Slough Borough Council

Inspection of services for children in need of help and protection, children looked after and Care Leavers[1]

and

Review of the effectiveness of the Local Safeguarding Children Board[2]

Inspection date: 19 November – 11 December 2013

The overall judgement is **inadequate**

There are widespread and serious failures that create or leave children being harmed or at risk of harm and serious failures and unnecessary delay in identifying permanent solutions for looked after children which result in their welfare not being safeguarded and promoted.

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

1. Children who need help and protection		**Inadequate**
2. Children looked after and achieving permanence		**Inadequate**
	2.1 Adoption performance	**Requires improvement**
	2.2 Experiences and progress of Care Leavers	**Inadequate**
3. Leadership, management and governance		**Inadequate**

The effectiveness of the Local Safeguarding Children Board (LSCB) is **inadequate**.

The LSCB is not demonstrating that it has effective arrangements in place and the required skills to discharge its statutory duties.

[1] The sections of this report that are about the local authority were originally published on 11 February 2014

[2] 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 Inspection 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.

Contents

Section 1: the Local Authority

Summary of key findings

This Local Authority has serious weaknesses and is not yet good because

- Children's social care services in Slough have not made sufficient progress since the previous Ofsted inspection in May 2011, when safeguarding arrangements were judged inadequate and the looked after children's service was judged adequate. Both the procedures in place and the practice of professionals working with children have not ensured the voice of the child is heard sufficiently in their assessments and plans.
- While the Council has taken action to develop senior leadership capacity in children's social care services, its impact in driving improvement has been too limited. There are widespread and serious weaknesses in Slough's child protection service. As a result, children do not always receive the protection they need when they require it. Many children who are looked after by Slough do not do as well as they could in their education. In addition, services to help Care Leavers are seriously inadequate.
- There has been insufficient progress in the development of multi-agency child protection work between the police and children's social care, particularly in the response to problems at an early stage and the development of a multi-agency referral hub (MASH) for Slough. While there is evidence of some recent improvement, for example in the appointment by police to a new post, co-located with children's social care, to improve risk assessments in domestic abuse cases, it is too early to see significant impact.
- There are some examples of good collaborative work in the early stages that reduces risks for children and young people. However, overall, partner agencies are not getting involved with children and families early enough, in order to help resolve their problems before they become worse. The number of early help assessments completed by partner agencies is falling and too often assessments are not focused on those actions which will make the most difference to children's lives.
- Many of the referrals made by partner agencies to children's social care do not contain enough information. This absence wastes valuable social work time, and that of the referrer, which is hindering the efforts of children's social care to improve their service for children and families.
- Too many children and families receive a poor quality service. Slough has been unable to recruit enough qualified and suitably experienced permanent social workers. There is an over reliance on temporary staff, with many examples of their poorly completed work be undertaken. A significant proportion of work is seriously inadequate and has had to be redone, leading to delays and drift in many children's cases. As a result, nearly all social workers have excessively high caseloads. In the majority of cases, they do not have sufficient time to spend

with individual children to learn about their lives. This lack of knowledge often leads to poor quality assessments, plans and outcomes for children.

- Insufficient priority is given to children in need, causing their situations to escalate into the child protection system. Many children and families, including those with child protection concerns, experience delays in getting the service they require. They also have too many changes of social worker, requiring them to tell their story more than once to workers they do not know, leading to even more delay. The Council's own audit activity recently recognised these problems and as a result has introduced a new pathway to provide more effective integration of child in need and child protection provision. However, the impact of this is not yet evident in practice.
- Social workers report that the current organisation and physical location of social work teams do not support effective team work. Co-location with other council services means that there is insufficient privacy to discuss children's cases without being overheard by non-social work staff. As a result, cases are not as closely monitored, nor progressed as quickly as they should be.
- The number of looked after children in Slough has been consistently lower than in similar local authorities. This is due to a legacy of poor social work assessments and an overly high threshold for access to services. Although the number of looked after children is beginning to rise, there are many examples of children entering the care system too late, having experienced situations which impact negatively on their future development.
- A significant proportion of children who become looked after experience too many changes of social worker and other important professionals. This inconsistency means that they do not develop meaningful, trusting relationships with adults. It also leads to their needs and wants not being consistently understood or used to plan how they will be helped, hindering their progress and adversely affecting their outcomes.
- Although a high proportion of looked after children are placed with foster families, over a quarter are more than 20 miles from their home community. This makes it difficult for them to maintain regular contact with their family and friends, or get the help and support they need from Child and Adolescent Mental Health Services (CAMHS) and other services. As a result, too many children experience significant problems in their placements, causing many arrangements to break down. This has a serious impact on how looked after children feel about themselves and their ability to achieve their full potential in adulthood.
- The Local Authority does not have an effective recruitment strategy to ensure that it recruits sufficient local foster carers. While it has had some success in placing children for adoption, it has not been able to recruit enough adopters to meet growing demand. Although many children are successfully adopted, some children with placement orders are waiting to be matched with a family. In addition, foster carers seen by inspectors were not aware of whether they had a personal development plan to ensure they receive and benefit from appropriate training.

