

West Berkshire Council

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 Board¹

Inspection date: 3 March – 25 March 2015

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The overall judgement is that children’s services are inadequate

There are widespread or serious failures that create or leave children being harmed or at risk of harm. Leaders and managers have been ineffective in making improvements in this area. The characteristics of good leadership are not in place but failures have been identified by the local authority and are being effectively addressed.

It is Ofsted’s expectation that, as a minimum, all children and young people receive good help, care and protection.²

The judgements on areas of the service that contribute to overall effectiveness are:

1. Children who need help and protection	Inadequate
2. Children looked after and achieving permanence	Requires Improvement
2.1 Adoption performance	Requires Improvement
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.

² A full description of what the inspection judgements mean can be found at the end of this report.

Contents

The local authority	3
Summary of findings	3
What does the local authority need to improve?	4
The local authority’s strengths	6
Progress since the last inspection	6
Summary for children and young people	8
Information about this local authority area	9
Inspection judgements about the local authority	11
The Local Safeguarding Children Board (LSCB)	35
Summary of findings	35
What does the LSCB need to improve?	36
Inspection judgement about the LSCB	36
What the inspection judgements mean	39
The local authority	40
The LSCB	40
Information about this inspection	41

The local authority

Summary of findings

Children's services in West Berkshire are inadequate because:

Leadership and Management

- There are widespread and serious concerns about the protection and assessment of children who are most vulnerable to harm. The pace of change since the last inspection has been too slow. Performance declined significantly in 2014 and, despite remedial action by senior managers, child protection and children in need services are inadequate.
- The local authority does not have a stable workforce. A significant proportion of social workers and managers in key social work teams are agency staff and turnover is high. This has resulted in children experiencing unacceptable disruption, uncertainty and inconsistency.

Missing children and Child Sexual Exploitation

- Risk assessment of children vulnerable to sexual exploitation is inconsistent. Action plans to protect children and young people from child sexual exploitation are not always effective or shared with professionals working with the child.

Quality of practice

- Frequent changes of social workers and managers mean that plans to reduce risk for children lose momentum. Too many children have experienced unacceptable drift and delay in having their needs met. A significant proportion of child protection enquiries, assessments and plans for children are poor.
- Weak operational management oversight, supervision and quality assurance processes mean that poor practice is not sufficiently challenged and children's needs are left unmet.
- Where risks to children are not reducing, the local authority does not consider legal action soon enough.
- Overall, plans for children are not outcome focused, and in some cases fail to address risk, contingency planning and visiting frequency. Child protection chairs do not provide sufficient challenge to bring improvement in these areas.
- The Independent Reviewing Service is not effectively fulfilling its function. Independent reviewing officers (IROs) do not consistently drive forward plans to ensure progress for looked after children. Looked after and adopted children do not receive timely or good quality life story work or later life letters.

What does the local authority need to improve?

Priority and immediate action

Leadership management and governance

1. Implement the following areas for improvement from the previous inspection:
 - Legal advice is sought when necessary and this leads to appropriate action and timely legal intervention.
 - Management oversight is both reflective and challenging and focused on the child's experience, current risks, needs and strengths and the effectiveness of the current plan and interventions.
 - Ensure core groups and child protection conferences effectively monitor cases to ensure that where there is a lack of progress in improving a child's situation this leads to robust action.

Quality of practice

2. Prevent unnecessary drift and delay in all stages of social work intervention. Ensure, through robust management oversight and decision-making, that work with children and their families is purposeful, timely and of a consistently good standard.

Child Sexual Exploitation

3. Ensure that screening tools are always used where there is a potential risk of child sexual exploitation, and that action plans are outcome-focused and shared with all professionals working with the child.

Workforce

4. Implement the workforce strategy as swiftly as possible to improve workforce stability and ensure that children have consistent social workers, who see them on their own and with whom they can develop meaningful relationships.

Areas for improvement

Leadership management and governance

5. Develop a revised and updated looked after children strategy, aligned with the sufficiency strategy and based on a clear analysis of current and future need, with clear actions to address these.
6. Ensure that the corporate parenting board and children in care council (R:Vue) consistently contribute to improved outcomes for looked after children.

7. Conduct a robust test of assurance of the dual role of the Director of Children's Services (DCS) and act on its findings.
8. Ensure that all operational and strategic managers understand and use the management information and data available to them in order to oversee and improve practice and performance.

Quality of practice

9. Ensure that assessments and plans are of a consistently good standard, with analysis and consideration of risk and protective factors and the individual needs of all children in the family.
10. Ensure that staff and case supervision complies with the local authority's own supervision policy, and that rigorous tracking of plans for children takes place through this process.

Looked after Children and Adoption

11. Ensure that all looked after children receive timely health and dental assessments and that looked after children and care leavers have prompt access to services from Child and Adolescent Mental Health Services (CAMHS).
12. Ensure timely assessment and updating of children's care plans following significant changes in their circumstances.
13. Ensure that, following reviews, all looked after children receive a timely written record of the outcome of their review.
14. Ensure that life story work is completed for looked after and adopted children, and that good quality life story books and later life letters are completed for adopted children in a timely manner.

Care Leavers

15. Establish effective processes to enable care leavers' views to inform service development.
16. Ensure that all care leavers have access to good quality information about their health histories and their entitlements.
17. Improve the quality of pathway planning by:
 - ensuring that assessments and plans are updated when young people transfer into the care leaver service
 - strengthening the involvement of care leavers in their pathway planning process

- ensuring that care leavers have detailed pathway plans that address their health and educational needs, with clear targets and outcomes.

The local authority's strengths

18. The Family Resource Service (FRS), comprising the Domestic Abuse Referral Team (DART), the Family Intervention Team (FIT) and the Family Support Team (FST), is effective in delivering intensive and bespoke support to children and families who may be subject to domestic abuse, at risk of family breakdown or who are on the edge of education and care. Good outcomes have been achieved with families and their children, and these outcomes are well evaluated and documented, ensuring that lessons can be learned and practice further improved.
19. The implementation of the Help for Families (HFF) multi-agency team has seen a steady increase in referrals for early help from across services and from families themselves. Professionals bring a wide range of experience and knowledge from diverse backgrounds, including health, youth services, schools and children centres. They make sure that children and families receive swift access to the most relevant services that will result in positive and sustainable changes for them.
20. The quality of Personal Educational Plans (PEPs) is of a consistently good or very good standard.
21. Placement stability for looked after children is strong, and the proportion of looked after children in family placements is high.
22. Unaccompanied asylum seeking children receive sensitive and effective support.

Progress since the last inspection

23. The last Ofsted inspection of West Berkshire's safeguarding and looked after children services (SLAC) was in August 2012. The local authority was judged adequate for its safeguarding services and good for looked after children's services.
24. Instability, staff turnover and a high proportion of agency staff in key social work teams has become a significant challenge for West Berkshire, particularly over the past 12 months. The local authority has recognised this challenge and has responded by investing in an ambitious and creative recruitment and retention strategy, but it is yet to have significant impact.
25. A range of early help services has underpinned a service redesign to establish HFF as the early help hub in the district. This is proving to be effective in coordinating the early help offer and supporting the involvement of a wider range of partner organisations, including a dedicated health visitor, in good quality early help work. The local authority has thought creatively about how it can respond to local need in a way that achieves statutory compliance, quality

and good value for money. The 'Adopt Berkshire' collaboration and tripartite training arrangements are two examples where this is proving to be effective.

Summary for children and young people

- The last time Ofsted inspected West Berkshire's safeguarding and looked after children services was in 2012. The inspection judged that safeguarding services were adequate and services for looked after children were good.
- In this inspection in March 2015, inspectors found that some things have not improved, like making sure that when families' problems get more serious a social worker assesses their needs properly and arranges help so that problems do not get worse.
- Over the past year it has become much harder for managers to employ enough social workers to do this important work.
- Many social workers have left after a short time, and promised help hasn't always been provided. This is difficult for some parents who haven't been sure what they should do to make their children's lives safer. It is especially hard for children and young people, who have been upset about having to say goodbye to social workers they are just getting to know.
- Because of how worried inspectors are about the help being provided to children who most need help and protection, they have judged these services to be inadequate. Services for children who are looked after and care leavers require further improvement but are better, along with adoption and leadership and management.
- Leaders are working very hard to employ more social workers and to improve the help provided. The social workers and support workers that inspectors met are committed to their jobs and care about the children and families they are trying to help. They would like to see services for vulnerable children and families improve.
- Inspectors have said that more looked after children should be helped to join the R:Vue children in care council, and senior managers and politicians should spend more time getting to know looked after children.
- More work needs to be done to improve the accommodation provided to young people who have left care. Feeling safe and secure where they live is important to these young people if they are going to achieve the things they are capable of.
- In other areas, things are working well. Services like the Help for Families team are supporting families who are just beginning to have problems. This is helping parents and children to improve their lives. It is good that children who cannot live with their own families are found a new permanent family, and a high number of looked after children live with their carers without having to move too often.

