children looked after. For example, they are not routinely shared with health partners to inform health assessments.

51. The small team of permanent IROs demonstrates a robust understanding of how effectively the needs of children looked after are met. They meet regularly with children and with social workers in and outside of reviews and maintain the same reviewing officer, where possible, to provide consistency for the young person. Where practice falls below required standards, IROs initially use informal methods to address these. Where this does not resolve the matter, appropriate use of dispute resolution notifications is made.

52. A commissioned service undertakes return interviews following incidents of children and young people going missing. However, the interviews are not timely and the take-up by children and young people is low. Between July and September 2015, 14 children out of 22 referrals received by the service declined an interview and only one was within 72 hours of the child returning from a missing episode. As a result, important information is not captured and the risk of repeat episodes is not reduced. Inspectors saw more timely return interviews where individual social workers had completed them. The Pan Berkshire child sexual exploitation indicator tool is used to identify and assess risk. Cases seen by inspectors demonstrated clear risk assessments and issues being presented to the child sexual exploitation and missing operational panel.

53. The health needs of children looked after have not been consistently addressed. Initial and review health assessments were significantly delayed between March 2014 and May 2015 as a result of staffing issues in the small looked after children health team. This has recently improved, with all health assessments being brought up to date at the time of this inspection.

54. Children looked after are prioritised by local Child and Adolescent Mental Health Services (CAMHS) for assessment. However, few are provided with direct support or intervention. CAMHS do provide advice and guidance to children looked after's social workers and foster carers, which is greatly valued, and all expressed a need for much more therapeutic support to address the complex emotional and behavioural needs of the looked after young people. Where CAMHS intervention is not available, alternative

bespoke therapeutic provision is commissioned by the local authority. The local authority and its partners were developing the range of emotional and mental health provision for children and young people at the time of inspection.

55. Following re-launch in April 2015, the virtual school has made significant progress in improving support to the educational needs of children looked after. Key improvements include improved personal education plans (PEPs) that are reviewed and updated for every child on at least a termly basis. A member of the virtual school team attends every PEP meeting. Plans that are more recent are of better quality. Further improvement is required in the analysis of the impact of the Pupil Premium on improving progress.

56. The vast majority of children looked after are in good or better schools. The three children in schools that require improvement are carefully monitored to ensure that they get the support they need, where broader permanence factors outweigh the benefits of moving them to a good school.

57. The educational attainment gap between children looked after and all children is closing at Key Stage 4. Half of the small number of children at this level achieved at least five GCSEs at grades A* to C, including English and mathematics, which is well over twice the national rate for children looked after. Just over half of children looked after have identified special educational needs. Overall, the majority of children looked after make expected or better progress, although those in Key Stage 2 do not do as well as others.

58. Sufficiency of local placements is a priority for the local authority. A clear and detailed sufficiency strategy to meet the placement needs for children looked after and care leavers for 2014 to 2017 has been reviewed. However, despite the extensive and wide-ranging campaigns in recent years, the local authority has not achieved its own targets for the recruitment of local foster carers and supported lodgings for care leavers. Efforts to recruit local carers were being renewed at the time of this inspection.

59. In the past 18 months, the local authority has renewed efforts to place children looked after more locally and within 20 miles of the area. This has resulted in around half of children looked after being placed closer to home. While every effort is made to ensure that the needs of those young people are promptly met, the distances have a negative impact on the ability of those young people to maintain local contacts. Also the distance adversely impacts on how readily social workers and IROs see children, with excessive time taken up with travel.

60. Placement stability for children looked after is good and almost all are living in high-quality placements, in suitable accommodation, that take account of the wishes of the children and young people. Overall, children looked after are in foster or residential placements that are meeting their needs. Clear arrangements are established for managing situations where standards in residential or foster placements are not of the level required by the local

authority. Arrangements to enable children looked after to remain in placements beyond their 18th birthdays are now well established and are working well for those young people.

61. The fostering panel is well established, with diverse representation from a range of people, including a former looked after person. New members and a new chair were appointed in early 2015 and have received training to underpin their role. The panel meets regularly and carries out its core duties robustly. Information provided to the panel is of a high standard, with few cases being deferred for further information. Social workers and foster carers presenting to the panel are consistently able to respond to questions, which enables the panel to reach its recommendation immediately. Over the past year, appropriate and prompt action has been taken to de-registered foster carers in a very small minority of cases.

62. Foster carers report that they generally feel well supported by the local authority and by their supervising social workers. Almost all report that they received thorough induction training and were able to access further training, or information, to enable them to support the complexity of needs of the children and young people they care for. Foster carers are able to raise concerns with their supervising social workers and are confident of how to escalate these with managers. However, foster carers expressed frustration at the frequent changes of social workers that children in their care experience, often without notice, and the negative impact that this had on the young persons' willingness to trust or engage with other social workers. Foster carers report that often actions or care plans are delayed where social workers are temporarily allocated to children.

63. Foster carers report that they are clear about the plans for children looked after and that they are able to contribute to these, particularly through children looked after reviews. However, they often do not receive the minutes from these reviews until the next review. When they are not able to attend, they are not always aware of any changes in the plan or actions required from them.

