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Dear **local partnership**

Joint targeted area inspection of the multi-agency response to abuse and neglect in Wokingham Borough Council

Between 22 May and 26 May 2017, Ofsted, the Care Quality Commission (CQC), HMI Constabulary (HMIC) and HMI Probation (HMI Prob) undertook a joint inspection of the multi-agency response to abuse and neglect in Wokingham Borough Council.[1]

This letter, to all the service leaders in the area, outlines our findings about the effectiveness of partnership working and of the work of individual agencies in Wokingham.

This joint targeted area inspection (JTAI) includes an evaluation of the multi-agency 'front door' for child protection, when children at risk become known to local services. In this inspection, the evaluation of the multi-agency 'front door' focused on children of all ages who are being or who have been neglected. The JTAI also included a 'deep dive' focus on children between seven and 15 years old who have been neglected. This group of children will be referred to as 'older children', for the purpose of this letter.

The partnership in Wokingham is well established, and partners are clearly focused on driving improvements to ensure the appropriate recognition and response to the neglect of children. The often-hidden nature of neglect in a relatively affluent area such as Wokingham is understood by partners. Good use is made of external scrutiny to support

[1] This joint inspection was conducted under section 20 of the Children Act 2004.

improvements in practice, such as the current engagement with a local university research project on neglect in affluent areas.

The development of the multi-agency safeguarding hub (MASH), created in 2016, is ensuring that professionals receive the support and advice they need to refer concerns about children to children's social care. Most children experiencing neglect have their needs promptly assessed and appropriate services provided, including support for families while social work assessments are being completed.

There is partnership commitment and good attendance at multi-agency meetings such as child protection conferences and core groups. The use of advocates for children is a strength, meaning that their views, including their experience of neglect, are well represented at key multi-agency meetings such as conferences. The importance of the child's voice is understood across the partnership, and staff across agencies, including health, the police, children's social care, schools and the Youth Offending Service (YOS), engage effectively with children who are or have been neglected to ensure that they know them well and understand their views.

Outcomes for children experiencing neglect are seen to improve when professionals have effective working relationships with families, and skilled partnership work to ensure this was seen in some cases. Schools play a crucial role in working with partners and parents to understand children's needs, and good examples were seen of effective transition planning between schools to help older children who had experience of neglect to settle into a new environment and to provide support in schools to meet their specific needs.

The Wokingham Safeguarding Children Board (WSCB) has identified tackling neglect as a priority for this year. To assist in this, it recently commissioned a peer review of neglect, the findings from which informed its recently implemented neglect strategy. This work is at a very early stage, but the board has built on learning from previous targeted activity on factors that can cause neglect, such as domestic abuse, parental mental health and substance misuse.

A range of areas for improvement have been identified during this inspection. A number relate to the early response to neglect, in particular early multi-agency risk-assessment and better engagement and communication between the police and children's social care at the very early stages, when children at risk of neglect are first identified.

The initial risk-assessment of neglected children within the MASH is undertaken by children's social care and, although information is shared, this is a missed opportunity for a joint risk-assessment of children at risk of neglect and for joint decision-making. Information on the outcome of referrals to the MASH are not routinely shared with partners, such as the police.

A small number of examples were identified in which the police had failed to effectively investigate cases linked to children who were experiencing neglect. As all cases were referred to children's social care, children were not left at risk of harm. However, opportunities for the police and children's social care to jointly investigate and coordinate plans were missed.

Risk-assessment forms are not routinely completed by the police. This means that it is not clear if the police have identified and responded to risk, including neglect. Adult services, including substance misuse and mental health services, are not always appropriately identifying and responding to the neglect of children. Health services outside of the MASH are not routinely using chronologies, and this limits their ability to build a clear picture of cumulative neglect and to refer concerns on in an informed way.

Multi-agency plans generally highlight all areas of risk identified through assessment, but they are not ensuring that children who are neglected make good progress. Plans are not regularly updated, are too focused on adults and do not make clear what needs to happen and when, and what the consequences will be if the neglect of children is not addressed. A key finding is the lack of management drive and challenge to ensure that situations of neglect improve in a timescale that meets children's needs. In addition, members of multi-agency groups such as core groups do not take joint responsibility for driving forward the progress of plans to ensure that children do not live for too long in situations of neglect.