Information about this local authority area³

Children living in this area

- Approximately 35,700 children and young people under the age of 18 years live in West Berkshire. This is 23% of the total population in the area.
- Approximately 11% of the local authority's children are living in poverty.
- The proportion of children entitled to free school meals:
 - in primary schools is 8% (the national average is 17%)
 - in secondary schools is 7% (the national average is 15%).
- Children and young people from minority ethnic groups account for 8% 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 Mixed and Asian or Asian British.
- The proportion of children and young people with English as an additional language:
 - in primary schools is 6% (the national average is 19%)
 - in secondary schools is 5% (the national average is 14%).
- Polish is the most spoken language of new pupils in the district's schools and Portuguese the second. This has been the pattern for the past seven years. There is a well-established traveller community in the district, including settled traveller families.

Child protection in this area

- At 28 February 2015, 874 children had been identified through assessment as being formally in need of a specialist children's service. This is an increase from 838 at 31 March 2014.
- At 28 February 2015, 134 children and young people were the subject of a child protection plan. This is an increase from 107 at 31 March 2014.
- At 28 February 2015, four children lived in a privately arranged fostering placement. This is an increase from three at March 2014.

Children looked after in this area

- At 28 February 2015, 176 children are being looked after by the local authority (a rate of 50 per 10,000 children). This is an increase from 160 (45 per 10,000 children) at 31 March 2014. Of this number:
 - 72 (or 41%) live outside the local authority area

³ 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.

- 12 live in residential children’s homes, of whom 58% live out of the authority area
 - four live in residential special schools⁴, of whom 75% live out of the authority area
 - 101 live with foster families, of whom 50% live out of the authority area
 - one lives with parents, within the authority area
 - 12 children are unaccompanied asylum-seeking children.
- In the last 12 months:
- there have been five adoptions
 - 11 children became subjects of special guardianship orders
 - 68 children ceased to be looked after, of whom 3% subsequently returned to be looked after
 - eight 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.

Other Ofsted inspections

- The local authority operates one children’s home, which was judged adequate in its most recent Ofsted inspection.
- The previous inspection of West Berkshire’s safeguarding arrangements for the protection of children was in August 2012. The local authority was judged to be adequate.
- The previous inspection of West Berkshire’s services for looked after children was in August 2012. The local authority was judged to be good.

Other information about this area

- The Director of Children’s Services also has responsibility for adult services. She has been in post since March 2013.
- The Chair of the LSCB has been in post since August 2014.

⁴ These are residential special schools that look after children for 295 days or less per year.

Inspection judgements about the local authority

Key judgement	Judgement grade
The experiences and progress of children who need help and protection	Inadequate
<p>Summary</p> <p>Partner agencies understand and appropriately apply thresholds. A range of effective early help services and prompt referrals for early help services are making a difference to children, young people and their families.</p> <p>However, there are serious and widespread weaknesses in services for children who need help and protection. An over-reliance on agency staff in key social work teams, and the continual workforce churn, is severely restricting the local authority's ability to provide a consistently safe and effective service.</p> <p>Too many children have experienced drift and delay because of constant changes of social workers and managers. As a result, children remain in situations of potential risk of significant harm for too long. Unassessed risk and a lack of progress to improve outcomes for children are common features in too many cases.</p> <p>Families express frustration about how difficult it is to develop a trusting and meaningful relationship with their social worker. They are unclear what they have to do to make progress.</p> <p>Poor practice is evident in too many cases. There is chronic delay in progressing assessments and plans to protect children and meet their needs. Management oversight of social work practice is inconsistent and weak, and leaves poor practice unchallenged.</p> <p>Initial child protection conferences are not timely, and children subject to child protection plans do not see their social workers as often as they should. Child protection chairs do not rigorously monitor or challenge delays in the progression of plans.</p> <p>When risks for children escalate or do not improve, legal meetings are not held quickly enough.</p> <p>Social workers do not consistently use screening tools to identify the level of risk of child sexual exploitation. As a result, plans are not focused on reducing risk.</p> <p>Delay in effective case management was noted by inspectors to be widespread across all four core social work teams, including the contact, advice and assessment service (CAAS).</p>	

26. When children are referred to children's social care because they have significant needs or are vulnerable to harm they are not consistently or effectively assessed, supported or protected. Too many of these children do not receive the timely services they need. Social workers and operational managers report that services have been in crisis for some time. The local authority is aware of these weaknesses, with audit activity regularly identifying inadequate practice. In October 2014, senior managers recognised that services to children were weak and that this inadequacy would take time to address. Although appropriate actions are starting to address the significant shortfalls, for example through the restructuring of the referral and assessment service and the appointment of interim managers, the changes are very recent and staff instability is still a significant problem. For too many children, the assessment and help they have recently experienced or are still receiving is not good enough.
27. During this inspection, inspectors identified 28 cases where there were current or recent delays in children receiving support or protection. These delays did not relate to one specific area of practice, but were widespread across three of the four core social work teams, including the contact, advice and assessment service (CAAS). The connection between these concerns and significant workforce instability is clear and known, but this does not negate the impact on children, young people and their families. These children have waited too long, either for needs and risks within their families to be recognised; or for the escalation of concerns to a level where there is a sharper focus on risk, such as a strategy discussion, S47 enquiry or child protection conference; or for legal advice to be sought regarding whether the care threshold has been met. In four of these cases, actions relating to the assessment of child sexual exploitation had not been completed in a timely way. In the majority of cases seen by inspectors where children had recently become looked after, there had been a lack of effective or purposeful work to understand or reduce risk and need. This led to children being left at risk of significant harm for too long.
28. In cases seen by inspectors, referrals to the contact, advice and assessment service (CAAS) were appropriate. In the vast majority of cases, decisions are appropriate and made within 24 hours. However, inspectors saw cases that were stepped down to a lower level of help inappropriately. For example, in one of these cases, a child had been physically assaulted and was not spoken to or assessed by a social worker prior to being stepped down to the HFF service.
29. Management oversight in a majority of cases is inadequate, resulting in a lack of prioritisation in protecting children. Where managers and audits identify poor practice there is insufficient evidence of effective action taken to address deficits. The local authority identified that a failure to follow through on previous audit recommendations was a 'big issue' in October 2014, with a total lack of progress on inadequate audits. This was still evident in this inspection.
30. The quality of social work practice is too variable. Single assessments take too long to complete and the majority lack sufficient analysis. In February 2015,

28% of single assessments (year to date) were not completed within the authority's own target timescale. Where assessments are good, they are detailed, descriptive and analytical, and the wishes and feelings of children are evident. However, during the assessment period, support is inconsistent and children are regularly waiting too long to be helped.

31. Social workers use a number of tools to support them in their discussions with children, including 'worry work' and the 'three houses' model. However, this practice is not consistent. Inspectors saw three cases where brothers and sisters in the family had not been considered and risks were overlooked. One of these was a child protection enquiry where only one child in the family was included in the assessment of risk.
32. Where child protection referrals lead to strategy discussions, they are generally well recorded. However, the majority only involve police and social care. As a result, not all information is available to make informed decisions. The large majority (76%) of S47 enquires were not of a good enough standard. Deficits included three blank S47 enquires, delays in completing risk assessments and failure to consult key agencies. Inspectors saw delays in progressing the strategy discussions, S47 enquiries or child protection conferences. This delayed the multi-agency consideration of risk.
33. The local authority has improved the percentage of initial child protection conferences (ICPC) held within 15 days of a strategy discussion, with a rise from a low base of 50% in May 2014 (year to date) to 78% in February 2015 (year to date). However, this still means that for 22% of these children, decision-making about the level of risk within their lives is delayed.
34. Child protection chairs do not provide sufficient challenge to enable service improvements. Overall, plans for children are not outcome focused, and in some cases fail to address risk, contingency planning and visiting frequency. Plans do not address the individual needs of children, because brothers and sisters have generic plans. The majority of plans lack achievable timescales and are not used to routinely drive and measure improvement and progress. One parent spoken to by inspectors said, 'how do they know if things are ok? Nobody comes, nobody phones, meetings get cancelled.'
35. In the majority of children in need plans seen by inspectors, actions were not linked to outcomes; they lacked timescales and in some cases were overly focused on adults rather than the needs of the children. The local authority's own re-audit of children in need plans in April 2014 identified that a third of plans did not have actions and timescales that were achievable.
36. When risks increase, actions are not taken quickly enough to progress plans. Inspectors found inconsistent use of the Public Law Outline (PLO) to bring about improvements at an early enough stage, particularly in seeking legal advice where risk is increasing or change is slow. Chronologies and historical family information are not used to make prompt decisions on current casework.