64. Children looked after who met with inspectors report that they are well represented by the Children in Care council and that it enables their voice to be heard by the local authority. Those on the council feel that they are listened to and are treated with respect. Young people looked after receive free passes to the local authority commissioned leisure provision and are supported to participate in Duke of Edinburgh programmes and in running a football team. Children and young people looked after actively participate in the corporate parenting board and are involved in the development of information for young people, such as the pledge, the care leavers' charter and health passport. They have undertaken questionnaires with peers to gain wider views that influence the work of the corporate parenting panel.

The graded judgement for adoption performance is that it is good

65. Adoption is appropriately considered as a permanent option for all children who cannot live with their birth family. The local authority is part of Adopt Berkshire, a collaborative arrangement with three other neighbouring local authorities. The agency decision maker (ADM) arrangements are effective, with each local authority participating in a tenure taking responsibility for oversight of the panel. The head of service for Wokingham, informed by relevant legal and specialist advice, effectively determines all decisions in Wokingham children's cases. Decisions are documented in children's files supported by clear rationales.

66. Berkshire Adoption Advisory Service (BAAS) administers the adoption panel, which serves six local authorities across the county. The panel adviser is the service manager for both Berkshire Adoption Advisory Service and Adopt Berkshire and provides an effective link between the panel and senior managers in the local authority. The adoption panel is chaired well. It meets twice a month to avoid any delay and provides effective scrutiny and oversight of the approval of adopters and matching recommendations.

67. The local authority performance against the Department of Education (DfE) adoption scorecard of the average time taken from when a child enters care to moving in with their adoptive family has deteriorated from the 2011–14 figure of 600 days to 669 days during 2012–15. This is outside the government target of 487. This performance reflects a small number of harder to place children, staffing challenges and the transitions arrangements to Adopt Berkshire. Performance over the last year has significantly improved, with the local authority's own data demonstrating an average time of 425 days. The time between the granting of a placement order and children moving to their adoptive family is 92 days. This is significantly better than the government target of 121 days, the national average of 217 days and statistical neighbours average of 196 days. This means children are placed quickly with their new families once a placement order has been made.

68. Decisions not to pursue a plan for adoption are carefully considered and timely alternative permanence plans are progressed. Rigorous and effective oversight by managers and the adoption agency manager mean that child permanence reports (CPRs) help agency family finders to secure the right family for a child. The CPRs seen by inspectors were well written and provided a good standard of information about the child, their history and the circumstances that led them to be considered for adoption. They identify the child's current and potential long-term needs.

69. Adopt Berkshire recruit, prepare and assess all Wokingham adopters. During 2014–15, only two of 13 adoption applications were approved within six months, with the average length of time from application to approval being 38.5 weeks. This is well below the national target of six months from

application to approval. The majority of these delays were due to the individual circumstances of prospective adopters and the transition arrangements to Adopt Berkshire. The timeliness of applications during 2015–16 is improving significantly, with the majority completed within the government's six-month target. Adopt Berkshire actively promotes fostering for adoption placements to reduce delay for children. Prospective adopters are encouraged to consider this option. Adopt Berkshire has arranged five fostering for adoption placements to date including two from a neighbouring authority. However, the local authority is not sufficiently promoting concurrent placements as a potential option for children locally and nationally.

70. A social enterprise company, sponsored by the DfE and run by adopters, provides peer mentoring for prospective adopters through the period of assessment to matching. They provide a range of support, which includes specialist individual support, therapeutic parenting and group training, which continues after approval. Adopters spoke highly of the training and support they receive.

71. The quality of prospective adopters' reports is good. They are clear, concise, and evaluate adopter's experiences and their suitability to adopt. Adopters told inspectors that they found the approval process appropriately challenging, it was facilitated by staff who were knowledgeable and reliable and supported them sensitively.

72. Adopt Berkshire has a sufficient number and range of adopters available to meet the needs of children with a plan for adoption. Currently, there are adopters waiting to be linked to children, which is a national trend. Wokingham adopters receive timely referral to the adoption register and adoption link. Adopters who are waiting are prepared and supported well. This support is enhanced by the agency's placement officer, who has regular contact with adopters both informally and through monthly profile meetings. The service is working actively to help adopters to develop their confidence in caring for children who are older or who may have needs that are more complex. As a result, no children are currently waiting to be linked or placed with potential adopters.

73. Good preparation for children with plans for adoption is in place. Children are effectively supported by social workers and foster carers and have access to therapeutic support to assist in the transition. This high level of support has enabled children with significant complex needs to achieve permanence through adoption. Therapeutic life story books and later-life letters are of good quality and routinely addressed as part of the reviewing process for all children considered for adoption. As a result, children live in adoptive placements where their adopters have material available to them to support children to make sense of their past experiences. Children's racial and cultural heritage are well considered in plans.

74. Good post-adoption support is available for both adopters and children to ensure the future stability of adoptive families. Adopters confirmed that they are aware of the range of services available within the partnership and

externally. Twelve requests for assessment for post-adoption support resulted in all families receiving support services. Four successful applications have been made to the adoption support fund for individual specialist support packages. There have not been any recent adoption breakdowns. Inspectors also saw evidence of good-quality support offered to older young people living in Wokingham who had been adopted in other areas. These young people benefited from effective help because the authority is informed about the needs of adopted children and adopters at all stages in the adoption process.