Key strengths

- Strong and visible leadership by the Wokingham director of children's services is evident in promoting a clear and shared direction with partner agencies in safeguarding children and young people at risk of neglect. The work undertaken alongside senior leaders in partner agencies whose responsibilities span a number of other local authority areas has helped to ensure that the specific needs of Wokingham's population are recognised. The development of the local MASH in 2016 is a strong example of ensuring that the needs of Wokingham's children are prioritised and responded to.

- Wokingham leaders across the partnership are ambitious for all local children. They actively seek to learn from research and have welcomed external scrutiny of their safeguarding practice. The WSCB commissioned a team of external consultants to review the 'front door' (MASH) in November 2016. This has resulted in focused work to drive improvements in areas of work such as ensuring the timely management of contacts to the MASH. As a consequence, performance improved from 59% of contacts being completed within 24 hours in March 2017 to 80% in May 2017.

- Frontline practitioners across agencies report that the creation of the MASH has had a positive impact, meaning that children experiencing neglect have their needs promptly assessed and appropriate services provided, in the vast majority of cases. Practitioners across agencies are supported to refer concerns about children, including neglected children, and are provided with appropriate expert advice when they have a concern about a child.

- Most multi-agency referral forms seen provide the required information for social workers to make decisions about the next steps for children, and some were of high quality. For example, a police officer who was called out to a home assessed the neglectful home conditions of the children and provided a very insightful report to the MASH. In another case, a school provided a detailed chronology of concerns in relation to neglect. In both of these examples, the good work by partner agencies supported staff in the MASH to recognise that the threshold for statutory intervention had been reached.

- A well-resourced duty, triage and assessment social work team in the MASH triages referrals effectively in new cases of neglect. Wokingham is generally a very affluent area, but social workers see beyond the families' wealth to the needs of the children, and the initial identification of neglect means that children receive the correct level of support.

- The social work team offers a high level of service, such as advice to parents and professionals, child protection enquiries and brief interventions while assessments are ongoing so that children do not have to wait for a service.

- The health professional within the MASH is vigilant in identifying risk and is aware of additional vulnerabilities when assessing neglect, such as care arrangements for children who have special educational needs and/or disabilities. The effective development of chronologies by the health professional in the MASH means that the assessment of patterns of neglect and parental engagement, including failing to bring children to medical appointments, is used well to identify risk.

- There is timely and effective communication between the YOS and the MASH to appropriately share information about children at risk, or potential risk, of neglect. In the cases seen, this was contributing to protecting children from harm. The MASH has a shared case management system with the YOS, meaning that access to records is prompt, and the YOS regularly attends key multi-agency meetings, including strategy meetings, to contribute to decisions about children.

- Effective partnership work was evident, with good attendance at initial and review conferences and core groups. In most cases, this was supporting a shared understanding of risk and approach to managing neglect. Police within the MASH provide detailed reports for conference and reports, and the minutes of conferences are visible to frontline staff on police systems, so that when they attend incidents they have details of risks, including risk of neglect.

- The use of advocates for children at multi-agency meetings is resulting in children's voices being clearly articulated at key meetings, meaning that their views, including their experience of neglect, are well represented at key multi-agency meetings such as conferences.

- Most health professionals are supported by processes that aid the identification of neglect. For example, the arrangements for tracking concerns about children and their families who are moving between local authorities/health organisations are well managed, including checks with general practitioners (GPs). Universal services, such as school nurses, can remain working with a child who moves temporarily to a neighbouring borough.

- A particular strength is the offer of a school nursing service to children who are home educated or excluded from school, meaning that children who do not attend school are offered a thorough health assessment.

- Most social work assessments of neglect are timely and of a reasonable quality, and some are good. There is clear input from professionals across agencies to social work assessment which helps to provide a more comprehensive picture of needs and risks of neglect. Health assessments are mostly good, with key factors that contribute to neglect being considered, such as issues of bonding and attachment and parents' own experiences of being parented.