Inspectors saw examples where known, long-term risk had not been reduced or acted upon to protect children. At the time of the inspection, 35 cases (56 children) were subject to PLO proceedings and 19 cases (27 children) were in the court arena. Inspectors sampled a fifth of the cases on the local authority's legal tracking system. In the majority of these cases subject to PLO, drift and delay were evident. The delays were because of poor quality evidence resulting in social work statements having to be rewritten, parenting assessments not being progressed, social workers leaving the authority and delays in making applications to the court. In four cases where care proceeding had started, the judiciary had specifically expressed concerns about delays in making applications to the courts for (section 31) interim care orders, and about the lack of planning and progress.

37. In three out of four pre-birth assessments sampled by inspectors, there was delay in undertaking an assessment, convening an ICPC, and arranging legal planning meetings to consider thresholds for PLO. As a result, there were delays in parents accessing legal advice, and in parenting assessments and plans being made for the children.
38. Visits to children on child protection plans are not always completed within the local authority's own timescales. According to the local authority's figures, the frequency is inconsistent (December 2014, 92% on time; January 2015, 78% and February 2015, 89%). This means that one in ten children is not seen as often as needed.
39. At the time of the inspection, 134 children and young people were subject to child protection plans. Neglect featured in 62.1% of plans, emotional abuse in 36.3% and sexual abuse in just 1.5%. Domestic abuse is a feature in 43%, parental substance misuse in 37%, and adult mental health problems in 22% of child protection plans. In a number of cases, sexual abuse and child sexual exploitation were significant risk factors, but only two children are subject to child protection plans under the category of sexual abuse. The local authority acknowledges the disparity in the use of child protection plan categories but an under-representation continues. This means that plans do not always address the risk of sexual abuse, and the local authority's understanding of the prevalence of sexual abuse within its vulnerable children population is reduced.
40. Despite neglect being a risk factor in 62.1% of child protection plans, the local authority has been slow to introduce a tool to help social workers to understand the impact of neglect within families. A pilot involving four cases has only recently started. Insufficient focus on the child's needs and timescale for change for families where neglect is a risk factor was also highlighted as a concern in the previous inspection in 2012.
41. A commissioned service provides advocacy, independent visitors and mentors to children in West Berkshire. Forty-three per cent of children between the ages of seven and 18 who have a child protection plan are benefiting from an independent advocate to support them through the process, which includes

meeting the young person regularly, attending conferences with them and, where appropriate, speaking on their behalf. Conference chairs know it is a valuable service for children that enables them to be at the centre of the child protection process.

42. A specialist team works with disabled children and provides good quality child-focused work. Cases seen by inspectors were of a good standard and, in one example, research supported the social worker's analysis of the case.
43. Social workers are alert to young people at risk of radicalisation. Inspectors saw a case where appropriate action through multi-agency strategy meetings was taking place where risks were identified.
44. The operational multi-agency child sexual exploitation and missing panel reviews all children who are missing, vulnerable or at risk of child sexual exploitation. The meeting effectively shares intelligence on potential victims and perpetrators. At the time of the inspection, two young people were considered to be high risk and four medium risk. Targeted police operations have resulted in successful prosecution, and five abduction notices have been served since January 2015. Raising awareness of child sexual exploitation has taken place in the town centre of Newbury and with hoteliers, fast food outlets and taxi firms.
45. Social workers do not use child sexual exploitation screening tools consistently, and action plans are not always in place or robustly monitored. Therefore children are not effectively protected. The local authority's audit of child sexual exploitation in December 2014 identified that children in need plans, child protection and care plans do not always reference the involvement of the child sexual exploitation operational group, or that the young person is at risk of child sexual exploitation. As a result, important information is not always available to all professionals involved.
46. The missing person co-ordinator attends all operational child sexual exploitation meetings, ensuring that the links between missing children and child exploitation are robust. A pool of 40 specially trained professionals makes contact with all children and young people who go missing. The majority of return interviews occur within 72 hours. Return interviews seen were of a good quality in the majority of cases. Police and children's services share information from safe and well checks and return interviews to identify patterns and trends.
47. There were 218 missing episodes involving 107 children between September 2014 and March 2015. In 74 (69.1%) return interviews, domestic abuse was shown as a reason for children going missing. Nineteen (17.7%) young people refused to participate in a return interview and, where children have been missing only once, 24 (22.4%) received an information pack highlighting the risks they may be exposed to, and signposting to relevant support services.
48. Private fostering arrangements are known and understood across the service. Advice to professionals is provided through CAAS, and an assessment of need is

undertaken by a social worker. Three current private fostering arrangements are being appropriately monitored. However, in one case there was evidence of a delay in making an initial contact through a home visit. In another case, the assessment had not been properly progressed because of an error in transferring information from CAAS.

49. The arrangements for investigating complaints against adults who care for and work with children are well embedded. The service benefits from two designated officers (LADO), each with a specific responsibility, including working with schools to provide advice, training professionals, raising awareness of the reporting process and attending strategy meetings. Cases seen by inspectors show that the local authority has appropriate reporting processes in place. Referrals are responded to in a timely way and appropriate action taken. Disciplinary action and, in some cases, a criminal prosecution ensures that children are protected by robust action. In 2013–14, there were 57 LADO cases.
50. The Emergency Duty Service (EDS) provides a statutory crisis social work and homelessness service for the six unitary authorities which make up Berkshire. Close links with the CAAS and key personnel within West Berkshire provide systems for ensuring that referrals and action taken are immediately reported to day staff. Information on children who go missing is reported through a separate email account to the young person's social worker, the youth offending service and the missing person co-ordinator. The implementation of the management information system has been relatively recent and, as a consequence, it is too early to see how effective it is in enabling any analysis of trends to inform future practice development.
51. Arrangements are in place for young people aged 16 to 17 years who become homeless. CAAS offers mediation in order to reduce the risk of homelessness. Where young people and families are requesting help to resolve their difficulties, the intervention is effective. However, attempts to engage hard to reach homeless young people are not consistently assertive. In one case seen by inspectors, a vulnerable young person was re-directed to housing, and insufficient subsequent attempts were made to ensure that his needs were being assessed and met.
52. Children, young people and families access a broad range of effective early help and support services. In cases sampled by inspectors, HFF referrals were targeted at the right level of support. They demonstrated good management oversight and clear decision making about the levels of support needed, and whether cases should be stepped up for more intensive or statutory interventions or stepped down.
53. Troubled families (Turnaround Families) work in West Berkshire is achieving good results. In September 2014, 137 of 145 families had achieved positive outcomes.

54. Parents said that they have found asking for help and guidance through HFF simpler than the previous Common Assessment Framework process. They attend Signs of Safety (SOS) meetings and Team Around the Family (TAF) meetings, which result in good action planning and clear decisions about who is to do what and by when.
55. The scale and prevalence of domestic violence is well known and understood. West Berkshire has a strong commitment to providing early intervention through a good range of support services to families experiencing abusive situations. Notifications of domestic abuse are showing an increasing pattern, with 1,068 notifications from the police to children's social care over the course of the last ten months.
56. Multi-agency risk assessment conferences (MARAC) are well established across the partnership. Children facing risks associated with domestic abuse are protected through a coordinated approach. The DART team provides a rapid response and, where risk is heightened, cases are escalated through the CAAS to MARAC. Key partners, including the domestic violence co-ordinator and Independent Domestic Violence Adviser (IDVA), all attend MARAC meetings. Information sharing across the partnership is embedded in practice, and attendance at MARAC by key partner agencies ensures that children living in and witnessing domestic abuse are protected. Signs of safety plans record the actions and interventions agreed to support children.
57. Arrangements for monitoring and tracking children missing education are robust. Systems for reporting children missing from roll are well-established, and procedures are known and implemented by schools and alternative provision as required. The database is updated daily and procedures implemented swiftly and effectively when concerns are raised about the absence of a child. At the time of inspection, 25 children were known to have been missing education for a period of time. All had been located and were attending education or awaiting allocation to a school. The team works closely with schools and the missing children coordinator, as well as other local authorities, especially those bordering West Berkshire, to share information about those children who are looked after out of the authority and to track those families, such as from the traveller community, who are more transient.
58. The local authority has systems in place to monitor and track children known to be receiving elective home education (EHE). Data are robust. At the time of inspection, 71 children were known to be home educated. This includes children from all key stages as well as reception age. Officers work closely with the education welfare service and the children missing education team. Parents are encouraged to engage positively with the local authority, and visits to homes are made more frequently if there are concerns about the quality of education. When children are not seen at visits, officers raise alerts appropriately and these are closely monitored. Referrals to CAAS are made if there are safeguarding concerns.

59. Alternative curriculum provision is judged by Ofsted to be good with some outstanding features. Monitoring and tracking processes are robust. All children receive personalised and bespoke programmes to ensure that they keep on track and are re-integrated to mainstream education when possible. Currently six children who are educated at home have involvement with social care services, and seven children from the traveller community are being supported jointly with the Ethnic Minority and Travellers Achievement Service (EMTAS).

