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Dear Ms Dodds

Monitoring visit to Reading Borough Council children's services

This letter summarises the findings of the monitoring visit to Reading Borough Council children's services on 6 and 7 February 2018. The visit was the fifth monitoring visit since the local authority was judged inadequate in June 2016. The visit was carried out by Nick Stacey, Linda Steele and Tracey Scott, Her Majesty's Inspectors.

The local authority is making uneven and overall slow progress in improving services for its children and young people.

Areas covered by the visit

During the course of this visit, inspectors reviewed the progress made in the area of help and protection, with a particular focus on the work carried out in the safeguarding teams and children and young people's disability team. Inspectors concentrated on children who are the subject of child protection and children in need plans.

The visit considered a range of evidence, including electronic case records, supervision notes and performance information. Interviews were held with social workers, team managers and independent reviewing officers. Inspectors also met with senior managers and the chief executive.

Overview

The local authority has made little progress in improving the standard of statutory social work with children and their families when there are serious concerns that require a statutory child protection or child in need plan. There is a significant number of unallocated child in need cases of which senior managers were not fully aware until shortly before the visit. Although most of these children's case files have been recently reviewed by senior managers, many children have not been seen for

substantial periods of time and their current circumstances and safety is unknown. Too many children are repeatedly placed on child protection plans, and some are stepped down from plans too quickly. There are delays in implementing child in need plans and a lack of management oversight or rigorous, regular multi-agency reviews. The majority of child in need plans, and some child protection plans, have shortfalls in their objective to help parents and children promptly improve children's circumstances, safety and well-being.

Findings and evaluation of progress

Inspectors were told during the visit that 53 children in need did not have an allocated social worker. This number has reduced from an original cohort of 128 identified in January 2018. A smaller number of children in need had been allocated to team managers who were unable to visit the children and families concerned. Senior managers had only recently become fully aware of all of these cases, and had reviewed them either shortly before or during the visit. They were investigating how their performance management system had failed to highlight these cases and make them immediately visible. The recent abrupt departure of three senior managers was referenced as a possible factor, but it was not made clear to inspectors how their exit undermined accurate core performance reporting, and why system checks and balances had not identified the cases immediately. Senior managers were implementing remedial measures at the time of the visit, primarily the urgent formation of a children in need project. Social workers and managers from other parts of the service were being assembled to visit the children and families concerned and undertake a brief assessment. Inspectors sampled a small number of these children's cases and no immediate, urgent safeguarding risks were found. However, many children had not been visited for many weeks or months and their circumstances could have deteriorated further.

Inspectors asked senior managers to urgently review the cases of 10 children following the visit. These children were the subject of child in need or child protection plans; significant safeguarding concerns had been identified, but electronic case files did not demonstrate whether they had been rigorously addressed and significant delays were apparent. These cases provide further evidence of the weak management oversight and review of these children's circumstances. The management review of these cases will be provided to the lead inspector when completed.

Too many children and families are subjected to statutory social work assessments which are subsequently closed without any further social work intervention provided, indicating that the threshold is not being appropriately applied. This means that social workers in the advice and assessment teams are assessing families and children to receive statutory services when their needs could be suitably met by a targeted or universal early help offer. The previous monitoring visit assessed threshold decision-making at the single point of access as largely reliable, but a

recent auditing programme in the service appears to have resulted in a lowering of the threshold, resulting in a greater number of referrals inappropriately proceeding to statutory assessments. Internal thresholds and gateway management in the children's service are confused and inconsistent, meaning that many children are not offered appropriate help and support at the right part of the service.

The quality and impact of interventions offered to children and families on child in need plans are largely ineffective. Only half of children are visited in accordance with their six-weekly plan timescales. Some direct work with children is skilful and provides rich accounts of their personalities, interests and worries, but this was not evident in most of the cases seen during the visit. Home visit recordings by social workers were often unfocused, and conversations and observations of children hurried and superficial. Management supervision rarely highlights children's experiences and the extent to which social workers are able to develop constructive, trusting relationships with them. Social workers are not offered sufficient professional, reflective advice by their supervisors to help them when children and their parents are resistant to and avoid contact.