75. The local authority offer support services to birth parents, with the service supporting 13 adults since 2012. Letterbox arrangements are in place for over 100 cases and a small of children are supported with ongoing direct contact with their birth family.

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

76. The local authority children looked after and care leavers team, Here4U, currently works with 29 care leavers. Personal advisers have manageable caseloads and work with young people to support them emotionally and to secure housing and independence. However, the quality of this support varies, with some care leavers not receiving the level of help they need to develop independent living skills. As a result, a small number of care leavers are not adequately prepared for a successful move to adulthood. Planning and progress towards independence is also hindered for some disabled young people by a lack of timely coordination and joint planning with adult and specialist services.

77. Personal advisers visit young people in line with statutory requirements, but many visits lack purpose and do not meet the young person's needs. In some cases seen by inspectors, young people would benefit from greater levels of support through more frequent visiting. Young people themselves identified this in a survey conducted by the Children in Care council to determine whether the promises set out in the Care Leavers Charter had been delivered. Overall, there is insufficient management oversight and the standard of service young people receive is too variable.

78. Care leavers spoken to expressed their frustration about frequent changes of social worker, which prevents them from developing trusting relationships. Some young people were more positive about the work of their personal advisers, with one describing her personal adviser as a 'rock'. Another care leaver was very unhappy with the service received from a succession of social workers and said that the service received now, from their personal adviser, demonstrated to them what they should have received previously.

79. The quality of pathway planning is too variable, with some not sufficiently outcome-focused or providing enough detail about who will do what and by when. Too many plans are not reviewed according to the changing needs of the young person or in line with statutory guidance. As a result, young people are not consistently challenged when they make poor choices or decisions or when their needs and circumstances change. Plans and reviews lack contingency planning and, as a result, personal advisers are not always as responsive as they should be to the changing circumstances of young people. There is also a lack of independent oversight in reviewing pathway plans. The introduction of 16-plus PEPs is, however, a very positive addition to the planning pathway for care leavers.

80. The local authority is in touch with all their care leavers. The vast majority live in suitable accommodation and have a good choice of accommodation, with the offer of additional help and support from tenancy sustainment officers. Young people who met with inspectors advised they felt safe and were satisfied with their accommodation. There is no set limit on the number of housing offers made to young people through the well-developed arrangements with the housing department, which include access to housing association and privately rented property. Young people are encouraged to remain in their foster placements after their 18th birthday through staying-put arrangements, which are also available to young people placed with independent fostering agencies. Currently, two young people are benefiting from this arrangement. At the time of the inspection, no young people were homeless or living in bed and breakfast accommodation.

81. Young people are actively encouraged to pursue healthy lifestyles and to address unhealthy choices. Sexual health workers take part in care leavers' events to encourage young people to access services and information is provided on health promotion and substance misuse. Personal advisers are aware of the risk of child sexual exploitation and of the local authority's procedures for investigating and addressing this risk. The children looked after health team undertakes the assessments for those aged 16 and over. Young people have the opportunity to discuss their health histories with a specialist nurse at their final health assessment. A health passport is available to young people and for those who decline the offer the information is kept securely until they are ready. However, young people do not have timely and effective access to CAMHS and therapeutic services to meet their assessed needs. The co-location of a CAMHS worker in the service for part of the week is a positive development but has not yet had a significant impact and care leavers wait too long for CAMHS services.

82. The enhanced midwifery and health visiting service supports care leavers who are parents or expectant parents and works closely with personal advisers. A high number of care leavers are parents (31%); these young people are actively encouraged to engage in activities and programmes on offer in children's centres through a special project undertaken this year. Children's centre staff make contact with all care leavers who are parents and encourage them to engage in the activities and services on offer. These include parenting and support groups and education and training to help

young people to plan for their futures. The local authority is actively working to increase the support offered to these young people with plans to improve the link to Family Nurse Partnership support for care leaver parents. There are also plans to develop a targeted positive activity and sports service for female care leavers, prioritising care leavers who are mothers.

83. The local authority football team for care leavers, Here4U United, has been particularly successful in engaging young people who had previously withdrawn from their personal advisers. Here4U has had a positive impact on young people's health and self-esteem, with young people having secured employment or training linked to potential employment opportunities.

84. Good written information is available to young people to help them understand their financial rights and entitlements. Young people spoke positively about the 'pledge' and the support they receive from the children's rights officer who actively advocates on their behalf. The authority celebrates the achievements of young people by running events that included care leavers. Young people have access to leisure provision and participate in Duke of Edinburgh programmes.

85. A broad range of well-coordinated support is available to care leavers to help them successfully transition to employment, further education or training. This includes access to good information, advice and guidance throughout the care-leaving transition period.

86. The destinations of all care leavers are tracked effectively and the majority are in education, training or employment. The 10 care leavers who were not in education, employment or training (NEET) at the time of inspection were continuing to receive support and managers knew their individual, mainly challenging, circumstances very well. Although this represents a comparatively high proportion of care leavers, inspectors could not identify any specific lack of support that had contributed to these young people being NEET.