Key judgement	Judgement grade
The experiences and progress of children looked after and achieving permanence	Requires improvement
<p>Summary</p> <p>Decisions to look after children are not always made early enough. This contributes to delay in achieving permanent families for some children who need them.</p> <p>Children and young people experience too many changes of social worker and this affects their ability to develop consistent and meaningful relationships with them. Children enjoy stable foster placements and most children looked after live with foster carers with whom they have good relationships.</p> <p>At the time of the inspection, the local authority reported improvements in the timeliness of health assessments for children looked after. Children are not readily able to access support from CAMHS when they need it. This means that the individual health needs of some children are not responded to quickly enough.</p> <p>Care plans are inconsistent in quality and not updated following significant changes in the lives of children and young people.</p> <p>Reviews of care plans are timely, but the impact of the role of the independent reviewing officer in reducing drift or challenging delay is insufficient. The number of children attending their reviews is low, and not all receive a written record of the outcomes from reviews.</p> <p>Education outcomes for looked after children have improved for 11-year-olds in reading and mathematics and are better than the national average for this group. The small cohort of 16-year-olds eligible to take GCSEs do less well, with too few achieving 5 A*-Cs. The gap between this group and their peers is too wide.</p> <p>West Berkshire performance on the adoption scorecard measures is good across all of the timescale indicators. However, the proportion of children leave care through adoption is small.</p> <p>Later life letters and life story work for children is not completed in a timely way.</p> <p>The range and availability of accommodation options for care leavers is limited, and too many are living in unsuitable accommodation. The quality of pathway plans is too variable, and more work is necessary to ensure that all care leavers are aware of their medical histories and their entitlements.</p>	

60. The Family Resource Service provides effective help to families where children are at risk of becoming looked after, providing coping techniques and building on families' own strengths through the use of outcome stars. This service currently provides support to 27 children and their families. The use of family group conferences (FGC) is increasing, with 34 held in 2012–13 and 72 in 2013–14. In some cases these have led to helpful and creative plans for children to remain in their families. However, in a minority of cases, the family could have been brought together in this way at an earlier stage. For these children, opportunities to improve their outcomes and their family lives had been missed.
61. Decisions to look after children are made by a senior manager, and records demonstrate a clear rationale for each decision. Inspectors considered recently looked after children's files and found that it was appropriate for all of these children to be in care. However, more effective assessment and intervention with some of these families is likely to have resulted in an earlier decision for them to come into care.
62. In West Berkshire 43% of looked after children are subject to an arrangement under section 20 of the Children Act 1989, where parents have requested that the local authority provides care for their children. This figure has risen steadily over recent years and is now much higher than their comparators' average, which is 32%, and the England average of 28%. There is a link between the high proportion of these arrangements, weaknesses in care planning and delays in securing permanence for children. In some cases, legal proceedings should have been instigated earlier to support the achievement of a care plan which met the child's needs. A strong contributing factor is high staff turnover, leading to frequent changes in allocated social workers. This has led to a loss of momentum in care planning for too many children.
63. Children looked after are well matched, safe and well cared for, but their need for permanence has not consistently been prioritised. Scrutiny by IROs has not effectively challenged these practice deficits for individual children or across the looked after children's service as a whole. Practice that is more recent is beginning to demonstrate timely use of pre-proceedings agreements under the Public Law Outline (PLO), and this has been supported by the introduction of a regular legal tracking meeting and tracking spreadsheet. This tracking tool, which includes all children who are subject to proceedings and pre-proceedings, has highlighted considerable drift and delay in a significant number of cases. In February 2015, 35 cases were subject to pre-proceedings (PLO), and in 18 of these the local authority had already decided that a section 31 (interim care order) application was necessary, but there had been delay in social workers completing the necessary paperwork to the court.
64. Assessments and care plans include family history and the reasons for children becoming looked after, but do not routinely include an analysis of the child's needs or the views of parents. Care plans are not always updated following significant events, for example a placement move.

65. When the care plan is for children to return home, decision making is based on a clear assessment and analysis of risk. In cases seen by inspectors, appropriate support and monitoring to prevent re-admission to care support were in place. However, eight (26.6%) out of 30 young people who went home under a care plan in the last year have returned to the care of the local authority.
66. The quality of looked after children's reviews is not of a good enough standard. Plans for children to achieve permanence are not given sufficient consideration at their second review. IROs do routinely meet with children and young people before their review. However, 12 young people spoken to by inspectors said that this was a cursory meeting with limited purpose. Young people are encouraged to chair their own review, and 14 have done so in the last year. This helps them to feel more engaged in planning and decision making about their lives. Attendance of looked after children at their review is low at 51%. While all children share their feelings and wishes at their review, only 70% of looked after young people received a written record of the outcome of their review in good time. This is particularly important for those children and young people who were not present and were unable to hear what was discussed and decided about them.
67. Inspectors saw examples of social workers helping looked after children to have safe and meaningful contact with family members. However, foster carers and young people spoken to by inspectors said the frequent changes of social workers contribute to a lack of consistent oversight and planning to facilitate contact. This is creating anxiety and disruption for some children.
68. The large majority of looked after children do not experience many placement moves, which means they are able to settle and develop attachments with their carers. Short-term stability of placements is strong, with just 6% of children experiencing three moves or more in a 12-month period in 2013–14. West Berkshire ranked first nationally for the three-year average of this measure. Long term placement stability is also good, at 73%, compared with the national average at 67%.
69. All looked after children live with foster carers unless their assessed needs cannot be met in a family environment. Currently 82% live in foster families. The number of looked after children placed within 20 miles of their home is low at 58% and is below the national average of 77%. In the majority of cases where children live some distance from their home, their welfare is well monitored and access to education and health services is timely. Children are matched with suitable carers. Children and young people spoken to by inspectors say they feel safe in their placements, are encouraged to live healthy lifestyles and to participate in a range of social and recreational activities.
70. West Berkshire has a stable group of foster carers, with 121 currently approved (LA's own data) and seven new households recruited since April 2014. Foster carer files demonstrate regular and purposeful supervision with carers. Issues

relating to individual children are explored well. Foster carers receive an annual review and their individual training records are comprehensive and up-to-date. Carers receive intensive and creative support to care for challenging children. This contributes to the stability of placements. Assessment processes and panel arrangements to approve foster carers are robust and the quality of foster carer assessments is good.

71. Foster carers report good access to training and they are financially rewarded to attend. However, only 37% (at 31 March 2014) of carers meet DfE Training, Support and Development Standards. The Family Placement Team is reinforcing this as a requirement of approval but the impact of this work is limited.
72. Case records do not always consistently reflect the individual needs of looked after children. This is because some care plans are generic, combining plans for brothers and sisters in one document. In some cases sampled by inspectors, specific information was copied from one child's file to the next. This means that individual children's records are not focused solely on them. There is a danger of the specific and particular needs of some children being lost within these records. Life story work is not begun early enough nor given sufficient priority. The quality of this work is poor in the majority of cases. This means that children and their carers do not have important information to help them understand their past.
73. Viability assessments of prospective family and connected carers seen by inspectors were timely, comprehensive and supported by a clear rationale for decisions made. At the time of the inspection, 13 children were living with family and friends foster carers. In the majority of cases, respite care arrangements are appropriate, well planned, and meet the needs of the child. Special Guardianship Order (SGO) arrangements are effective, with clear assessments and creative support packages. During 2013–14, ten children became subject to an SGO.
74. Arrangements to monitor and reduce the risk of children going missing from care are mostly robust. Young people who do go missing routinely receive a timely return interview, where the reasons for them going missing and what they did while they were away are explored well. Information from this process is used to prevent future missing episodes. Seventeen looked after children have gone missing from care in the last year. At the time of the inspection there were no missing looked after children. There is a small number of looked after children identified as being at risk of child sexual exploitation. Whilst these young people are identified well in the majority of cases, the child sexual exploitation screening tool is not consistently used to identify and understand the level and nature of risk.
75. Advocates effectively support children and young people. The advocacy service has been used by 42 looked after children over the last six months and 16 children and young people have been supported by an independent visitor. Children and young people spoken to as part of the inspection did not know

how to make a complaint, but felt they had someone they could raise concerns with. However, inspectors saw timely responses to complaints from young people and evidence of direct contact between the head of service and looked after children in order to explore the issues and apologise where appropriate.