- Too many looked after children have poor school attendance and low levels of educational attainment. The quality of their personal education plans varies greatly and the quality of schools attended by looked after children is not regularly monitored. This lack of knowledge makes it unclear if looked after children are getting the best possible help and support to achieve their full potential.
- The quality of pathway planning for Care Leavers is poor. Plans do not provide young people with a clear picture of the plan for their future; many were not involved drawing-up their plan and are unaware of its content.
- Although there are examples of the education and training needs of some young people being met well, the rate of Care Leavers who are engaged in employment education and training is too low.
- The looked after children who spoke with inspectors said they feel safe where they live. However, they do not feel social workers spend enough time with them or understand their needs and wishes. Care leavers expressed anxiety about where they are going to live in the future and many do not have a clear understanding of their rights and entitlements. Changes of their social worker and personal adviser mean it is difficult for young people and care leavers to form trusting relationships with their assigned workers at this critical transition point in their lives, particularly as they move on to live independently.

The Local Authority has the following strengths

- There have been no permanent exclusions of looked after children in the last three years and few fixed term exclusions.
- Social workers and their managers closely monitor and support children into their adoptive placements. Post adoption support plans are thorough and of good quality. This contributes to good outcomes for children placed with adoptive families and a low rate of breakdown.
- Arrangements to identify and track children missing from home or care are well-coordinated, with good follow-up arrangements.
- Nearly all looked after children are placed in provision rated good or better by Ofsted. Corrective action is taken when services subsequently fall below good, to ensure there is no risk to children and that their care plans are not compromised.

What does the Local Authority need to improve?

Priority and immediate action

- Develop and put into operation a comprehensive workforce strategy to attract and keep high quality, experienced permanent staff in Slough.
- Ensure newly qualified social workers have a protected case load and the necessary support to provide a rich learning environment, such as an assessed and supported year in employment programme.

- Ensure that social workers are able to have confidential discussions with their managers and other members of their social work team without being overheard by non-social work staff.
- Review the capacity of senior management to ensure there is sufficient dedicated time available to successfully drive improvement.
- Ensure that early help, children in need and child protection assessments are comprehensive and timely, that they identify risk and protective factors to mitigate risk and ensure that children and young people are protected.
- Ensure all children and young people are visited regularly and are seen alone by their social workers. Ensure sufficient time is taken to build and maintain positive relationships with the child or young person. Take action to ensure that social workers know and understand the wishes and feelings of children and young people and that they use this knowledge to help write assessments and plans to address these needs.
- Improve the performance management and audit programme so that it is sharply focused on the risks posed to children. Take action to effectively evaluate practice and efforts to reduce risk, including reporting on the quality of work and whether outcomes for children have improved.
- Ensure that the Local Authority, as corporate parent, makes the aspirations and attainment of children in care, and the needs and experiences of Care Leavers, their highest priority. Ensure that this priority is reflected in all partnership agreements, strategies and plans and acted upon as a matter of urgency.
- Improve preparation for independence and housing options for Care Leavers to ensure that all young people leaving care can chose to live in safe, permanent housing and have acquired the skills they need to live independently.

Areas for improvement

- Ensure that the thresholds for access to early help and children's social care services is disseminated effectively by the Local Safeguarding Children Board and is consistently applied and understood across the partnership.
- Ensure that all plans regarding children in need and child protection include a contingency plan. These plans must be specific, measurable and realistic to enable the robust protection of children and young people.
- Child protection chairs should provide rigorous challenge to ensure that children's progress is closely monitored and partner agencies are held to account.
- Ensure Independent Reviewing Officers track individual looked after children effectively, have regular contact so that they know and understand the wishes and feelings of children and young people and provide robust challenge to all agencies involved to ensure that children needs are met.
- Ensure that all foster carers are effectively supported to undertake continual professional development set out in a personal development plan which is subject to review.