87. Wokingham has one care leaver apprentice and has set improvement targets to employ seven vulnerable young people as apprentices next year. Although care leavers form part of this group, none of these planned apprenticeships is specifically targeted to help Wokingham care leavers. Apprenticeship opportunities are also identified within commissioned services, for example six apprenticeships for care leavers working in leisure centres.

88. Having secured funding through 'City Deal' in autumn 2014, the authority's 'Elevate' initiative has successfully established a much enhanced, easily accessible 'one-stop-shop' that supports young people into work, education or training. Innovative approaches to linking with local employers to develop the skills that meet the needs of local employers help improve employment prospects.

89. Links with local colleges and training providers have been established and have enabled a range of opportunities for care leavers to develop their work-

related skills so that they are ready for traineeships, apprenticeships, or further education courses. These include work placements with local employers, courses that develop work-related skills and a project that provides training and support to help young people set up their own businesses. One care leaver was on a higher education course.

90. A notable strength of the local authority is listening to and acting on the views of children and young people. Following feedback from care leavers, the local authority has funded an additional part-time post to support care leavers aged over 21.

Leadership, management and governance	Requires improvement

Summary

The director of children's services (DCS) shows strong and tenacious leadership that has impacted positively on the service, the local authority and wider partnerships since she came into post in February 2014. As well as a clear vision, she holds an accurate picture of the service she leads. With the support of her senior leadership team, she is driving plans to strengthen the service. A comprehensive annual report and updated self-assessment identifies many of the deficits seen in this inspection. Good use has been made of findings from external audits and a peer review to help target priority areas for improvement. A quality improvement plan with clear priorities is in place and is used effectively to monitor and review progress. However, these elements of good leadership and governance have not yet secured consistently good outcomes in social work practice and frontline management.

The DCS, chief executive and lead member discharge their statutory responsibilities effectively and are well known to frontline staff in the service. Partners are confident in the DCS, with evidence of police, health, and education working closely together to implement the early help model. As a result, a robust early help offer and a 'front door' to children's services are in place that effectively assess risk and ensure that the needs of children and families are correctly identified and timely services put in place. Thresholds for services are clear to agencies and operate effectively.

The local authority has taken significant steps to stabilise its workforce and is able to demonstrate success, both in reducing its reliance on the use of agency staff significantly and in retaining staff. There is strong multi-agency partnership working in relation to children at risk of child sexual abuse and those who go missing and a range of policies, procedures and practices in place to minimise that risk. However, further work is required to improve the timeliness and take-up of return interviews.

Quality assurance arrangements are under-developed. Internal case audits are not demonstrating rigour in judgements about the quality of work carried out. The quality and frequency of social work supervision is too variable and not in accord with the local authority's policy standards. As a result, a small number of children experience delay in having their needs met. The corporate parenting board is ambitious about the service and opportunities provided to children looked after. Corporate parenting arrangements are strong, with appropriate challenge to partners to improve services for children looked after. The local authority has an established Children in Care council and the local authority listens and learns from the experiences of children and young people.

Inspection findings

91. The DCS shows strong and tenacious leadership that has impacted positively on the service, the council and wider partnerships since she came into post in February 2014. As well as a clear vision, she holds an accurate picture of the service she leads. With the support of her senior leadership team, she is driving plans to strengthen the service. A comprehensive annual report and updated self-assessment, identifies many of the deficits seen in this inspection. Good use has been made of findings from external audits and a peer review to help target priority areas for improvement. A quality improvement plan with clear priorities is in place, and is used effectively to monitor and review progress. However, these elements of good leadership and governance have not yet secured consistently good outcomes in social work practice, and frontline management.

92. The local authority has been instrumental in effectively pursuing opportunities to secure additional funding through government-funded innovations and collaborative working arrangements. The Adopt Berkshire and Signs of Safety projects are two positive examples. The practice framework underpinned by Signs of Safety is leading to stronger assessments with a clearer focus on the voice of the child, reduced caseloads and increased parental understanding of what needs to change. Adopt Berkshire is showing early indications that children referred to the service are being matched to prospective adopters more quickly, reducing delay in children securing permanence through adoption.

93. Performance information is not yet sufficiently developed to provide a clear picture of practice and to identify where action needs to be taken to address shortfalls. Managers have access to weekly performance information but the format of the data does not allow quick assimilation and is not in a user-friendly format. Some fundamental performance information, which is central to frontline practice, is not included – for example, statutory visiting to children and the time taken from child protection enquiries to initial child protection conference. As a result, managers are not able to fully scrutinise the data to ensure that quality is maintained and improved. Monthly performance scorecards are tailored to meet the needs of senior managers and report on a range of national and local performance information.

94. Quality assurance arrangements are in the early stages of development. The quality assurance framework has the right components for the development of a practice-improvement culture but is yet to be sufficiently embedded to address the variability in social work practice. A newly formed commissioning board, set up in July 2015, provides additional governance to support improvement and drive operational priorities to ensure a 'golden thread' from strategic priorities through to operational delivery. However, it is too early for it to have had a measurable impact.