76. The timeliness of health assessments for looked after children has recently improved, from a low base of 68% in 2013–14 to 81% reported to inspectors by the local authority during the inspection. Take-up of dental assessments remains poor at 69%. While looked after children do not routinely receive a prioritised service from the child and adolescent mental health service (CAMHS), an initial assessment of their needs is prioritised. However, there are significant waiting times for CAMHS. In some cases, the local authority purchases therapeutic help such as play therapy for children, so that they do not have to wait for a CAMHS service. CAMHS is currently working with 15 looked after young people and primary mental health workers are working with an additional four young people.
77. The Children in Care Council (R:vue) meets regularly and members have contributed to the revision of The Pledge. Children and young people regularly attend the corporate parenting panel and share the issues that are important to them. However, none of the children or young people spoken to as part of the inspection knew about R:vue.
78. Education outcomes for looked after children have improved in reading and mathematics for children aged 11. The gap between this group and their peers is closing. However, progress between 11 years and 16 years is below expected levels, and for young people aged 16 years the percentage achieving five good GCSEs including English and mathematics is below national results for looked after pupils. The cohort is very small and a disproportionately high percentage of pupils have special educational needs. Of the nine pupils who sat public examinations, all achieved at or above their expected levels. Work to narrow the achievement gap is prioritised by the Virtual Head Teacher and this is reflected well in the Personal Education Plans (PEPs) and in the management of the pupil premium funding.
79. Personal Education Plans (PEPs) completion rate at 95% at the end of quarter four (2014) is high, and those PEPs reviewed were of a consistently good or very good standard. The virtual head teacher monitors the use of pupil premium plus funding to ensure that it is used to improve the educational achievement and attainment of looked after children.
80. At the time of inspection, 75% of school aged looked after children attended good or better schools. Attendance for looked after children is good for the large majority of children and is well monitored both within West Berkshire and elsewhere. In 2012/13, 76% attended for at least 95% of the time. There have been no permanent exclusions of looked after children since the academic year 2007/8. In the last academic year (2013/14) there were nine fixed term exclusions from West Berkshire schools involving children who were looked

after at the time of exclusion. This is a rise of two exclusions from the previous academic year (2012/13). Five looked after children had alternative education programmes or were on reduced timetables. The education of these children is closely and effectively monitored by the virtual head and Looked after Children Education Service (LACES) consultants. The Alternative Curriculum Service has very recently received an Ofsted inspection and was judged to be good.

81. Comprehensive work is undertaken by LACES consultants in collaboration with the ethnic minority and travellers achievement service (EMTAS) to support unaccompanied asylum seeking children and those from Gypsy Roma communities in schools and further education settings.
82. The local authority provides all looked after children with leisure passes. Children and young people's successes are formally celebrated at an annual event for all looked after children hosted by the Corporate Parenting Board.

The graded judgement for adoption performance is that it requires improvement

83. West Berkshire's 'adoption scorecard' is good across all three indicators and shows that the three-year average time between a child entering care and moving in with its adoptive family is 506 days. This performance compares very favourably with the national threshold of 547 days. Despite this positive performance indicator, some cases sampled by inspectors showed delay in the progression of children's plans for adoption.
84. Of all the children who left care during 2011–14, 9% did so because they had been adopted. The local authority's own more recent data show that of the 75 children and young people who left care in West Berkshire in the 12 months prior to this inspection, 7% did so through adoption, which is a slight fall from the previous three-year period. This performance is also well below the 2013–14 England average of 17%. Fifteen children were adopted over the three-year period 2011–13. The local authority's own data show that six children were adopted in 2013–14 and a further seven were matched with adopters. West Berkshire has successfully increased its use of Special Guardianship Orders by 50% (11) on the previous year.
85. The most recent score card performance shows that the average time taken to identify a match once court authority has been given, is 108 days in West Berkshire. This compares very favourably with the national threshold of 152 days and the England average of 217 days. However, more recent data provided by the local authority shows that this has increased to 149 days. In cases seen by inspectors, family finding had not always started quickly enough nor been pursued with enough vigour. Two of three adopters spoken to by inspectors who had children placed with them during the last 12 months said

that they had experienced frustration and distress because of avoidable delay in progress made in the adoption process.

86. The whole process from when a child enters care to when they start their life with their adoptive family, including those placed but without an adoption order, took less than 18 months for 61% of adopted children in 2011–14. This is better than the national average of 51%.
87. Adoption services have recently transferred to the new 'Adopt Berkshire' arrangements, which is a collaborative, shared practice between four local authorities. The service provides recruitment, preparation, training, assessment and supervision of adopters. Whilst this is a relatively new service (January 2015), there is early evidence of a more focused and proactive approach to family finding. This means that children who have been waiting are now matched to prospective adopters. This includes a brother and sister group and an older child with high level needs. Adopt Berkshire is working closely with a local social enterprise company run by adopters. This has a target to recruit 40 new adoptive families across Berkshire in the next 12 months, 20 of whom will be for older children. This pilot is a positive feature but it is too early to measure any impact or positive outcomes for children.
88. At the time of this inspection, there were six children with a placement order who are waiting to be matched with adopters and seven adopters who have been approved. In the past six months the authority has received 20 adoption applications, of which ten have progressed to stage two with dates booked for panel hearings. Five of the applicants have completed stage one in a timely way and the remainder are on hold awaiting further health assessments or references. The average time between prospective adopters making an application to adopt and approval is 47.8 weeks. In the 12 months preceding this inspection 11 new adopters were approved.
89. Responses to initial enquiries are swift and progressed quickly on to preparation groups. Adopters are satisfied with the preparation and assessment process, but those spoken to by inspectors felt less prepared and supported during the period of waiting for matching to be approved, which some found particularly difficult.
90. Children's permanence reports (CPRs) sampled by inspectors were focused on the needs of children and clearly explained the goals for children in relation to securing permanency. Inspectors saw examples of sensitive matching, such as a child who uses a hearing aid matched with a family where one of the parents wore a hearing aid, and a child with speech and communication difficulties matched with an experienced special needs teacher. There have been no adoption breakdowns in the past three years.
91. Fostering to adopt is a high priority, and included as part of the assessment process. Eight foster to adopt families are available across Berkshire. This

provides children with continuity of care. Inspectors saw a positive example of a young baby in a fostering to adopt placement during the inspection.

92. The adoption panel chair is independent, experienced and knowledgeable. Social workers provide detailed, clear information about children, which enables the panel to make good decisions for them. The adoption panel is shared with the other authorities in the Adopt Berkshire partnership and meets twice a month, which means there is no delay putting cases before panel. The Agency Decision Maker, while new in post, is an experienced head of service who knows the role and responsibilities involved. Records sampled by inspectors demonstrated effective scrutiny of matching reports to endorse decisions to match children with their adoptive family.
93. In the majority of cases, life story work, books and later life letters have not had sufficient priority, which means that children do not have details of their case history and details of their birth family history. Adopters told inspectors they were unhappy that this important work had not been available to their children when required.
94. In the past 12 months, there have been 12 requests for post-adoption support. All resulted in appropriate support packages or signposting to relevant services. A range of services is on offer to families, including bespoke support packages. There are currently six active post-adoption support packages. The local authority is funding 19 adoption allowances. The LACE service supports adopted children and their families where appropriate. Two families are being helped pre-adoption order to strengthen the placement and encourage attachment behaviour. In addition, the team is providing post-order support to three families who have secured SGOs, and it funds SGO allowances in respect of 34 individual children.

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

95. Young people transfer to the leaving care service at 16 years. An enthusiastic leaving care team supports them. Young people spoken to by inspectors were resilient and ambitious, and were positive about their relationships with their personal advisors (PAs) and their social workers. This is evident through the persistent efforts made by personal advisors to maintain contact with young people who do not wish to engage.
96. Care leavers are seen regularly and are actively supported by their PAs and social workers. West Berkshire is in touch with the vast majority (54 out of 58) of its care leavers. Despite persistent efforts made, one young person does not wish to engage with the service, and three young people are unaccompanied

asylum seekers (over 18 years) who have had their appeals rights exhausted and despite the efforts of staff, have been unable to be located.

97. Young people are actively encouraged to remain with their foster carers after the age of 18. A total of nine young people who were in foster care turned 18 in 2013–14. Four of these remained in their foster placement beyond their 18th birthday. At 44%, this is lower than the national average of 52%. One young person (aged 19–21) also remained with foster carers during the year. The three-year average (2012–14) for the proportion of looked after children aged 16 who remained looked after when they reached 18 years of age was 65%, which is broadly in line with the national 3 year average of 67%.
98. The vast majority of care leavers live in appropriate accommodation. The local authority does not rule out the use of bed and breakfast accommodation as an emergency short-term measure, but has not used it in the last 12 months. A 24-bed purpose-built unit, including 'crash pad' provision, is used as emergency accommodation while an assessment is undertaken. Of seven care leavers spoken to by inspectors, three had been unhappy at times with their accommodation. The local authority had taken appropriate action to address these concerns and two young people were being moved to new placements imminently.
99. Liaison with the Housing Department to enable care leavers to access social housing is not effective, and there is no quota of tenancies available to care leavers. A young person's housing panel is now in place but has only a limited range of options open for use.
100. The Care Leaver Pledge is aspirational but does not include systematic information about young people's entitlements. Young people spoken to did not appear aware of their entitlements, though they knew that they could contact their worker if they wished to complain and said staff are open to challenge.
101. The quality of pathway plans is too variable, with the majority lacking analysis. Health needs are not sufficiently recorded, and young people are not involved enough in drawing up their plans. There is often delay in updating assessments and plans when young people transfer into the Leaving Care team at aged 16. This means that opportunities are lost to recognise their achievements and to make timely plans.
102. There is effective and appropriate partnership work with the Youth Offending Team where young people are in contact with the criminal justice system. Two young people over the age of 18 and open to the Leaving Care Team are currently in custody. Risks associated with drug or alcohol misuse and going missing are well managed and reduced.
103. West Berkshire has only just introduced health passports, with only one young person having received this important information. Not all care leavers were

aware of their entitlement to their health information. Young people and workers also report difficulty in accessing mental health services.