Most child in need and child protection plans do not illustrate how social workers will use their own professional direct work skills in their visits to families to address identified risks and concerns. Direct work is often referred to other internal services, such as the edge of care service, or to external agencies focusing on domestic abuse or substance misuse. This leads to a dominant case management approach by many social workers and their case supervisors, where the impact of interventions is primarily measured by the take-up of services rather than a careful evaluation of improvements in children's circumstances.

The increasing use of the signs of safety model is evident in child protection and child in need plans, child protection conferences and management supervision records. Danger statements capture the primary risks to children concisely. Most summaries of strengths, worries and grey areas are informative and relevant. However, the content of children in need plans is generally not specific enough to progress the improved outcomes sought for children. Plans are not reviewed regularly, and when reviews are held, few of the involved agencies attend. Team managers do not attend child in need reviews and rarely attend child protection conferences. This means that managers are not involved enough in shaping plans or the progression of them. This is a significant factor in widespread drift and delay in children's cases allocated in the safeguarding teams. The weak engagement of external agencies is also a major shortfall in effective child in need planning and reviewing.

Recognised and well-established tools to help social workers understand and measure the impact of neglectful home circumstances on children's well-being are not used. This means that the severity, duration and forms of neglect that children

experience are not clearly understood, and the efforts to reduce them are not well directed.

Too many children on child protection plans are stepped down at the first review conference, three months after the initial conference is held. This indicates that decision thresholds for implementing the plans are misplaced, and that sustained improvements in children's circumstances and safety are not evidenced. Inspectors saw a small number of cases where the decision to remove children from a plan at this early stage was premature. This is likely to be a significant factor in the comparatively high rate of children repeatedly placed on child protection plans. The independent reviewing officer service had not examined this trend sufficiently closely, and could not clearly explain the reasons for it.

Child protection plans clearly stipulate the outcomes sought to improve children's circumstances, but not all outline plans are sufficiently specific and targeted. Core group meetings are not held regularly and there are often delays in recording them on the electronic case files. Many core group meetings focus largely on case updates, omitting to closely evaluate the impact of plans and refine them accordingly. Inspectors saw the continuing use of inappropriate written agreements with parents. Positively, there is increasing evidence of independent reviewing officers' footprints between child protection conferences, particularly in mid-way reviews with social workers. This provides a helpful and increasing thread of challenge and support.

Some letters before proceedings to parents are specific and clear, but inspectors saw significant delays in completing subsequent pre-proceedings work in a small number of cases seen during the visit. This particularly concerned the late completion of parenting assessments and progress of work when parents did not attend meetings. Managers have implemented effective measures through a recent review of all these cases, and either concluded the pre-proceedings work or instigated care proceedings. Consequently, there are a high number of children in care proceedings. More rigorous tracking arrangements have been introduced to prevent a recurrence of further delays and reduce the associated uncertainty for children and families.

Only two children in the young people's disability team were on child protection plans. Inspectors judged that in both cases the plans should have commenced sooner. Not enough social workers in the team are able to use augmentative communication methods such as 'Makaton', and are therefore restricted in their ability to communicate with non-verbal children who may also have learning difficulties. There was evidence of more direct work with children who have receptive and expressive language ability. Supervision is provided regularly for social workers in the team, but is more focused on the management of the child's disability than on a holistic review of the family and child's circumstances.

The workforce environment continues to be unstable. Three senior managers have recently abruptly left in quick succession, including the interim head of safeguarding and improvement. Caseload pressures and numbers in the safeguarding teams are

high and some social workers reported that their workloads are unmanageable. This pressure is largely due to a high number of allocated lower level children in need cases, which senior managers are planning to transfer to a dedicated team that was forming at the time of the visit. While this arrangement may address the immediate crisis, the longer term solution requires more effective threshold management to reduce the continuing high rate of children in need cases managed in the statutory safeguarding teams.

Inspectors saw a high rate of social worker and team manager turnover in the safeguarding teams, resulting in numerous changes of social worker for families and inconsistent case management and supervision for social workers. This turbulent workforce environment is undoubtedly an important factor in the predominantly weak standard of social work provided to children and families, where there are significant needs and child protection concerns. Team managers are responsible for too many children's cases, and some conscientious and industrious managers struggle to provide rigorous and secure management oversight.

I am copying this letter to the Department for Education.

Yours sincerely

Nick Stacey

Her Majesty's Inspector