- Ensure the voice of the child is recorded and used in children in need, child protection and looked after children reviews to understand their lives and inform their future plans.
- Ensure that case records are up-to-date, reflect children's views and contribute to effective care planning that is understood by children and their parents and carers.
- Conduct regular and rigorous monitoring of the quality of education for looked after children to ensure children get the best possible support to achieve their full potential. Take action to ensure that schools set challenging targets for these children in order to raise standards and close the gap between their achievement and that of the rest of Slough's school population.
- Ensure that all incidents of bullying against looked after children are reported by schools to the Local Authority, so that patterns can be monitored, appropriate action taken and the Authority can better fulfil its role as corporate parent.
- Develop and implement a strategy for the recruitment of adopters based upon an analysis of the needs of those children requiring adoption to meet the demand for service.
- Ensure that comprehensive and up-to-date information is made available to all care leavers about their rights and entitlements, particularly in relation to housing, education and financial support. The impact of this work should be closely monitored through the Corporate Parenting Committee.
- Improve pathway planning to ensure that these plans are an effective tool for driving forward plans for young people in which they play a full part.

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 LSCB 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: Gary Lamb

Team inspectors: Emmy Tomsett, Bill Wallace, Michael Ferguson, Aelwyn Pugh, Peter McEntee and Fiona Parker.

Information about this Local Authority area[3]

Children living in this area

- Approximately 38,300 children and young people under the age of 18 years live in Slough. This is 27% of the total population in the area
- Approximately 25% of the Local Authority's children are living in poverty
- The proportion of children entitled to free school meals:
  - in primary schools is 15% (the national average is 18%);
  - in secondary schools is 13% (the national average is 18%)
- Children and young people from minority ethnic groups account for 66% of all children living in the area, compared with 22% in the country as a whole
- The largest minority ethnic groups of children and young people in the area are Asian and Asian British (44%) and Black and Black British (12%)
- The proportion of children and young people with English as an additional language:
  - in primary schools is 58% (the national average is 18%);
  - in secondary schools is 42% (the national average is 14%).

Child protection in this area

- At 31 March 2013, 1,132 children had been identified through assessment as being formally in need of a specialist children's service. This is an increase from 980 at 31 March 2012.
- At 31 March 2013, 147 children and young people were the subject of a child protection plan. This is a reduction from 209 at 31 March 2013. This number had increased to 243 at the time of the inspection.
- At 31 March 2012, the number of children living in a privately arranged foster placement was five or fewer. The number at 31 March 2011 was zero.

Children looked after in this area

- At 31 March 2013, 182 children were being looked after by the Local Authority (a rate of 48 per 10,000 children). This number had increased (to 243) at the time of the inspection.
- Locally provided data for 2013 shows that:

[3] The local authority was given the opportunity to review this section of the report and has updated it with local invalidated data where this was available.

- Of this number 125 of the total looked after population (or 69%) live outside the Local Authority area;
- 25 of these live in residential children's homes, of whom 40% live out of the Authority area;
- no children live in residential special school[4] in or out of the authority area;
- 146 (or 80%) of the looked after population live with foster families, of whom 75% of these children live out of the Authority area;
- Four children live with parents, in the Local Authority area under placement with parent regulations;
- 10 children are unaccompanied and seeking asylum.

- In the 12 months up to 31 March 2013 there have been:
  - nine adoptions;
  - 10 children who became subject of special guardianship orders and four who became subject of residence orders;
  - 99 children who have ceased to be looked after, of whom none has subsequently been readmitted to care;
  - 13 children and young people who have ceased to be looked after and moved on to independent living.

Other Ofsted inspections

- The Local Authority operates two children's homes. One was judged to be good and the other requires improvement in their most recent Ofsted inspection.
- The previous inspection of Slough's safeguarding arrangements which also considered the arrangements for the protection of children was in May 2011. The Local Authority was judged to be inadequate.
- The previous inspection of Slough's services for looked after children was in May 2011. The Local Authority was judged to be adequate.

Other information about this area

- The Strategic Director Wellbeing has been in post since July 2012
- The Chair of the LSCB has been in post since March 2012.

[4] These are residential special schools that look after children for fewer than 295 days.