104. Care leavers are supported to maintain contact with family and friends where appropriate. There is sensitive and purposeful work to help young people maximise their potential. Personal advisors recognise and respond to the importance of diversity factors. Translation services are readily available for young people who need them. Unaccompanied asylum seekers are supported to join English language classes and to connect with appropriate cultural groups. Young people spoke of being well prepared for independence, and were positive about the independent living course. Care leavers who are parents are well supported by the Family Nurse Partnership and, where appropriate, the poppy midwife service.
105. Young people receive good support from the LACES team in addressing their educational needs. There is good collaboration between LACES, the Leaving Care team, schools and colleges to plan and support transition for young people pre- and post-16 who are preparing to leave care. PEP meetings have been introduced for 16–18 year-old care leavers and unaccompanied asylum seekers aged 16–21. Work to embed the PEP into pathway plans to support all post-16 care leavers in education and training, is in progress.
106. Four care leavers are currently studying at university; two have graduated this academic year. They receive appropriate study and financial support to achieve positive outcomes. Numbers are small and have dropped over time from 11 in 2011 to five in 2013. Care leavers access appropriate funding for higher education through the student grant scheme, the 16–19 student bursary scheme and other funding sources.
107. At the time of inspection, approximately 31% (18 out of 58) of care leavers were not in education, employment or training (NEET). Three of this cohort are aged between 16-18 years and are being closely supported by the LACEs team and the Connexions intensive support service. Six are parents or are pregnant and three are UASC with 'appeal rights exhausted' status. The remaining seven are receiving careers advice and guidance from an independent provider but it is not clear what this entails. A range of suitable training provision and further education options in the county is available, but data do not currently show where care leavers are employed or engaged in training or whether they are in provision that is appropriate for their level of ability and likely to help them achieve independence. There is only one West Berkshire Council-sponsored apprenticeship placement, which is ring-fenced for care leavers, but this is unfilled.
108. Young people clearly have good relationships with their social workers and personal advisors, who understand their needs and are committed to supporting them. There is a celebration of achievement event held each year, attended by senior council leaders. However, the voice of young people in planning services is weak.

Key judgement	Judgement grade
Leadership, management and governance	Requires improvement
<p>Summary</p> <p>West Berkshire’s early help services are strong, with effective strategic and operational partnerships. Lines of communication between political, strategic and operational leaders work well. This contributes to a clear corporate understanding about the weaknesses in the effectiveness of support for those children who are most vulnerable to harm. Strengthening services for vulnerable children is a key priority and appropriate action is being taken to address weaknesses.</p> <p>The key social work teams have experienced high vacancy and agency staff rates. This has had a significant impact on the consistency and quality of practice. In response to this staffing crisis, the local authority has invested in an ambitious and creative recruitment and retention strategy and has restructured the ‘front door’ of children’s social care. This has begun to make a difference.</p> <p>Over the past six months, actions to address poor performance have been sharpened. Operational, strategic and political leaders are aware of practice weaknesses and are committed to improvement. The cycle of improvement has also recently been strengthened through collating and tracking learning and actions from a variety of sources. This is leading to practice improvements in some key areas, although there is still much work to be done.</p> <p>Staff supervision is regular but task-focused, and does not pay enough attention to the analysis of children’s experiences or the next steps social workers should take. Management oversight at all levels is not consistently driving practice improvements.</p> <p>A good range of management information and data is available and is increasingly relied on by managers to inform them about performance. Not all managers have used this consistently or effectively, and this has hindered the improvement journey.</p> <p>Some strategic documents are strong and evidence clear partnerships and plans. In key areas the local authority has thought creatively about how it can respond to local need in a way that achieves both quality and good value for money, for example the Adopt Berkshire collaboration and tripartite training arrangement. However, other key documents, such as the looked after children strategy, do not clearly reflect the local authority’s thinking about current and future need. This is likely to reduce their ability to plan effectively for the future.</p> <p>The Principal Social Worker has a highly valued and increasingly effective role in improving the experiences of children, young people and families.</p>	

109. Workforce instability has become a significant challenge for West Berkshire, particularly over the past 12 months. Staff turnover is high at 29%, and within children's social care, 50% of social workers and managers in the core social work teams are agency staff. The local authority has responded appropriately to this challenge by investing in an ambitious and creative recruitment and retention strategy, implemented in September 2014. A key component of this strategy is the creation of a social work academy, a positive development that is enabling newly qualified social workers to spend six months in a protected learning environment before moving into one of the core social work teams. To date, four social workers and a team manager have been appointed. This significant financial investment demonstrates that leaders and politicians have understood the impact of their recruitment difficulties on frontline services and have taken decisive action to address these problems.
110. There are positive signs that the recruitment and retention strategy, combined with a sharper focus on poor performance, is beginning to have an impact with five permanent social work appointments recently being made. Start dates are imminent in some cases. However, this is yet to make a tangible difference to the experiences of children, young people and families.
111. Despite the considerable challenges these workforce issues have created, social workers are positive about working for West Berkshire. They describe an environment where managers are visible, supportive and enabling, and social workers value the direct involvement and interest of the DCS. Inspectors met a number of social workers and managers who have remained committed to West Berkshire through this difficult period, and who demonstrate warmth and genuine care for the children they are helping.
112. The training offer, provided through a tripartite arrangement with neighbouring local authorities, is comprehensive. The local authority has continued to prioritise the training and development of permanent and agency staff throughout this extended period of turbulence. Social workers' caseloads are on average 20 children. Managers use a caseload-weighting scheme to gain a clear view about the volume and complexity of work allocated to frontline staff, and this is identifying that the caseloads of some social workers, including NQSWs, are too high. Staff supervision files reflect that this issue is regularly considered and addressed. Sickiness rates are relatively low.
113. The Principal Social Worker is highly valued by social workers, and has been instrumental in highlighting practice deficits and strengths, as well as raising standards in key areas such as court work. Direct links to senior managers are ensuring a better understanding of what is happening on the frontline.
114. Over the past six months, the local authority has begun to deal with poor practice more robustly, helped by clearer information about performance and driven by a sharper focus on the ability of social workers and managers to deliver a safe and effective service.

115. There are regular and effective lines of communication between strategic and political leaders, such as monthly briefings between the Chief Executive, Lead Member, DCS and Head of Service. The Lead Member and the Chief Executive have a clear understanding of the strengths and weaknesses of children's services, and this enables the DCS to seek the support of political leaders when required. These lines of communication have facilitated the sharing of concerns about the delivery of frontline social work services, and this is supporting the change process. The DCS is actively involved in the LSCB and there are regular meetings between the Chief Executive, LSCB Chair and DCS. Although the role of overview and scrutiny has demonstrated some appropriate challenge when considering matters relating to children, a specific focus on children's services would further strengthen the scrutiny provided.
116. Social workers say that they have regular informal and formal time with their managers, although the records of these discussions lack attention to personal and professional development. Regular case supervision is evident, but it is task-focused with little reflection or analysis, for example about children's need for permanence and how this will be achieved. A key feature of cases seen by inspectors where children have waited too long to be assessed, helped or to have their permanence secured, is an absence of management oversight and grip. Although inspectors saw many examples where operational managers had identified poor practice or delay, actions were not followed up rigorously or consistently to ensure that the required changes were made.
117. The quality assurance framework includes a monthly cycle of deep dive case auditing, dip sampling and direct observation of practice, with themes and issues brought together in the quality assurance board, chaired by the DCS. A well-established audit cycle has accurately identified similar strengths and inadequacies in practice as those highlighted during this inspection. The ability of managers to address the practice issues identified is hampered by the churn in social work staff, and the improvement journey has been described as 'swimming against the tide', with some re-audited cases continuing to be inadequate. Appropriate steps are being taken to address poor performance, and tracking tools and processes are being used to identify drift and delay. However, the overall response to practice deficits highlighted through audit activity lacks drive and rigour. This means that opportunities to improve children's experiences and outcomes have been missed. In the majority (80%) of cases, the findings from audits undertaken by the local authority for this inspection concurred with those of inspectors. However, some audits were overly positive and lacked sufficient detail, challenge and analysis of the impact of practice on children's outcomes.
118. Poor management information and data have affected the line of sight of managers and strategic leaders within children's social care. This has been a particular issue in the CAAS, where managers did not use live data relating to key areas of practice and performance until October 2014. Staff and managers in other social work teams report that they, too, have only recently begun to use data to monitor important activity such as social work visits. Since the

introduction of the Data Zone in April 2014, the quality of management information available to staff and managers at all levels has steadily improved. Where this is being used well, it is enabling managers to focus more keenly on poor performance. The usefulness of this information would be strengthened by the inclusion of narrative and comparative data.