95. Frontline management oversight is weak in teams where the new practice framework has not yet fully established, in particular within the neighbourhood teams. Supervision records are of variable quality, with some lacking sufficient detail. The regularity of supervision is also insufficient, with

some significant gaps. Developing and ensuring robust supervision and case management oversight and decision-making by first and second line managers remains crucial to improving social work practice and outcomes for children and young people in Wokingham.

96. The local authority triangulates performance, intelligence, practice and user feedback to establish an accurate self-assessment of practice strengths and weaknesses. The internal management audit programme has not robustly scrutinised case file audits as set out in the quality assurance framework. As a result, core audit activity is not rigorous in its evaluation of the quality of social work practice. By contrast, the audits for the purpose of this inspection were good, using a comprehensive audit tool and moderation process not in place prior to the inspection. Inspectors agreed with the local authority judgements and, where deficits in practice were found, appropriate plans had been put in place. A further component, the use of quality circles as an audit tool, has not been rigorous in its application or resulted in any tangible action plans.

97. A principle social worker and four practice consultants are in post to drive up practice standards through the delivery of learning on topics identified from audits, complaints, and individual staff appraisals. They also support newly qualified social workers in their assessed social work year of education (ASYE) and lead the step-up programme. Action plans to drive this work forward are not robust and lack specific, measurable actions and targets. As a result, learning from this approach is not effective in driving and role-modelling good practice and securing improvements.

98. The local authority's key strategic priorities have been to stabilise the workforce and implement a model of change exemplified by the early help and innovations programme. Although it is too early to evaluate impact, early signs are positive. The pace of change is now gathering momentum to ensure that progress achieved is sustainable. However, the legacy of an unstable workforce means too many children have experienced serial changes of worker, which has negatively affected the quality and consistency of practice.

99. The DCS and elected members are acutely aware of the detrimental impact of an unstable work force on the quality of support to children and young people. They have worked hard to strengthen the workforce and have placed a significant emphasis on being a learning organisation, with regular 'stocktakes', peer reviews, commissioned external audits and themes from complaints as sources for practice improvements.

100. The workforce strategy is comprehensive, ambitious and realistic and has been effective in reducing a previous heavy reliance on agency staff. A range of strategies, including overseas recruitment, has begun to stabilise the workforce and has seen a significant reduction in the previously high turnover of staff from 33% in 2013–14 to 14% by March 2015. Information on why staff leave is being used to consider barriers to successful recruitment and retention. Interim staff of good quality are afforded the

same conditions and training opportunities as the permanent workforce. Senior managers track social work caseloads weekly, with average caseloads being on target at 18. Sickness rates are relatively low.

101. The management of individual performance is in place with a clear system of appraisal to ensure that social workers and managers understand their priorities and the expectations of the organisation. The local authority is proactive in developing potential social workers through a number of different routes – for example, being part of a regional commitment to the 'step up to social work' programme, sponsoring three places at the Open University as an alternative pathway to social work qualification and 'home grown' future managers. Morale is generally good within children's social care, with social workers and managers speaking positively about working for Wokingham.

102. The DCS, chief executive and lead member have a strong presence within frontline services, making regular visits to teams and ensuring that they meet children and young people to inform and evaluate practice. They have a good knowledge of individual children and young people, including high-profile cases, those in care proceedings and those placed outside of Wokingham.

103. Links between the chief executive, the DCS and the Local Safeguarding Children Board (LSCB) Independent Chair are clear, with regular meetings in place. The chief executive meets regularly with the LSCB chair and respective roles are clear and understood, which helps to ensure that the needs of children are effectively prioritised.

104. Senior managers have developed effective strategies and led their implementation, although the full impact is yet to be established. There are examples of effective commissioning and re-commissioning of services. However, joint commissioning of children's services with partners is under-developed. Pooled funding arrangements are not well established, although the local authority has agreed development work, key priorities and strategies with partners and commissioning actions are being progressed as a result. For example, a joint review by the Clinical Commissioning Groups (CCG) and local authority of CAMHS has resulted in significant additional investment from partners and change in service specification. Partners have also developed a joint 'children with disability strategy' for approval, but it is too early to assess any impact.

105. The local authority has strengthened its commissioning function over the past year and introduced performance monitoring and quality assurance functions. A small number of targeted services, such as independent visiting and advocacy services, are commissioned. While recent, these are beginning to show improved take-up. The local authority commissions bespoke packages for individual children and families on an individual needs basis. The local authority has reviewed its grants to the community and voluntary sector. Several groups that support children and their families have received funding to promote key areas, such as awareness of child sexual

exploitation, support for disabled children and opportunities for young people to act as volunteers in the community.

106. Most of the key recommendations from the safeguarding and looked after children's inspection (SLAC) 2010 and the child protection inspection in 2012 have been successfully implemented, although some, such as improving the quality of chronologies and stabilising the workforce, continue to be work in progress.