Inspection judgements about the Local Authority

The experiences and progress of children who need help and protection are inadequate

- There are widespread failures, by the children's social care service, to ensure children are effectively protected. Too many children and their families with an allocated social worker receive a poor quality service. Although there are some examples of good work with children and families, the large majority of casework undertaken by social workers is not of a good standard. A significant proportion of work is seriously inadequate and it takes too long for social workers to see vulnerable children who need help. Most children experience too many changes of their social worker, poor quality risk assessments and delays in receiving the service they require.
- Early help services for children and families are not well targeted and coordinated. Too many children are not able to access the help they need early enough. There has been a considerable reduction in the number of early help assessments completed, particularly by schools in the most deprived areas of the borough. This means that opportunities to meet the welfare needs of children are being missed. Also there are missed chances to meet other needs, such as additional support for children's education. There are some examples of good collaborative work and improved outcomes for children and their families; however, early help partnership work remains underdeveloped. Some partners are confused about how information should be shared, so children and young people experience delays in receiving the service they need.
- Historically, the threshold for access to children's social care was too high. It was modified in April 2013 and as a result is now operating at an acceptable level. However, there is a legacy of unmet need, with children being left too long without a service. This has caused a high and rising rate of referrals to children's social care as a response to concerns about children's welfare. This trend has resulted in a significant increase in the number of children subject to a child protection plan and those entering the looked after care system.
- The threshold for access to services is not yet embedded across all partner agencies. Children's social care services are further stretched because some partner agencies do not fully understand the threshold for access to services. This has led to a high number of inappropriate referrals.
- The out-of-hours service, provided through a pan-Berkshire agreement by another Local Authority, offers a good level of support to children and families.
- Although there are examples of good quality referrals made by partner agencies to children's social care, some referrals do not provide sufficient information. This leads to delay in the decisions and actions taken by social workers for those children. A high number of poor quality notifications are made by the police regarding domestic violence incidents. Many of these do not contain sufficient detail on the welfare of the child at the time of the incident, so it is difficult for

social workers to assess the level of risk posed to children and determine what action to take.

- Once child protection concerns are identified, decisions are made in a timely manner and case records are accompanied by a clear rationale and initial action plan. Although referrals are always investigated by a social worker, there are many examples of children waiting too long for their situation to be assessed. Too many of the case records for children found to be at risk of harm do not clearly describe how children will be kept safe until their initial child protection conference.
- There is not always a timely and robust response to children who require social work intervention to reduce risks to their safety. Social workers in the Children in Need and Assessment Teams have high caseloads and do not have enough time to do their work thoroughly. Children with a disability or learning difficulty receive a good level of support from a designated social work team for children with disability. However, other children in need do not always get the service they require early enough as social workers must prioritise children who are at risk of significant harm.
- The quality of children's assessments varies greatly. Although there are some good assessments, such as those completed by hospital team social workers to ensure unborn babies are protected, most do not consider risk and protective factors thoroughly. In addition, most assessments do not sufficiently reflect the views of the child, nor fully consider patterns of behaviour, family history or previous events.
- The quality of case file recording is inadequate overall. There were some good examples of record keeping; however, too many files lacked detailed records of intervention, what worked well and did not work well to reduce risk for children. There is often a failure to provide an audit trail of decisions taken and outcomes in cases, including chronologies to support effective work to ensure children's safety.
- While the Council's performance data show an improvement in carrying out visits to children on child protection plans, inspectors found that too many children are not seen regularly nor visited as frequently as stipulated within their protection plan. While some children report that there has been good continuity in their relationship with their social worker, many deal with too many different people, which makes it difficult for them to develop meaningful, trusting relationships. There is low attendance of young people at child protection conferences and a poor level of independent advocacy means they are not well supported to make their views known.
- While plans are normally reviewed regularly, children in need and child protection plans are not consistently focused on outcomes. They are not always specific or measurable and often lacking clearly identified outcomes or timescales. There is not enough consideration of contingency planning for children and young people, and plans do not always enable parents to understand the expectations on them or the consequences of not meeting their expectations.

- Decisions for children who no longer need a child protection plan are timely. However, subsequent multi-agency support and monitoring are not always sufficiently robust. In some cases, social work involvement is concluded too early and before there is clear evidence of sustained improvements being made by parents.
- There is a clear commitment by social workers and their managers to work in partnership with parents. In some cases, this leads to improved outcomes, enabling children to remain at home safely. However there are examples when continued work with parents has been unrealistic, leaving some children at risk for too long, particularly in cases where there is domestic violence. In many cases, assessment, intervention and planning are predominantly focused on supporting the adult, rather than the experience of the child.
- Multi-agency meetings are mostly well attended. However, police attendance at initial and review conferences is poor and their absence inhibits effective information sharing, comprehensive risk assessments and the development of well-coordinated services to children and young people.
- Core group meetings take place regularly, but there is limited evidence that they are effective in developing and implementing the protection plan and monitoring progress.
- Information sharing at multi-agency risk assessment conferences (MARAC) and as part of the multi-agency public protection arrangements (MAPPA) reflects a clear understanding of the dangers posed to children living in circumstances where domestic abuse is a risk factor. However, while the management of allegations regarding professionals is robust, there is insufficient awareness across the partnership of the role and purpose of the Local Authority designated officer (LADO), with low numbers of referrals received from key agencies.
- The Local Authority has clear systems for establishing the whereabouts of children missing from education, although not all cases have been pursued with sufficient rigour. Arrangements to identify and track children missing from home or care are well coordinated and robust, with good follow-up arrangements.
- Slough has made progress in developing a coordinated, multi-agency approach to identify and protect young people at risk of sexual exploitation. However, although partner agencies are beginning to work together, this work is not yet embedded and it is too early to measure the impact on young people.
- Arrangements to raise awareness about private fostering have not been effective. The number of known private fostering arrangements has been consistently low.

