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Ms Ann Marie Dodds
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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 25 and 26 October 2017. The visit was the fourth monitoring visit since the local authority was judged inadequate in June 2016. The visit was carried out by Nick Stacey and Linda Steele, Her Majesty's Inspectors.

The local authority is making purposeful 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 targeted early help services, the children's and families' single point of access (SPA) and the quality of social work practice in the advice and assessment service.

The visit considered a range of evidence, including electronic case records and interviews with social workers, early help workers and their managers. Inspectors also spoke to senior managers, the chair of the children's services improvement board (CSIB) and the lead member for children.

Overview

The local authority has made substantial progress in the areas considered during the visit. The quality and impact of early help work are improving children's outcomes. Skilled, experienced early help practitioners and their managers have a stronger profile and influence in children's services. This is demonstrated in greater workforce confidence, exemplified through, for example, more rigorous escalations of safeguarding concerns to the children's SPA. Contact and referrals in the SPA are managed promptly, supported by consistent management oversight. The quality and reliability of threshold decision-making in the SPA have improved considerably, but is



not yet entirely consistent. However, the SPA became fully operational only shortly before the monitoring visit.

Most referrals and decisions to proceed to child protection investigations are appropriate and timely. Children are safeguarded when risks are initially identified. The majority of child protection enquiries are of a good quality and closely reviewed by managers. The quality of single assessments continues to improve, and most are of a competent standard.

The children's improvement plan has been shortened and is rightly focused on key outcomes for children. This provides better evidence of the progress made in improving services, and supports more effective scrutiny of those areas that require further work.

Findings and evaluation of progress

The recently established SPA includes a range of partner agencies, most of which are helpfully located together, with others readily available through effective communication arrangements. Additional agency partners are quickly integrating with the SPA, and well-attended daily meetings have been introduced to consider more complex cases, including domestic abuse and missing children. These arrangements are quickly developing more effective inter-agency working relationships. This is resulting in a shared understanding and application of threshold decision-making, particularly concerning domestic abuse, which comprises a large percentage of contacts and referrals. Parental consent to share information is understood well and is appropriately sought or overridden, as necessary. Previous contacts, referrals and interventions are quickly and capably summarised to inform more considered decision-making.

Experienced, committed social workers and managers have been recruited to work in the SPA, and the impact is demonstrated in prompt responses to contacts and referrals, and in improved decision-making. Regular management oversight is evident and comprehensively recorded in all contacts and referrals. There are clear processes in the SPA to gather and share information between partner agencies to inform decisions. Children at risk are quickly identified and allocated without delay in the advice and assessment service.

The recently introduced SPA operational manual and accompanying workflow charts provide a clear process and are helpful guides for staff. Contacts are rated red, amber or green (RAG) by social workers, and are subsequently threshold RAG-rated by managers.

In a small minority of more complex cases, threshold decisions in the SPA were questionable. This did not leave children at risk, but did suggest a strong likelihood of subsequent re-referrals. Some long-standing parenting difficulties which adversely affected outcomes for children were not fully explored and referred for a single assessment or to early help services. However, continuing internal quality assurance



of SPA decisions and case disposals is ensuring a greater consistency of threshold decisions.

Weekly consultations between early help services and the SPA reflectively and rigorously consider increasing risks. When children's cases escalate to statutory services, early help workers continue to work alongside social workers where they have established constructive, trusting relationships with children and their families. The integration of early help in the SPA is increasingly ensuring that families and children with complex needs and higher levels of risk are not inappropriately and prematurely stepped down to early help services. Performance information in the SPA is useful, but too limited. This is understood by senior managers. The local authority's performance team is working purposefully with SPA managers to develop this further.

Managers recognise that referrals from the SPA to early help should be quicker to enable children to be seen more promptly. Overall, the quality of targeted early help provided to children and families is of a good standard. Direct work is purposeful. Children are seen alone, and careful efforts are made to engage them and understand their experiences using a range of direct work tools and outcome measurements. In some cases, direct work should be more aligned with the objectives of a child's plan to avoid work drifting and becoming aimless. However, effective planning and reviews were strongly evident in the majority of cases seen during the visit. Early help assessments were well written, incorporating the views of other involved agencies, and most contained well-balanced analysis. In some cases, the views of extended families and networks were not sufficiently explored.