107. Corporate parenting arrangements are strong. The lead member chairs the corporate parenting board effectively and has good representation from elected members. The board exerts appropriate challenge to partners to improve services for children looked after. For example, health reviews for children looked after were not sufficiently up to date, which has led to significant recent improvement. The children's scrutiny panel is also active in ensuring challenge to senior officers and the lead member.

108. The Children and Young People's Plan (CYPP) sets out the priorities for children and young people, is aligned with the Joint Strategic Needs Assessment (JSNA) and is driven by an active Children's Partnership. Vulnerable children are a high priority, including those who have mental health problems and those who are looked after. The Children's Partnership is the sponsor and accountable body for the innovation programme practice framework Signs of Safety project in Wokingham and a number of other projects linked together under the single brand 'Wokingham for Children'. As a result, an established programme of activities across the full range of children's services is being delivered in partnership.

109. Partners are committed to working together and have a clear vision for improving outcomes for all children in Wokingham. The DCS and partners hold one another to account appropriately. There are clear and established links with the Health and Wellbeing Board (HWB), Clinical Commissioning Group (CCG), the Children's Partnership and the LSCB. The DCS is an active member of all four.

110. Wokingham's levels of need and intervention guidance explains thresholds for services clearly and is understood by practitioners and partner agencies. A re-focused approach to early help with joined-up early help services, delivered through the early help hub provides a range of intervention to support children and their families based on assessment of need. Arrangements for stepping up from early intervention to statutory intervention, or stepping down when needs are reduced, are sound.

111. There are effective relationships with the Child and Family Court Advisory and Support Service (Cafcass), the family courts and the local Family Justice Board. This has resulted in improved timescales in private and public law proceedings, reducing delay for children and young people.

112. A strong multi-agency partnership and an agreed child sexual exploitation strategy and action plan are in place. Management oversight and assurance

are in place through a child sexual exploitation strategic and operational governance structure shared jointly and co-chaired between children's social care and the police with regular reporting to the LSCB. Child sexual exploitation champions have been developed across every childcare team, have received specific training on all issues relating to child sexual exploitation and provide effective consultation and guidance to their colleagues. Commissioned child sexual exploitation training has been comprehensively rolled out across all agencies in the borough, providing greater awareness of the many guises and risks of child sexual exploitation.

113. The local authority has an established Children in Care council that is supported by the children's rights officer. The local authority listens to the experiences of children and young people. For example, they have established a post for a care leaver over the age of 25, after care leavers said they are not always ready to listen to advice and accept help at an earlier age.

114. The local authority collates data relating to complaints and aggregated information is fully utilised to inform service developments. It is positive that 37% of complaints are resolved through the offer of a meeting, enabling resolution at an early stage. The response to individual complaints is timely, with the children's rights officer sensitively supporting children and young people.

The Local Safeguarding Children Board (LSCB)

The Local Safeguarding Children Board requires improvement

Executive summary

The Local Children's Safeguarding Board in Wokingham requires improvement to be good. Wokingham's Local Safeguarding Children Board complies with its statutory responsibilities and the requirements of 'Working Together 2015'. The chair of the Board and its members work closely together. The Board has a number of joint working arrangements with other LSCBs across Berkshire and exercises robust oversight of that work. The Board has been able to demonstrate a range of improvements since the chair was appointed in October 2014, but there is further work to do in order for the board to have a consistent overview of practice and practice developments in safeguarding across Wokingham.

The LSCB business plan does not adequately reflect all the work of the Board and progress made in its priorities. The plan's lack of inclusion of the partnership adopted 'Signs of Safety' model, intended to enhance safeguarding practice across Wokingham, reflects a weakness in governance arrangements, with the Board poorly represented at both the Health and Wellbeing Board and the Children's Partnership Board. This challenges the LSCB's ability to influence and set agendas and secure a complete overview of safeguarding developments. Multi-agency training for staff is poorly evaluated for its impact on practice and improving outcomes. As a result, the Board cannot determine whether training offered is as effective as it should be.

The Board, however, is able to demonstrate a range of purposeful activity. This includes a wide range of multi-agency audits seeking to evaluate practice and from which there is a comprehensive action plan designed to improve partners' practice and safeguarding in Wokingham. The Board is active in ensuring that there is a partner-wide understanding of child sexual exploitation and that there are processes and policies in place that ensure that need and risk are recognised and appropriate services offered including early help interventions.

The Board has a willingness to challenge poor services and can evidence improvements as a result. The Board focused on key areas of concern such as domestic abuse, early help and child sexual abuse. It has assured itself of individual agencies' understanding of these issues and how their services work to offer help and reduce risk through a series of multi-agency challenge days. The Board has ensured agency compliance with safeguarding policies and procedures through section 11 audits.

The Board has been able to work closely with young people, including those most vulnerable, identifying issues of concern to them in Wokingham. As a result, reducing bullying is now designated as an LSCB priority. The Board has issued a pledge to young people to use its influence to improve how they are heard and the responses they receive. Two young commissioners attend the Board to ensure that young

people's voices are heard.

Recommendations

115. Review the LSCB business plan to ensure that it contains sufficient detail in relation to its priorities and their progress against clearly identified timescales. The plan should also include explicit reference to Signs of Safety and its implementation across the partnership (page 38, paragraph 119).