119. West Berkshire's IROs also chair child protection conferences. They have high caseloads (74 to 92 children), which include both looked after children and children subject to child protection. This service is an important component of the quality assurance process, and the IRO service is not effectively fulfilling its function to identify and escalate practice issues relating to individual children. As a result, wider learning opportunities have been lost. The IRO service has introduced a process for formally recording issues that have been escalated, along with the outcome and learning. However, this is a very recent development and there is limited evidence yet that it is making a difference to individual children or improving wider practice.
120. The response to individual complaints seen by inspectors has been timely, with evidence of the direct involvement of senior managers and sensitive personal contact with young people. However, the cycle of learning from complaints and representations is significantly underdeveloped, and there is no formal record where practice improvements and changes can be recorded and tracked.
121. Corporate parenting members demonstrate a commitment to looked after children in West Berkshire. Looked after children attend the Board and share what is important to them. The Board has secured leisure passes, work experience and has heard first-hand about the worries that looked after children have about the number of changes of social worker they experience. The Board receives appropriate quantitative and qualitative performance information about looked after children, and this is used to challenge performance. Current priorities of the Board are improving the timeliness of health and dental assessments as well as securing consistent social workers for looked after children. There is limited evidence that the engagement of children and young people with the Board has led to tangible changes, and the Board has not been proactive in championing access to better housing for care leavers, or the need for looked after children and care leavers to have swifter access to CAMHS.
122. Placement stability for looked after children is strong, and the proportion of looked after children in family placements is high. The importance of ensuring that there are sufficient local placements for children with more complex needs is recognised, and a retained foster carer scheme has been launched, championed by the Lead Member for children's services. Although recruitment has begun, the local authority has yet to appoint any foster carers to the scheme.
123. The sufficiency strategy was amended to reflect the local authority's current thinking while inspectors were on site. Although it demonstrates an

understanding of how the local authority plans to respond to changes in demand and capacity, this thinking is not clearly articulated by managers. For example, there is no clear plan to reduce the proportion of looked after children who live more than 20 miles from West Berkshire.

124. There is a strong and shared commitment within the local authority to the educational achievement of looked after children. Strategic and political leaders share the ambition and passion of the virtual head teacher and the LACES service. The achievements of looked after children and care leavers are recognised by an annual awards ceremony. However, the Chief Executive has not used the opportunities available to him to have direct contact with looked after children so that he can hear first-hand the issues that they are most worried about, and the achievements they are most proud of. The local authority has not been sufficiently proactive in securing apprenticeships nor a sufficient range of suitable accommodation for its care leavers.
125. The local authority has developed some effective partnerships grounded in strong strategic documents, for example the West Berkshire Domestic Abuse Strategy and Strategic Intent 2015–2016. However, it has been slow to underpin other work with clear strategic plans. The child sexual exploitation strategy is more of a helpful working guide for practitioners than a strategy, and this means that although partnerships are working well in this area there is no written multi-agency arrangement to plan and develop this important work for the future. The looked after children strategy 2014–15 is not sufficiently detailed. It does not effectively identify some key issues, such as the high number who are looked after under Section 20 of the Children Act 1989.
126. The local authority is proud of its early help services. The Domestic Abuse Response Team, Help for Families and the Family Resource Service all evidence effective partnership arrangements, child and family centred practice and improving outcomes for those families who receive help at this level. Strategic and political leaders and their partners have recognised that early help services are crucial in preventing difficulties within families from escalating, and in supporting families who no longer need the help of children's social care. The early help offer is supported by strong commissioning arrangements and a shared vision. This work is underpinned by a thresholds document that is well understood, and this is helping practitioners to make decisions about the level of need within families, and where help and support should be sought from. This is in direct contrast to the services received by children who have complex needs and require statutory or specialist services from children's social care. Ongoing assessment, planning and management oversight of work with children in need and those subject to child protection plans is inconsistent and not sufficiently robust across all of the core social work teams. This has led to drift and delay for some children and not all of their needs being consistently assessed or met. Management action to address these shortfalls has not yet been sufficiently effective.

127. Commissioning arrangements are working effectively, with services such as advocacy and family group conferencing meeting demand and contributing to improved outcomes for children. The local authority also purchases creative bespoke packages for individual children and families. However, there is no overarching commissioning strategy for children's services, which means that the local authority's thinking about future need is not informed by a plan based on emerging or predicted need.
128. The local authority has notified Ofsted of three serious incidents in the past two years. One of these resulted in the LSCB commissioning a serious case review, 'Child G', which was published in May 2014. The remaining two incidents have been appropriately considered by the LSCB case review sub-group where decisions were made not to undertake serious case reviews. The local authority was in the process of submitting two further two serious incident notifications to Ofsted during this inspection.
129. Safeguarding and looked after children information is included in the Joint Strategic Needs Analysis (JSNA), for example highlighting the need for timely health assessments for looked after children. The key priorities of the health and wellbeing strategy include promoting the emotional wellbeing of children and improving the health and educational outcomes of looked after children, but there is little evidence that safeguarding is a key focus for the Health and Wellbeing Board (HWB). The Lead Member for children's services, DCS, Chair of the LSCB and Chief Executive are engaged in the West Berkshire HWB, where the health and educational outcomes of looked after children are one of its 'hot focuses'. Berkshire East & Berkshire West Clinical Commissioning Groups are taking appropriate steps to address the significant capacity issues within CAMHS, and to provide more creative emotional and mental health support to children and young people.
130. Although consideration of the capacity of the DCS (who has responsibility for both children's and adult's services) through self-assessment and peer review has led to the appointment of an additional service unit head, there has been no externally commissioned test of assurance. This means the local authority cannot be sure that the DCS has sufficient capacity to effectively lead and manage the range of services for which she has responsibility has not been tested beyond that required by the statutory guidance.
131. The local authority has a strong presence at the Family Justice Board. The Judiciary and Cafcass are positive about social work reports and the improvement of the quality of evidence, but have also highlighted delays within pre-proceedings work.

The Local Safeguarding Children Board (LSCB)

The Local Safeguarding Children Board requires improvement

The arrangements in place to evaluate the effectiveness of what is done by the authority and board partners to safeguard and promote the welfare of children require improvement.

Summary of findings

The LSCB is requires improvement because:

Scrutiny, Awareness and Challenge

- The LSCB's self-evaluation in 2014 recognised a number of shortfalls and it has taken action to address them. A new, highly experienced chair has quickly brought a culture of challenge, openness and transparency to the LSCB. While there are promising signs of early improvement in the Board's scrutiny and challenge of partner agencies, it is too soon for there to have been a big impact on its effectiveness in carrying out its objectives.
- Historically, the Board has not had sufficient sight on practice at the frontline and has not had access to comprehensive, accurate performance data.
- Its work and scrutiny has not been sufficiently informed by the views of service users and staff.
- The Board's 2013–14 annual report lacks analysis and is not sufficiently challenging.
- Until recently, the Board lacked clear and appropriate priorities for improvement.
- The LSCB has overseen improvements in service responses for children at risk of child sexual exploitation, but work in this area lacks a clear strategic plan.
- The Board is now becoming better sighted on the quality of frontline practice. It has received reports from four thematic multi-agency audits, although these vary in quality and rigour
- The Board has a well-understood published threshold framework. This is ensuring that children and young people receive early help at the right time.

Business Costs

- The Board is under-funded when compared with LSCBs in comparable areas. Not all member agencies contribute enough to meet the costs of the Board's activities. This limits the Board's effectiveness to undertake the full range of business.

What does the LSCB need to improve?

Priority and immediate action

Performance information

132. Receive regular detailed reports on the impact of staffing shortfalls within children's social care and partner agencies, and where necessary raise challenge to the agencies concerned.
133. Make better use of performance management information to enable the Board to be sighted on partner performance.
134. Improve the range and quality of thematic and case file audits, and ensure that findings are addressed through robust action planning.

Child Sexual Exploitation

135. Review partners' approach to the strategic planning of work to protect children from child sexual exploitation to ensure coordinated CSE planning.