The experiences and progress of children looked after and achieving permanence are inadequate

- There are serious and widespread failures in the delivery of services for looked after children.
- Early opportunities to develop looked after children's independent living skills are missed. There is a failure to promote attainment at school and engage them in employment, education and training when they leave school.
- The legacy of poor quality assessments and decision-making has led to some children remaining in harmful situations for too long, which has seriously hindered their life chances for the future. However, more recently, decisions to look after children are timely and appropriate, with no children becoming looked after unnecessarily.
- Good use is made of the Public Law Outline to ensure children's welfare is effectively safeguarded once they are in the child protection system. Arrangements for the escalation of children's cases through the Public Law Outline are clear and well supported by senior managers. However, in a small number of cases action has not been considered early enough, causing delays to proceedings. Once initiated, care proceedings are supported by good-quality, timely legal advice and appropriate decisions to safeguard children's and young people's welfare.
- Despite social workers seeing looked after children regularly and seeing them alone, they do not spend sufficient time with children to establish and maintain a meaningful relationship. There are some examples of effective work by social workers, but children and young people told inspectors they were unhappy about frequent changes of social worker and the poor quality of support they receive. The high turnover of social work staff, combined with high caseloads, means that too many looked after children do not have the opportunity to develop an enduring relationship with a social worker.
- The Independent Reviewing Officer (IRO) service is not fulfilling key aspects of its responsibilities. They do not routinely meet children and young people outside their review cycle, and there is little evidence that they consistently track cases other than at statutory reviews. Children and young people do not have a meaningful and sustained relationship with their IRO to ensure they make good progress. Although children's wishes and feelings routinely contribute to reviews, insufficient time is made for children and young people to explore their views, wishes and feelings so they can contribute fully to the process.
- A number of successful measures are in place to help some looked after children to return to live in their own extended families. Support for these children is good quality and leads to sustained placements. For example, support, advice and financial packages have resulted in Special Guardianship Orders being used appropriately to support permanent places for children to live.
- Poor quality assessments and placement matching for those children and young people living with foster families has led to too many cases of disruption and placement breakdown. While the Council only places looked after children with

providers judged at least good by Ofsted, a high percentage of looked after children and young people live more than 20 miles from their home community. This distance reduces their ability to maintain contact with their family and friends and contributes to unacceptable delays for children in receiving services such as Child and Adolescent Mental Health Services (CAMHS). Delays in receiving specialist support services have directly contributed to the breakdown of some placements. Although additional measures have been taken recently to improve services for looked after children, it is too early to assess their impact.

- The Local Authority is successful in preventing disruption to the education of looked after children. As a result, most children in the early years are working at expected levels. However, those of infant and junior age make limited progress; by the time they have attended secondary school, almost half either make no progress or regress.
- The virtual head teacher knows her children well and has established appropriate systems to monitor pupils' performance. However, this information is incomplete because of a lack of consistent cooperation from schools within and outside the authority. These gaps make it difficult for the virtual head teacher to track pupils' performance and to challenge schools to make better provision for the looked after children in their care. Furthermore not all schools provide information on the use and impact of the additional funding they receive to support looked after children. The quality of personal educational plans varies greatly and expectations are often too low. The Local Authority does not systematically monitor the quality of the schools attended by looked after children, nor collect information on any bullying they experience in order to drive improvement.
- Although children placed out of area do not experience delay in accessing education, and very few have to change schools when they enter care, insufficient places for children to live locally causes many children to spend an inappropriate amount of time traveling to and from school. Most looked after children attend school regularly, but almost a quarter are absent too often. Fixed term exclusions are low and there have been no permanent exclusions in the last three years. The authority monitors the provision for children educated at home and takes appropriate action where the quality is unsatisfactory. Although Slough has invested substantially in the recruitment of foster carers, this action has not produced a sufficient number of local foster families for children to live locally, and too many children have to be placed out of the area. Foster carers are highly committed to Slough and report very substantial improvements in the support they receive from supervising social workers since the last Ofsted fostering inspection in 2012. However, there remain a number of areas for improvement, such as ensuring foster carers benefit from the active implementation of personal development plans, and responding to the findings of the last annual survey of foster carers.
- The children in care council (CiCC) is not representative of the views of all of Slough's looked after children. Although the CiCC meets regularly, meetings are only routinely attended by a small group of children in care. In particular, there is no care leaver representation and few looked after children living out of the area attend the meetings. However, the CiCC meets regularly with the Corporate