116. Ensure that its program of multi-agency training is subject to long-term evaluation of its impact on practice and outcomes (page 39, paragraph 123).

117. Ensure that the assessment of training needs from agencies is robust and to also include information from long-term evaluation to better enable the board to commission future training needs (page 39, paragraph 123).

118. Ensure that there is an appropriate pathway from the LSCB to both the Health and Wellbeing Board and the Children's Partnership in order to maximise the ability of the Board to influence strategic priorities and ensure that the Board's priorities and concerns are heard and considered (page 38, paragraph 121).

Inspection findings – the Local Safeguarding Children Board

119. The LSCB complies with its statutory responsibilities as defined in 'Working together 2015'. The Board is appropriately constituted and has the further benefit of two young commissioners attending relevant meetings. The Board has been revitalised since the appointment of a new chair in October 2014 and is now on an improving trajectory. Arrangements for conducting the Board's business are complicated by four out the eight board sub-groups covering multiple local authorities across Berkshire. In some instances, this allows Wokingham to benefit from wider learning and a greater range of professional inputs. However, the learning and development sub-group has struggled to function across six local authorities. The chair of the LSCB is also chair of two other Berkshire LSCBs and this has allowed her to undertake some rationalisation of the Board structure, reducing the learning and development sub-group's coverage to three LSCBs and focusing the quality and assurance sub-group on Wokingham only. Sub-group chairs are from a range of partner agencies, demonstrating cross-agency commitment to the Board's management and functioning. The Board has one current lay member and a recent vacancy from July for a second lay member.

120. The LSCB has set out a business plan for 2015–16 that identifies five key and appropriate priorities. However, in a number of areas, these are insufficiently detailed, with aspirational rather than quantifiable aims. For example, in relation to the child sexual exploitation, there is no measure to assess the effectiveness of the communication priority. There is insufficient detail in relation to the child sexual exploitation priority within the business plan. The child sexual exploitation strategic plan and action plan are not attached. This limits the business plan's usefulness. The business plan's stated aim of use is

as a tool by frontline staff and managers. However, there is insufficient information and detail in the plan to assist this group in meeting the priorities of the Board. This is further compounded by a lack of a progress and rag-rated section for all the priorities.

121. The plan does not identify Signs of Safety as a key priority for the Board or the need for the Board to have a demonstrable overview of its rollout across agencies. The Board priorities were established based on need prior to the programme launch, however, the Board should review the plan to set out clearly how the programme will support delivery of key objectives – for example, identification of domestic abuse and associated risk and enhanced numbers of children and parents who say they have been listened to. The LSCB has undertaken a challenge session to consider the impact of the model on the learning and development of staff and gathered some other information about activity and impact of services using this model. However, there remains a significant gap in not establishing more formal reporting and governance procedures on the progress of the implementation to the Board from the Children's Partnership.

122. Governance arrangements to ensure that partners, such as the Health and Wellbeing Board and the Children's Partnership, are able to assess whether they are fulfilling their responsibilities to help, protect and care for young people are challenged by a lack of appropriate representation from the LSCB on these bodies. The LSCB chair only attends the Health and Wellbeing Board annually and there has been a recent change in LSCB representation on the Children's Partnership Board with the business manager being prioritised away from Partnership attendance. LSCB members do sit on the Partnership from across statutory partnership agencies and understand the dual role they perform. Although Wokingham is a relatively small local authority, where partners know each other well, it is important that there are clearly identified formal pathways enabling the LSCB to influence priorities and actions. Currently, some of these are informal and undefined, potentially limiting the Board's effectiveness in this area. For example, the lack of formal pathways to underpin the current representation on the Children's Partnership board, which is responsible for Signs of Safety rollout, further limits the LSCB's overview of this area of safeguarding development.

123. The LSCB has a training improvement programme overseen by the learning and development sub-group, a joint sub-group covering three local authority areas across the county. It ran 22 courses in 2014–15, with 355 candidates attending and two e-learning courses: one on universal safeguarding and the second on child sexual exploitation. The completion rate of both courses was poor at 21% (73 out of 337 for the child sexual exploitation course). Reasons for the high drop-out rate have been analysed and indicate poor course design. Other well-designed training was offered, including e-learning and Lottie. The Board recognises that significant further development is necessary in order to assure itself that staff are being supported and equipped to respond effectively to safeguarding and protection needs. The annual training needs assessment to inform future training planning is under-developed with insufficiently assessed information on future training needs

obtained from partners by ad-hoc means such as e-mail and phone, rather than a more detailed and planned approach to assessment. Partners have been asked to complete a written needs assessment for 2016–17, although not to a common template.

124. The LSCB has not yet ensured that it is able to fully evaluate the effectiveness of multi-agency training and its impact on practice. Evaluation of training courses is under-developed and apart from those courses hosted by another local authority, little or no evaluation of impact on a medium- or long-term basis is undertaken. Immediate evaluation provides insufficient analysis of course usefulness and none on impact on practice and outcomes. The Board has recognised this deficit and is taking steps to ensure that longer-term impact information will be available to it during 2016.