- Supervision of children's health practitioners is effective in ensuring that the health interventions for neglected children are appropriate. This is well recorded on the child's records and action plans are informing delivery of care in cases where there is neglect. Examples were seen in which an escalation by health practitioners of cases of neglect was resulting in appropriate action by children's social care to intervene, for example in a case involving a child who was experiencing neglect due to her mother's mental health.

- Good practice was seen in one dental practice in which all staff receive mandatory safeguarding training that includes a module on neglect, with good consideration of the presenting features of medical, nutritional, emotional and physical neglect. Records within the practice included consideration of the wider family history, and the use of a 'concerns log' demonstrated that staff were

alert to the signs of neglect and were robust in following up on missed appointments.

- Many agencies across the partnership understand the importance of hearing the voice of the child in families where there is neglect, and it is a strength that children's views, especially those of older children, are evident across many records seen. These include school nursing, the children and young person's mental health services, children's social care and the police. Practitioners in health and children's social care use a range of tools to support them in gathering and recording children's views, and match the method of direct work to the age and interests of the child. The YOS routinely supports young people and their parents to undertake self-assessments, and this informs the assessment made by the YOS practitioner. Several examples were seen of frontline police officers engaging well with children, taking the time to understand how they felt and communicating this clearly to children's social care.

- In all agencies, there is a notable correlation between the quality of the professional relationship with families and children, and improvement in outcomes for children who have been neglected. A range of professionals, including community police officers, social workers, health visitors, school staff and children's advocates, were seen in some examples to build effective working relationships with parents and showed empathy to children. These professionals were seen to look beyond the sometimes challenging behaviour of older children to understand children's lived experiences of neglect. In better examples, support to families and appropriate challenge to parents were evident.

- Where outcomes for older children were improving, there was evidence of skilled partnership work across agencies, including the police, health, the YOS, schools and social workers to support parents to develop a safe nurturing environment for their children. When professionals provided a safe, supportive network for parents and worked with children directly to address their experience of neglect, this was mirrored in the more positive relationships that were developing between parent and child.

- In these cases, schools played a crucial role in working with partners and parents to understand the specific needs of older children. They then tailored additional support in schools to children to enable them to access education and begin to achieve their potential. Schools demonstrate a well-considered and thoughtful understanding of the needs of neglected children in structured planning for transitions between schools, particularly at the key transition from primary to secondary school. This was generally well planned and managed, and demonstrated the impact of good communication among professionals, for

example the matching of one child to specific education provision, which has improved his attendance and enabled him to engage in his education.

- Support from a wide range of services is available to families in which there is neglect, with services such as Home Start and Women's Aid supporting families to address some of the issues causing neglect. Therapists working in Wokingham are well equipped to deliver support to children who are experiencing neglect, and therapeutic interventions are available for those older children who do not meet the threshold for specialist mental health services. For example, there are primary mental health workers, including a nurse and therapist trained to deliver cognitive behavioural therapy, and the service has provided training for speech and language therapists that has included modules such as 'What to do if you are concerned about self-harm'.

- Wokingham has a range of well-targeted early help work, delivered in partnership with local community and faith organisations, to improve outcomes for children whose life chances and opportunities are relatively limited compared to others in the local area. The Duke of Edinburgh scheme and the local football initiative are targeted to include vulnerable older children, including those experiencing neglect, to support them to build relationships, expand their interests and enhance their future career prospects. Such schemes are evaluated positively by young people and have led to improved outcomes, and growing numbers are being helped.

- The WSCB now has appropriate representation at a board and sub-group level, and is able to evidence impact, including as a result of challenge within the board and from the chair.

- WSCB partners are very aware that reported incidents of neglect are much less prevalent in Wokingham's safeguarding children statutory work than in most other areas in England. The board has only very recently produced a neglect strategy (2017–19) which is comprehensive and provides a clear definition of neglect and the ways in which neglect may manifest itself in relation to children and young people living in diverse circumstances. Plans are developing well to support wider-agency recognition and assessment of risks in the context of the needs of the local population and the area's comparative affluence. Leaders across the agencies clearly recognise that the identification and reporting of neglect may present itself differently in an area such as Wokingham.