Management oversight of early help work is frequent and largely effective. In some cases, there is a need to ensure that all actions have been implemented, and in a small minority of cases seen where risks were escalating there were missed opportunities to step up the concerns to statutory services sooner. However, in other cases seen, the understanding and analysis of, and reflection on, increasing risks were competent, ensuring that those children were swiftly referred to the SPA.

Morale in the early help services is high. All workers and managers spoken to by inspectors reported that the importance and profile of early help are increasingly recognised, both in the council and across partner agencies. Managers are working constructively and purposefully with schools, health and other partner agencies. This is enabling them to build more capacity and confidence in universal services in order that they can manage children and families with lower levels of need without referring them to the SPA. An improving partnership engagement at strategic and operational levels, through the Local Safeguarding Children Board (LSCB) and the children's services improvement board, provides positive indications that these efforts will continue to gain momentum.

The local authority's ability to quality-assure its work with children and families effectively has continued to develop positively since the last monitoring visit. Inspectors agreed with the findings of the local authority in the six cases tracked



during the visit, and auditing appeared more proficient, outcome-focused and reflective. A new auditing model called 'Beyond auditing', valued highly by frontline workers and managers, is being developed across all service areas. In addition to seeking and sharing views on the findings of audits, the model includes live coaching and reflection with workers and managers on their work with children and families. This is creating a learning culture in children's services. Social workers and other frontline workers welcome discussion on their practice in a non-threatening, developmental climate.

Referrals and decisions to start child protection enquiries are appropriate and timely. The majority of strategy discussions are still held in telephone calls, mainly with the police and excluding other involved agencies. This is a missed opportunity, given that the police, health and other agencies are located in the SPA. The records of strategy discussions vary in quality, and some records of actions are too basic and unspecific.

Most records of child protection enquiries are thorough and closely overseen by managers. Children are seen alone, and interviews with them are detailed and well recorded. Most single assessments are competent, and have continued to improve since they were evaluated in an earlier monitoring visit. Assessments are well informed by involved partner agencies, but not all are sufficiently tailored to each individual child in the family. This could result in some children's individual needs not being fully understood.

The use of written agreements with parents where there are child protection concerns, and for children who are the subject of child in need plans, is too widespread and not always appropriate. Unrealistic measures to manage risks are evident in some agreements, and it is not clear how their impact is reviewed and monitored.

Effective direct work with children in the advice and assessment service enables social workers to understand children's experiences through the use of direct work tools. Children's voices are prominent in assessments. Management oversight in the service provides clear case directions for social workers, and the rationale explaining management decisions has strengthened. Social workers report that they are well supported by managers on a day-to-day basis and receive regular case supervision.

The children's improvement plan has been shortened and is now focused on important outcomes for children, with a more manageable set of performance indicators. Areas which are improving, and those which are not, are more visible, enabling a sharper focus. The emerging use of storyboards to scrutinise important areas of practice, such as child sexual exploitation, vulnerable adolescents and early help, is assisting the CSIB to focus on performance in greater detail. The LSCB has refreshed and developed the impact of partnership engagement and is more aligned with the CSIB, in which the engagement of police and health has significantly improved. Partners are expressing greater confidence in the progress of improvement in frontline practice and at a strategic level.



The recently appointed permanent chief executive has created a more supportive, corporate environment across children's services, and this is strengthening and accelerating the capacity for improvement. Finance, legal services, human resources and workforce development are now supporting and working alongside children's services senior managers rather than in isolation from them. This provides the director of children's services and her senior team with a more conducive setting in which to continue to address the significant challenges that remain. Good progress has been made with the recruitment of permanent third-tier service managers, and significant inroads are being made into the recruitment of more permanent team managers. The recruitment of more permanent social workers remains difficult. An effective workforce development plan is now in place, but it has taken too long to develop.

I am copying this letter to the Department for Education. This letter will be published on the Ofsted website.

Yours sincerely

Nick Stacey **Her Majesty's Inspector**