125. The LSCB has undertaken work in relation to the understanding of thresholds for service among partner agencies. It has ensured that a revised LSCB 'levels of mandated need' document, that included Signs of Safety, was disseminated to partner agencies and published in January 2015. The Board successfully conducted an early help challenge session in March 2015. This looked at thresholds and levels of need and the ability of services to evidence outcomes as a result of early help services being provided. It also commissioned an external audit to satisfy itself on the use of thresholds. This confirmed that the application of thresholds in relation to early help referrals to social care was working properly.

126. The Board has been active in seeking to improve services to children at risk of child sexual exploitation and those who go missing. It has set out a well-structured child sexual exploitation strategic plan for 2015–17. A robust action plan is in place that is regularly updated and reviewed for progress and overseen by the strategic child sexual exploitation sub-group. Chelsea's Choice, a theatre production on child sexual exploitation, has been made available to all schools and Lottie training (professional training on child sexual exploitation and online grooming) has been provided to the safeguarding leads at all schools. Child sexual exploitation was the subject of a multi-agency challenge session led by the LSCB in September 2015. This enabled the Board to monitor and evaluate progress and the effectiveness of services to young people at risk of both child sexual exploitation and missing. Although some work has been undertaken with businesses that young people might come into contact with, such as pharmacists, the Board recognises that further work is required in relation to hotels and taxis in particular. It has also identified that while the move to an independent agency undertaking return home interviews is positive, further work is required to ensure that information from those interviews is collated and analysed. The Board is aware of child sexual exploitation incidents in Wokingham. It has facilitated a day to raise awareness about child sexual exploitation and to help professionals reflect on whether they are fully considering the likelihood of child sexual exploitation in their work with children. The chair also hosted an assurance exercise on culture and behaviours in May 2015, in relation to child sexual exploitation and was able

as a result to assure herself that children were safer in Wokingham as a result of a rising level of awareness and work done by partners.

127. There is regular monitoring of multi-agency frontline practice. The LSCB has initiated an extensive program of commissioned audit activity. These include a review of transition arrangements, a review of the early help and children's services interface, a review of mental health practice, partnership working and children in need cases. While some have included detailed information and analysis, others have not measured impact and outcomes of practice. They have been useful in identifying individual casework issues but have not provided sufficient analysis. As a result, learning for the LSCB and individual agencies has been more limited than it could have been. The Board has recognised this and this has led to the production of a quality improvement plan, which identifies some core areas of practice for further scrutiny and improvement. Actions from this plan are detailed and regularly reviewed by the Board for progress. The LSCB has also received a number of single-agency audits, some of which it has identified as lacking in information and analysis and which it has asked to be re-done, demonstrating challenge to individual agencies.

128. The Board has ensured that there is a programme of section 11 audits on a three-yearly basis with mid-term reviews. The Board has challenged audits that have not met an appropriate standard, for example asking the central ambulance service for further information and a re-presentation to the section 11 sub-group.

129. The LSCB has initiated a series of 'challenge' sessions for partners on early help, child sexual exploitation, domestic abuse and learning and development. This has enabled it to inform itself about agency compliance of policy and process as well as practice and whether practice is making a difference. These are a valuable opportunity for the Board to assure itself of agency understanding and activity in relation to safeguarding issues and encourage challenge from partners.

130. The LSCB has a local learning and improvement framework with statutory partners, including procedures for serious case reviews (SCRs) and multi-agency and single-agency learning reviews overseen by an active SCR sub-group. Although there have been no recent SCRs, the Board has conducted two case-management reviews in 2014–15, with detailed multi-agency action plans arising. It has ensured that lessons learned have been disseminated through multi-agency practitioner sessions. Wider learning from SCRs is included in the LSCB training offer across a range of courses, including those concerning domestic abuse and neglect.

131. The child death overview panel covers the whole of the county but is able to provide the Wokingham LSCB with a local perspective. The panel is able to identify trends and is active in promotion of issues to improve awareness, including, currently, the risks associated with asthma.

132. The LSCB has a concerns log and can evidence effective challenge to partners. For example, it includes challenge to both health and social care to improve the timeliness of health assessments for children in care and attendance by the police and GPs at child protection conferences. Both have resulted in improvements to practice, including ensuring police attendance at conferences and an increase in reports to conferences by GPs.

133. The Board has engaged with young people and now has two young commissioners attending the board on a regular basis to contribute views and ideas. The Board also organised a day in August 2015 with young people who had been or were in care, or being supported by the targeted youth service. They identified bullying as a major concern and this has subsequently become an LSCB priority. As a result of this engagement, the Board is in the process of publishing a pledge to young people that includes promoting assurance and resilience, enabling members to hear and understand the voices of young people.

134. The annual report of the Wokingham LSCB provides a clear account of the working of the Board and its sub-groups in language that makes it accessible to a wider audience. The report from the quality and performance sub-group lacks detail on issues identified in audit activity. However, the report includes a section on challenges raised, together with the concerns log of the board providing information on issues that require further progress. This helps to ensure that the report is relevant and provides an account of safeguarding practice across Wokingham.

Information about this inspection

Inspectors 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 six of Her Majesty's Inspectors (HMI) and an additional inspector.

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