- The WSCB identified neglect as one of three key priorities for 2016–17. Prior to this, the approach of the partnership, coordinated by the board, had been to focus on targeting risk factors that underpin neglect, including domestic abuse, mental health and substance misuse. A range of review and organisational development activity has taken place. Examples include holding challenge sessions with partner agencies to support an understanding and identification of

areas for development in responding to domestic abuse, and commissioning external consultants to audit multi-agency responses to domestic abuse and neglect.

- The recent peer review of neglect has helped to raise the awareness of all agencies of how neglect may manifest itself in Wokingham, and this work has helped to inform the new neglect strategy. The peer review provides a good baseline of the effectiveness of current practice, and of areas in which the early help offer and tracking of outcomes for children and young people at risk of neglect require strengthening.

- Scrutiny and challenge by the WSCB is having an impact. For example, challenge about the waiting times for children to access specialist mental health services has helped to secure additional investment and improvement in the area's approach to managing increased demand or complexity of need, including better support for children and young people at risk of emotional harm and neglect. Waiting times for specialist child and adolescent mental health services have been significantly reduced, and most children are now offered an appointment within four weeks.

- The director of children's services and the senior management team in children's social care clearly demonstrate their commitment to driving improvements in social work practice through investment in staff to develop a well-qualified, skilled and experienced workforce. Innovation and child-focused practice are actively encouraged and supported.

- Addressing the instability in the workforce of children's social care has been largely successful through the development of an ambitious approach to workforce development. The local authority has developed a range of initiatives to recruit and support permanent staff. The achievement of greater stability in the workforce has had an impact on the cases of neglect reviewed in this inspection. Some parents reported that the more stability in social work staffing has helped them and their children to build better and more effective working relationships with professionals.

- The local authority is committed to further improving outcomes for children, including those with complex needs and who have experienced neglect. They are conscious of the specific needs of children in the Wokingham area and the importance of equipping staff with the skills they need to identify and respond to neglect. Significant investment in training is beginning to show impact, for example in the use of 'Signs of safety' to better inform social work assessments of children experiencing neglect.

- Duty triage and assessment social workers are supervised regularly and have access to a wide range of training. Direct examples were seen of social workers using WSCB training on neglect to influence their casework with neglected families. The team has an open learning culture and welcome and accept feedback, such as in their reflective practice group supervision.

- There has been a focus on improving the collation and analysis of performance management information in children's social care to drive improvement in practice. This is ensuring that senior managers have a good understanding of many aspects of social work practice, including at the 'front door'.

- Leaders and managers in health (spanning primary care, community and acute provision) have a good understanding of child neglect and its impact on the emotional health and development of children. Children and young people at risk of abuse and neglect are clearly flagged on records, with strong oversight and checks to ensure that children have good access to and benefit from appropriate medical care or treatment.

- Wokingham Clinical Commissioning Group, the Berkshire Healthcare and Royal Berkshire National Health Service (NHS) Trust have a number of joint programmes of work to share the lessons learned from inspection and audit and to support the delivery of WSCB priorities. Designated and named safeguarding professionals provide strong leadership and direction to help to strengthen the recognition of neglect. Improvements in management oversight, recording and analysis of risks within child health records are evident since the CQC inspection last year. The positive adoption of the 'Signs of safety' work by child health professionals has helped to clarify their role and contribution to safeguarding children and young people at risk of neglect. Regular audits of practice support ongoing professional learning and challenge to ensure that the experience and voice of children and young people are routinely captured and inform decision-making.

- A focus on neglect is embedded in a range of safeguarding training provided by NHS commissioners and providers. The safeguarding training offer is good and is delivered in line with intercollegiate priorities.

- Thames Valley Police have made an unambiguous commitment to the development of improved multi-agency working. They have worked closely with the local authority to ensure appropriate staffing levels in the MASH, and this has included financial support by the local authority to enhance the police presence in the MASH.