Parenting Panel and there are examples where the views of this group of children and young people have contributed to the shape of policies and services.

The graded judgment for adoption performance is requires improvement

- Slough has effectively prioritised placing children for adoption and is successful at obtaining placement orders for children. The time between obtaining a placement order and deciding on a match with an adoptive family is better than the England average. Outcomes for these children, including older children who are successfully placed with adoptive families, are good; with a low number of breakdowns.
- Although the Local Authority's performance on the rate of children placed for adoption is better than most local authorities, there is insufficient adoption placement provision for all the children who require it. Outcomes for some of these children are, therefore, more uncertain.
- Good arrangements are in place to ensure children's cases are progressed through regular permanence planning meetings which are driven by the family placement service. However, decisions about plans for permanence are not always well recorded at children's second looked after review meetings. This means it is not clear what action is being taken to develop concurrent plans, when this will be done nor who is doing it. This uncertainty causes delays for some children.
- Adopters are positive about the service provided by the family placement team in respect of the approval process. They describe feeling welcomed by the service when making initial enquiries and being fully involved in the process, as well as finding the assessment process rigorous. However, a large majority of the approvals of prospective adopters took more than eight months, which is outside the expected timescale. Slough has recently introduced an approval process which complies with the new six-month two-stage system, though it is too early for the impact of this to be measured. However, the local consortium arrangements mean that prospective adopters do not have to wait long before attending information evenings or preparation training.
- Adopters report that they are concerned about frequent changes in children's social workers. They worry about the impact the high turnover in children's social workers is having on their ability to move children's plans forward. In addition, this also means that practice on life story work and later life letters is mixed, so not all children are effectively helped to understand the circumstances which have resulted in them being adopted.
- Careful planning for children's transition to their adoptive placements ensures that they are successful. Adopters report that this planning and effectiveness is a strong feature of the service. Post-adoption support plans are thorough and of a good quality, taking account of the range of children's needs and ensuring they get timely help.

The graded judgment for the experiences and progress of Care Leavers is inadequate

- Care Leavers do not have good access to suitable accommodation nor adequate support from their allocated workers. A lack of information means they do not know where they will be living, nor where to get help in the future.
- The quality of pathway plans is poor. Plans do not provide young people with a clear picture of their future. Not all young people are aware of the contents of their plan and plans do not contain measurable targets with clear timescales.
- Care Leavers are not routinely provided with information about their rights and entitlements. In particular, the Local Authority does not actively promote a 'pledge' for Care Leavers so they are not clear what level of service they can expect. Young people who are about to leave care report that they feel safe where they live, but they expressed anxiety about where they are going to live in the future. They do not feel their social workers spend enough time with them or understand their needs and wants. Too many changes of social worker and personal adviser mean it is difficult for the young people affected to form trusting relationships with their assigned workers.
- Young people expressed concerns about the safety of one of the housing options offered to them by the council for when they leave care, describing regular fights and drug use within the setting. Overall, the range of permanent housing options for Care Leavers is poor, and there is no strategy in place to address this problem.
- Care Leavers are unhappy with the support they receive to prepare them for independence. They describe finding it hard to adapt to their new position once they leave care and report receiving insufficient support with tasks such as budgeting and cooking. One young person described being able to stay in a foster placement when she was 18 years old, saying that within six months carers helped her develop independence skills which were not addressed in the five years she spent with her previous carers.
- Not all young people in custody are visited by a social worker or have suitable plans in place to meet their welfare needs. This does not accord with recent changes to the care planning, placement and case review regulations.
- Overall, the number, of Care Leavers in education or employment is too low, although there are some examples of care leavers being accepted on to a council apprenticeship scheme.
- Not all care leavers are invited to the council's annual event to celebrate the achievements of looked after children and young people.
- Support workers acknowledge that young people have felt disillusioned and let down by the services they have received from Slough. They report that some young people do not have the skills they need when they move to independent accommodation post 18.