Areas for improvement

Feedback from staff and service users

136. Put in place arrangements to hear the voices of young people through engagement and consultation.
137. Consult staff regularly on their views and experiences on the sufficiency and quality of services in order to inform services.

Annual report

138. Embed the use of appropriate data within the new Annual Report and ensure the report provides a robust and transparent analysis of current service effectiveness.

Business Operation

139. Review the financial contributions made by member agencies to support the effective running of the LSCB.

Inspection judgement about the LSCB

140. Historically the work of the LSCB has been insufficiently focused on its key function of monitoring the effectiveness of local services and providing challenge to partners to improve services where required. The Board's own self-evaluation identified this in 2014 and it has taken appropriately urgent action to improve its functioning. This included the appointment in August 2014 of a new, highly experienced independent Chair, who commenced her duties in

October 2014. These changes have generated a step change in the operation of the Board, which now has a much clearer and more appropriate set of priorities, focused on those areas where services are most in need of improvement.

141. The new Chair has introduced more of a challenge culture between partners and this is starting to take effect. Partners report that her leadership is enabling the Board to provide robust scrutiny of frontline work. The Section 11 Panel has just completed its three-year cycle of work, with agencies' section 11 audits showing increased rigour. It has also challenged and overcome some resistance to agencies undertaking these audits.
142. The Chair is challenging partners to make contributions that are more proportionate to the work of the Board, which is underfunded when compared with statistical neighbours. The Board is appropriately staffed, though the Board Manager is new in post.
143. The Annual Report 2013–14, published in April 2014, lacked proper analysis and is not supported by appropriate performance management information. It does not identify weaknesses in practice nor does it sufficiently challenge partners to improve. The improvements undertaken by the Board since this report position it better to produce a much stronger annual report for 2014–15. The Board has published a new Business Plan, which is clear and sets out appropriate priorities.
144. West Berkshire LSCB has suitable arrangements for governance. The Chair of the Board regularly attends the Health and Wellbeing Board, where the Joint Strategic Needs Assessment is discussed, and meets regularly with the Chief Executive and the DCS. These relationships are open and positive, with the Chair able and encouraged to provide robust challenge. There are appropriate links with the Safer Communities Partnership and the Safer Adults Partnership Board. The LSCB has set in place a clear set of five priorities (early help; the voice and journey of children and young people; child sexual exploitation and missing children; domestic abuse and vulnerable groups; effectiveness of the LSCB) and these are forming the drivers for change and the forward planning agenda. The draft Business Plan for 2015–16 reflects this.
145. West Berkshire shares a number of its sub-groups on either a pan-Berkshire basis (Policy & Procedures, Child Death Overview Panel and the Section 11 Panel) or a West of Berkshire basis (Learning & Development and Case Review sub-group). It runs its own Quality and Performance and Child Sexual Exploitation sub-groups. The performance element has recently been brought back 'in-house' to strengthen its specific focus on West Berkshire. A range of senior professionals chairs these groups across Berkshire. Two lay members are engaged in the Board's work and bring valuable community links.
146. The Child Death Overview Panel is chaired on a pan-Berkshire basis and carries out its functions effectively. It reports regularly to the Board, and its most

recent report sets out appropriate priorities for prevention work, which were endorsed by the Board.

147. Appropriate policies and procedures are in place and subject to regular review and revision. The multi-agency thresholds document, reviewed in May 2014, is clear and concise. There is evidence that this is appropriately understood by referring agencies. Work to protect young people from CSE is developing. Although there is no overarching strategy, a framework enables professionals to work together supported by an information-sharing protocol and risk-assessment tool. The CSE action plan contains relevant actions linked to prevention, identification and support, and prosecution. Training is available for professionals. E-learning on CSE has been made available but has had limited impact, with only 57 professionals completing the programme. This shortfall is recognised and addressed in the CSE action plan. Regular operational meetings are held to coordinate work on missing children. The CSE sub-group is well attended and effectively monitors partner activity. Awareness raising in schools and the community has taken place. A co-ordinated programme of performances and workshops using 'Chelsea's Choice' has been delivered to local secondary schools. Return interviews of missing children are appropriately undertaken. Thames Valley Police have undertaken several local operations to disrupt perpetrator activity. The LSCB has undertaken a thematic audit of work to protect children from sexual exploitation, which produced some good learning.
148. The local learning and improvement framework does not reflect the views of staff or service users and does not include learning from audits or the impact of training. The case review sub-group appropriately considers multi-agency information about serious incidents that have been formally notified to Ofsted. This process led the LSCB to commission a serious case review in one case, 'Child G'. The report was published in May 2014. The impact of the review would have been strengthened by clearer findings about practice and where this required improvement. The LSCB has followed through its recommendations and delivered learning events for staff, which it evaluated.
149. The voice of young people has not yet been consistently heard at the Board and is now a priority. Annual reports on private fostering and on the Local Authority Designated Officer service have been received and scrutinised by the Board.
150. The Board has not been supported by access to accurate and reliable management information. This has improved recently, but performance information does not currently include comparative data, which would assist the Board to benchmark the performance of local services. A move to a more comprehensive dashboard approach is strengthening its ability to recognise issues as they emerge.
151. The Board is beginning to have a better understanding of the quality of frontline practice than previously. It has received reports from four thematic

multi-agency audits (children in need, child protection plans, CSE and safeguarding in schools) and receives the conclusions of audits undertaken within the local authority. Overall, these audits lacked rigour, but the one on CSE in particular is starting to help improve multi-agency practice. There is a stronger culture of mutual challenge developing within the Board. For example, it recently challenged partners on the completion of health assessments for looked after children. A paper came to the Board in March 2015 reporting that improved arrangements are being put in place and the completion rate has risen from 68% to 81%. The provision of reports by GPs for child protection conferences has risen to 50%, following challenge. This is evidence that increased scrutiny is enabling the Board to exert greater influence.

152. The influence of the new Chair is beginning to have an impact on the coordination of services for children. She is raising the profile of children's safeguarding at the Health and Wellbeing Board and with the Chief Executive of the local authority. Partners are beginning to respond to the culture of constructive challenge, which has, for example, recently led to increased health visitor capacity provided in children's centres. The Risk/Concern log that the Board now maintains ensures that it understands the wide range of improvements needed across services for children, including the capacity and effectiveness of children's social care staffing and access to CAMHS.
153. A commissioned programme of LSCB training is in place and is monitored by the Berkshire West group that reports into three local Boards. All LSCB partners support attendance at multi-agency training, which staff report to be of high quality. The LSCB is beginning to evaluate its impact further by follow-up with staff after learning events. An annual Safeguarding Conference in partnership with the Safer Adults Partnership Board is held, with one planned for later this year.

What the inspection judgements mean

The local authority

An **outstanding** local authority leads highly effective services that contribute to significantly improved outcomes for children and young people who need help and protection and care. Their progress exceeds expectations and is sustained over time.

A **good** local authority leads effective services that help, protect and care for children and young people and those who are looked after and care leavers have their welfare safeguarded and promoted.

In a local authority that **requires improvement**, there are no widespread or serious failures that create or leave children being harmed or at risk of harm. The welfare of looked after children is safeguarded and promoted. Minimum requirements are in place, however, the authority is not yet delivering good protection, help and care for children, young people and families.

A local authority that is **inadequate** is providing services where there are widespread or serious failures that create or leave children being harmed or at risk of harm or result in children looked after or care leavers not having their welfare safeguarded and promoted.

The LSCB

An **outstanding** LSCB is highly influential in improving the care and protection of children. Their evaluation of performance is exceptional and helps the local authority and its partners to understand the difference that services make and where they need to improve. The LSCB creates and fosters an effective learning culture.

An LSCB that is **good** coordinates the activity of statutory partners and monitors the effectiveness of local arrangements. Multi-agency training in the protection and care of children is effective and evaluated regularly for impact. The LSCB provides robust and rigorous evaluation and analysis of local performance that identifies areas for improvement and influences the planning and delivery of high-quality services.

An LSCB **requires improvement** if it does not yet demonstrate the characteristics of good.

An LSCB that is **inadequate** does not demonstrate that it has effective arrangements in place and the required skills to discharge its statutory functions. It does not understand the experiences of children and young people locally and fails to identify where improvements can be made.

Information about this inspection

Inspectors have 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 seven of Her Majesty's Inspectors (HMI) from Ofsted.

The inspection team

Lead inspector: Linda Steele HMI

Deputy lead inspector: Stephanie Murray HMI

Team inspectors: Helen Cawston HMI, Emmy Tomsett HMI, Susan Myers HMI, Andrew Wyatt SHMI, Stella Butler HMI

Quality assurance manager: Nick McMullen SHMI

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Piccadilly Gate
Store St
Manchester
M1 2WD
T: 0300 123 4234
Textphone: 0161 618 8524
E: enquiries@ofsted.gov.uk
W: www.ofsted.gov.uk
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