- It is clear that police leaders have prioritised the protection of vulnerable children, including those who suffer neglect. There is a clear determination to reduce the risks to those identified as being vulnerable, and there is evidence of police leaders working to develop a culture of continual improvement to

enhance decision making and protective practices, for example the significant investment in a sophisticated and robust performance management system. It is a positive that, within this, the force has recognised the benefits of a qualitative assessment of professional practice and has made tangible changes to processes to ensure that when the police attend incidents, children are spoken to and the voice of the child is captured in the records.

- The development of the safeguarding, vulnerability and exploitation (SAVE) police training programme is beginning to have an impact. The programme has been carefully considered, and its implementation across the force clearly places the experiences of, and outcomes for, victims at the centre of an effective police response. The development of bespoke inputs for different officers and staff who have different roles and responsibilities reflects the commitment of the force to improve. Impact was evident in examples seen during the inspection of frontline officers effectively engaging with children who were subject to neglect, and seeking to understand their views so that these could be clearly communicated to social workers and help to support the assessment of risk.

- The Community Rehabilitation Company (CRC), National Probation Service (NPS) and the YOS (which is managed within children's social care) show a commitment to keeping children safe from harm. Safeguarding is core to service delivery. Responsible officers, offender managers and youth justice staff have access to a range of agency specific guidance and support from managers. All staff, across the operational and management grades, have completed mandatory child protection training, as well as refresher training. The CRC supplements its formal safeguarding training requirements with additional online material to support work with neglect for its responsible officers. A 'safeguarding aide memoire', incorporating neglect, is provided to offender managers in NPS.

- There is an appropriate level of senior leader representation and engagement by CRC, NPS and YOS at partnership level, as well as attendance at other key strategic forums, including WSCB, to achieve better neglect safeguarding outcomes for children and young people.

- In the past six months, the YOS has introduced a case monitoring panel which includes not only key managers in the YOS but also key criminal justice partners. This multi-agency approach is used to better understand and assess the behaviours of children and young people. The impact of this has been that six children have been identified as needing interventions to address the neglect that they have experienced in the course of their childhood.

Case study: highly effective practice

The GP role in the recognition of neglect

The role of GPs in recognising and taking steps to reduce and help address harm to children and young people at risk of neglect was strong in two GP practices that were visited. The issues that GPs are helping young people and their families to deal with are hidden or difficult to detect in an area of relative affluence such as Wokingham. These include the impact on children's emotional and mental well-being where parents exert undue pressure and have 'idealised' expectations that their children will achieve highly in all aspects of their lives. Other circumstances in which neglect may be present include incidents of violence and domestic abuse in families where children and young people are living in fear of a parent, and situations where children and young people are not safe or appropriately supervised due to parental misuse of alcohol and/or substances.

In two cases seen, GPs were the first professionals to identify children at risk of being neglected, and made timely and appropriate referrals to children's social care. In one case, the GP identified serious and long-term abuse of children and their mother, resulting in child protection medicals being undertaken which established a chronic hidden history of physical abuse and neglect. The ensuing child protection meetings paid good attention to identifying and addressing the emotional harm caused to the young adolescents, including promoting a shared understanding of young people's self-esteem and support with issues such as obesity. This holistic approach is essential in helping to strengthen young people's confidence and resilience.

The GP role in safeguarding children who are or may be neglected is underpinned by alert systems that provide good oversight and tracking of risks to children who fail to attend hospital appointments, miss their immunisations or are not brought to routine appointments. Such events are logged and promptly followed up by the practice to ensure that children's needs are being effectively met. Learning from section 11 audits is helping to strengthen local practice in areas such as ensuring the timely transfer of records of children who have moved out of area.

Areas for improvement

Identifying and managing risk of harm at the 'front door'

- There are a number of areas of practice at the 'front door' of services, in particular in the MASH, where further work is needed to ensure a consistent, and considered multi-agency approach to joint risk-assessment and decision-making in cases of neglect. Most significantly, more joint work is required at the early stages of assessment, when agencies are first made aware of children at risk of neglect.