Leadership, management and governance are inadequate

- Insufficient progress has been made since Ofsted judged the Local Authority safeguarding arrangements inadequate and the looked after children service adequate in May 2011. Although the council has prioritised this area of work and provided sufficient financial resource to support improvement, the strategic leadership of the Council has not been able to make the required changes to establish good quality services for children and families. The Local Authority improvement plan has focused on the right issues. However, progress has been seriously hindered because efforts to recruit sufficient permanent, qualified and experienced social workers and managers do not go far enough and have failed to address this fundamental issue.
- The Local Authority lacks an effective workforce strategy and has not been able to ensure that the workforce is suitably experienced and qualified to deliver a good quality service for children and families. An over-reliance on locum staff means that services do not meet the needs of a large proportion of children and families, leaving some children at risk. These arrangements result in drift and delay in assessments and plans, leading to poor outcomes for vulnerable children. This challenge is the single most important priority for the council to tackle to secure improvement in the future.
- Newly qualified social workers do not always have a protected caseload or receive the support they need in a timely way. While the Council has recognised this and begun to take action to increase capacity, the impact of this is not yet evident and there were examples of new social workers undertaking complex work and having responsibility for too many cases. Although supervision is provided, insufficient focus is given to reflective practice. This oversight means opportunities to learn from cases are missed.
- Early help is insufficiently targeted and coordinated; not all partners are working together to build service capacity. This means that some families in need of help do not receive it early enough to prevent more serious problems arising. A strong focus on this area is the most pressing action for the partnership at present; this step must be undertaken in order to secure improvement in the future. Although there is a well-developed strategy for the delivery of early help, it has yet to be implemented.
- Elected members, and the Chief Executive of the Council, understand their roles and responsibilities and have secured increased service budgets. However, this has not ensured sufficient improvement since the last Ofsted inspection of children's services. This is particularly evident in key areas such as early help, child protection and services for looked after children, particularly Care Leavers. Important senior appointments have been made to key roles, including the Strategic Director, Wellbeing; Assistant Director; and the LSCB Chair. Their efforts are now beginning to make some improvements in managing a legacy of poor work. However, in a poorly performing children's social care service it is vital to ensure there is sufficient senior management capacity to drive improvement.

- The Children's Partnership board and the Health and Well-being Board understand the needs of the local community and joint commissioning arrangements are in place. However, in certain areas their plans lack quantifiable targets and timescales and services are not sufficiently influenced by the views of children. The joint commissioning strategy does not explicitly make reference to children in the care of the council under its 'raising achievement' priority.
- The authority has worked with partners to identify and agree thresholds for access to early help and child protection services. This is supported by the police's recent deployment of a new post within children's social care, aimed at improving joint decision-making about referrals. However, this work is recent and its application is not yet embedded. A key aspect of the threshold and early help process would be the establishment of a Slough Multi-Agency Safeguarding Hub (MASH); however, this has not been possible because of reported police reluctance to commit resources locally. As a result, 'front door' partnership working remains undeveloped and key opportunities to improve service responses so that they are sharply focused on the needs of the diverse communities of Slough have been missed. Nevertheless, the new threshold document and redesign of the children's social care contact arrangements have already had an impact, ensuring that children who need protection are identified correctly. This progress has resulted in a high and increasing rate of referrals of children who go on to receive an assessment.
- Senior managers have demonstrated a willingness to take action to deal with poor performance. They have intervened in frontline services on several occasions. However, their need to do this on a repeated basis demonstrates a significant weakness in the authority's ability to deliver an effective and safe service for the most vulnerable children and young people. There are many examples of poor work completed by temporary social work staff which has had to be redone. This is wasteful of social work and other agency staff time and it causes delay in understanding and meeting children's needs.
- Although the performance management framework in place provides senior managers with good levels of information and data, it has not been used effectively to reduce service deficiencies. There is a tendency to focus on process matters rather than the quality of work. While supervision of staff does take place, there is little evidence to suggest that work is properly analysed and assessed or that this reflection is used to inform professional development or in the consideration of the quality and impact of interventions in children's lives.
- Social workers reported that the current organisation and physical location of the social work teams does not support effective team work. Co-location with other council services means that there is insufficient privacy to discuss children's cases without being overheard by non-social work staff. This leads to cases not being closely monitored nor progressed as quickly as they should be. This is a serious weakness and a concern which was expressed by social workers themselves. The Council has recognised this and developed plans to improve the situation, but as yet these are not realised.