- There were examples in a small number of cases where police officers had failed to effectively investigate concerns about adults who were linked to children who are experiencing neglect. Issues include delay within investigations and, in one case, a failure to investigate an allegation of child sexual exploitation. Another police investigation was closed without informing partner agencies who continued to make plans around the family. The identification and focus on neglect in these cases are often lost among other complex factors such as drug offences, domestic abuse and antisocial behaviour.

- In a small number of these cases, where there were clear grounds for an investigation into neglect or other offences, and where a joint investigation between the police and children's social care should have been considered this did not take place. In these cases, referrals were made to children's social care by the police. Children's social care commenced work with families, but did not further engage with the police. This means that opportunities were missed to gather evidence and create better joint plans to safeguard children, including from the risk of neglect.

- When concerns about children at risk of neglect are referred to the MASH, although information is shared, the initial risk-assessment is only undertaken by children's social care and, while this is taking place, other agencies are not routinely involved. When the police refer neglect cases to children's social care, they do not direct what, in their view, should be the next steps, for example a strategy meeting or joint investigation. Multi-agency risk-assessment does not take place unless and until children's social care decides to call a strategy meeting. This is a missed opportunity within the MASH for early joint decision-making and full participation of all agencies in risk-assessment at this initial stage.

- Information on the outcome for children who are referred to the MASH, where there are concerns about neglect, is not routinely shared by children's social care with other agencies. This means that partner agencies are unaware of what current plans are in place to ensure children's safety.

- A risk-assessment form should be completed by police in the MASH when a child is referred to children's social care. In over half of the neglect cases sampled, the risk-assessment was either not correctly completed by the police or was absent. This means that it is not clear whether risks, including the risk of neglect, have been identified effectively by the police and mitigated following the initial police response. All these cases were referred to children's social care, and it was clear that single-agency action had then been taken by the local authority to ensure children's well-being and safety.

- Gaps remain in multi-agency safeguarding working arrangements between dentists and other professionals, including health professionals. Dental practices are not effectively engaged in the work of the WSCB, and referral and information-sharing pathways are not well understood. This means that if and when dentists identify children for whom they have concerns about neglect, they may not be clear how to seek advice or where to refer children for support and protection.

- Practice by social workers in identifying needs and risk, including risk of neglect among minority populations, is not always child focused, and the unique identity of a child is not explored or addressed in assessments and plans. This means that their vulnerability, such as social isolation within the local community, is not clearly addressed.

- Antenatal pathways to support the early identification of neglect and timely access to support services are not well established in Wokingham. Recent figures show that health visitors are made aware of only 26% of expectant mothers where there are safeguarding concerns, and this is a particular concern where neglect is prevalent.

- Staff in adult services do not always identify and respond appropriately to children at risk of neglect. Risks to children of neglect due to parental substance misuse is not always identified by adult substance misuse services, and in adult mental health services there is insufficient focus on the impact of parental mental health on children. This means that neglect is not routinely considered and, in cases seen in which a risk of neglect was initially identified, there is no sustained focus by professionals on the ongoing impact on children in households where the parents have mental health needs or misuse substances.

- In substance misuse and adult mental health services, when adults disengage from services and risks, including risks of neglect, potentially increase, it is not routine for the services to reconsider the risks to children. This significantly limits the ability of these services to identify increasing risk to children and refer them for the support they need. The young person's worker in the substance misuse service has not received the higher level of training that is expected in line with guidance. While the supervision of frontline practitioners in the substance misuse service includes a focus on child safeguarding issues, the supervision records are not explicit about the risk of neglect, parenting capacity and attachment to the unborn baby/other children.

- Health services outside of the MASH are limited in their ability to build and communicate an emerging picture of neglect, because they do not routinely use chronologies. Health practitioners do not always have a clear and holistic understanding of cumulative risk to older children. Examples were seen where this impeded the ability of practitioners to provide a comprehensive assessment of the impact and pattern of neglect when raising concerns with children's social care.

- Not all dental practices have a policy on the process for when parents do not bring children to appointments. This means that, in some instances, when a child had not been taken to an appointment this was not always followed up with the parents or included in on the child's record.

- The quality of initial referral information to the MASH from the NPS and CRC is variable. Offending history information is often missing from referrals, so the MASH does not receive the full history. Referrals focus on adult behaviour and do not link this to the risk of neglect, even where this is clearly evident.

- Within CRC/NPS and the YOS, assessments focus on children's vulnerability and their welfare, but do not explore sufficiently the risk of neglect. Within the YOS, the child's home circumstances and the underlying potential causes of exhibiting behaviours are not considered in the context of either current neglect or a history of neglect. This results in plans that do not set objectives to respond to the issue of neglect. This is a particular concern for older children who may have experienced neglect for many years.

Response to children living with neglect

- The cycle of improvement and regression within families in which there is neglect is often highlighted in social work assessments, but what is absent from assessments is an analysis of the impact of this on children and young people, including the long-term impact of living with neglect. This was particularly found to be an issue in the assessment of older children, meaning that

cumulative neglect was not always well understood and addressed, and the wider needs of children in this respect were not always addressed.

- Multi-agency plans generally highlight areas of risk, including neglect identified through assessment, but they are not regularly updated and are too adult focused. Where outcomes for children are included, they are too generic and do not consider the impact of neglect, including cumulative neglect, on the emotional development of children. Despite some of the skilled work with older children and the shared professional understanding of their needs in many cases, this is not translated well into planning to meet need. Actions for parents are often vague and lack clarity, such as an explanation of how parents can achieve the action and what the impact will be on the child.

- 'Trajectory planning' (forward planning on how work with families should progress) was very well used in one case seen, but this form of planning needs to be used consistently to enable practitioners to be clear as to the expected progress of children who are neglected and subject to plans. Plans need to clarify when and how professionals will take decisive action if sufficient progress to reduce neglect is not achieved. Parents and children also need to know what is expected, and parents need to understand what the consequences are if they do not adhere to the agreed plan. Plans are not sufficiently focusing on the key issues for children, and it is not evident that older children are involved in the development of their plans. Plans do not address fully the impact of neglect and do not enable agencies working with children to monitor and measure progress and to plan proactively as circumstances change.

Leadership and management and the Local Safeguarding Children Board

- There is a lack of management oversight and joint ownership of responsibility in partnership working to ensure that situations of neglect improve with sufficient urgency and to meet children's timescales for change. Across the partnership, supervision is not consistently regular or robust. Where there is evidence of supervision and management oversight in cases, there is a lack of evidence of challenge when progress for children is not made. This means that the cycle of improvement and then regression in children's circumstances is not recognised quickly enough, and some children live in unacceptable, neglectful situations for too long before they improve.

- Members of core groups and child in need meetings and chairs of child protection conferences are not jointly taking responsibility to drive forward progress for children who experience neglect. Core groups and child in need meetings are not prioritising actions so that some interventions that may reduce risk, including risk of neglect for older children, are not put in place quickly enough. This means that, in some cases, there is a lack of urgency in driving

forward improvements for children experiencing neglect where the multi-agency group is not sufficiently focused on the pace of change for the child. This is a concern for any child, but was a particular concern in cases seen of older children who may have been subject to neglect for some considerable time.

- This inspection has identified a number of areas for development in respect of the MASH. In particular the need for the partners to better engage and work together to ensure multi-agency participation in decision making at an early stage, to improve the quality and analysis of information at each stage, and to develop joint planning in cases of neglect. Plans are in place to further develop the MASH and involve other agencies such as adult services at the 'front door', and the police recognise that there are opportunities to further develop their role in the MASH.

- The WSCB does not have a shared multi-agency data set to enable member agencies to jointly review and oversee performance at the 'front door' of services. The current WSCB data set comprises a discrete set of indicators that relate to the priorities of the board. The recently agreed priorities, which include neglect, do not yet feature in the data set. This impedes the ability of the board to provide up-to-date assurance on the effectiveness of the 'front door' of all agencies.

- The neglect strategy action plan is underdeveloped at present and, as yet, not all partner agencies are aware or actively engaged in shared work to support its implementation. The planned outcomes of the plan are currently too vague to be easily measured, and accountabilities and actions are not always clearly defined.

- Children's social care has not developed a clear action plan as an outcome of all audit activity, including audits of neglect. Senior leaders acknowledge that there is more to do to pool learning from case reviews, audits and performance data to further inform the development of practice and to inform future planning.

- Given the diversity of providers and the episodic nature of health professionals working with children at risk of neglect, whose needs and risks may fluctuate, joint working, communication and information sharing between health teams and lead professionals can be challenging. Health professionals do not always communicate in a timely way with each other about their involvement with children who are neglected. Not all relevant health professionals are actively engaged in the management and monitoring of children and young people at risk of neglect. Further work in particular is required, with adult mental health and substance misuse services, to help to reduce the risk of neglect.

- Staff working in substance misuse services do not have the required level of safeguarding training for their work with children and families. Safeguarding supervision is also an area for development.

- The significant investment in a sophisticated and robust performance management and inspection framework demonstrates the commitment of the Thames Valley Police to improve and learn. However, the force is aware that there are opportunities to make further improvements. This will be of particular benefit in the MASH, where an improved understanding of the level and extent of demand, the nature and quality of assessments, and the timeliness of out of hour's referrals will support continued improvement in the services provided to those who are vulnerable and at risk of neglect.

- Within NPS, CRC, and the YOS, consideration of neglect is not sufficiently integrated into effective and holistic safeguarding practice. This leads to missed opportunities in working with children to meet all of their needs. Current training packages for CRC, NPS and the YOS do not explicitly provide sufficient neglect coverage and, in supervision meetings, line managers do not systematically explore neglect as a contributor to offending or the wider well-being of children.

- There is insufficient auditing of practice within the CRC, NPS and the YOS to determine how well issues of neglect have been dealt with.

Case study: area for improvement

Multi-agency planning for neglected children in Wokingham does not set out clearly what needs to change and how this will be achieved. Despite most areas of risk being identified through assessments, these are not translated well into comprehensive plans which explicitly and systematically address risk, including risk of neglect, at an appropriate pace. While most plans contain a statement relating to what children's social care would expect to see in order to close the case, the steps needed for families to undertake this change are not explicitly described. This is a particular concern when dealing with neglect, as professionals need to understand how they will know when positive change has occurred for the child and parents need to understand exactly what they need to do to achieve it. Vague objectives in plans, such as 'attending school', do not make clear the impact on the child of non-attendance or the outcomes hoped to be achieved by attendance, for example being able to make friends, and how professionals will know that this is happening.

Plans are not updated regularly, and this makes it hard to understand what the current risks and concerns are. It also hampers practitioners' ability to monitor what progress is being made to reduce neglect. This, together with vague goals, means that a lack of progress is difficult to demonstrate, leading to delays in taking decisive action when children continue to be subject to neglect.

Plans are too focused on adult behaviour and not the impact of neglectful behaviour on children. This means that it is hard to monitor progress for children. In some cases, social workers were able to describe their observations of children and how these demonstrated improvements in their well-being for example, the demeanour of children and how this had changed over time. However, these measures were not contained in planning documents.

These issues mean that plans are not fully owned by the multi-agency group, making challenge difficult. This leads to a lack of drive by agencies to ensure that plans progress at an appropriate pace and that the outcomes for children who are neglected improve.

Next steps

The director of children's services should prepare a written statement of proposed action responding to the findings outlined in this letter. This should be a multi-agency response involving NPS, CRC, the clinical commissioning group, and health providers in Wokingham and Thames Valley Police. The response should set out the actions for the partnership and, where appropriate, individual agencies.[2]

The director of children's services should send the written statement of action to ProtectionOfChildren@ofsted.gov.uk by 17 October 2017. This statement will inform the lines of enquiry at any future joint- or single-agency activity by the inspectorates.

Yours sincerely

Ofsted	**Care Quality Commission**
Eleanor Schooling National Director, Social Care	Ursula Gallagher Deputy Chief Inspector
HMI Constabulary	**HMI Probation**
Wendy Williams Her Majesty's Inspector of Constabulary	Alan MacDonald Assistant Chief Inspector