- While the senior leadership of the Council, corporate parenting panel and partner agencies express high ambitions for children and young people in their care and those leaving care, this is not reflected in the quality of services or pace of improvement. There is an insufficient focus on improving educational attainment; outcomes for a large proportion of young people remain poor. The authority is not actively seeking to narrow the achievement gap between children in care and children in the rest of the population. Care Leavers are not prepared well for independence and many are not in employment, education or training. As a result, they are unable to realise their full potential as they progress into adulthood.
- The council has engaged with local partnerships; however, some partners have shown a reluctance to undertake key roles in strategic groups which has slowed progress.

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.

Section 2: The effectiveness of the Local Safeguarding Children Board

The effectiveness of the LSCB is inadequate

Priority and immediate action

- Ensure all partner agencies are engaged in the delivery of the early help strategy that children and families have equal access to the services they need as early as possible.
- Ensure that agencies take full responsibility for their roles as set out in Working Together to Safeguard Children (Department for Education 2013) and that they commit to multi-agency strategies and working groups, including sharing responsibility and resources where necessary.

Areas for improvement

- Include an evaluation of the effectiveness of arrangements for children who are missing from home and education in the LSCB annual report. This information should be accompanied by an overview of private fostering in order to help make decisions and plan service improvements.
- Complete and implement a pathway for young people at risk of sexual exploitation, which clearly outlines multi-agency responses and interventions, setting out how risk will be continually reviewed on individual cases.
- Improve auditing activity and focus on evaluating the quality of interventions in order to draw the key lessons for improving management decision-making and oversight on cases.
- Ensure operational staff are included in multi-agency audits to provide the required expertise to ensure rigorous scrutiny. Individual agencies must own the findings of audits and use this information effectively to promote improvement.

Key strengths and weaknesses of the LSCB

- The LSCB has made clear improvements in the last year from a low starting point. This is particularly the case in the scope of its scrutiny and analysis activities. It is well placed to drive improvements, but as yet there is too little evidence of significant impact in key areas of child protection and early help.
- Accountabilities between the Independent Chair of the LSCB, the DCS and the Council's Chief Executive are clearly defined. There are formal and informal arrangements in place to ensure dialogue and challenge.
- Not all key partners are making a full and active contribution to improving the delivery of early help services for children and young people. This inconsistent performance is causing needs to go unmet. Children and families living in the diverse communities of Slough do not have equality of access to support services; their needs are not comprehensively met as early as they should be in order to prevent children's situations deteriorating and avoid children's social care

involvement. Whilst partnership work is becoming more effective in some areas, increasing the impact of its challenge to partner agencies, so that they cooperate fully in the improvement of early help, is the single most important area for the board to develop.

- Although the LSCB has appropriately challenged poor attendance and variation in different agencies' contributions, this has not been effective in securing improvement in important areas of work. For example, there remains a need to secure the routine involvement of the police at critical stages of the child protection process in order to complete risk assessments at initial child protection conferences.
- The LSCB has conducted audits of agencies' compliance with requirements in statutory guidance. However, not all partner agencies have complied fully with the audit process. The panel coordinating audits has been poorly attended and has only recently produced an action plan drive improvement.
- While the LSCB now considers and evaluates a good range of performance information from the partner agencies, its use in quality assurance remains under-developed. It has only recently commenced multi-agency case audits and this is not yet leading to consistent discernible improvements.
- The LSCB has clearly identified priorities which have been informed by local needs and the performance data provided by both the partner agencies and the Local Authority. However, although the data for missing children is detailed, there has not been sufficient oversight and reporting by the LSCB to determine the effectiveness of arrangements for missing children.
- The LSCB has taken effective action to address some of the shortfalls and weaknesses in the Board's operation which were identified at the last inspection. For example, it has identified key priorities with all strategic partnership boards across the area and taken decisive action to bring about improvements. However, progress in the key areas of children's services remains in the early stages.
- The LSCB has clearly identified priorities in the current business plan and regularly reviews its progress. The Executive Board scrutinises these decisions and actions. The LSCB has brought a clear focus to shaping strategy, policy and practice across the partnership; it has revised thresholds and engaged with children and families to improve their involvement and participation across services in regards to domestic violence, child sexual exploitation (CSE) and child trafficking. However, progress on priorities in the LSCB business plan is variable. For example, while the LSCB has been effective in raising awareness of CSE, with a corresponding increase in referrals, it has yet to complete work on a pathway to ensure a safe and consistent response to it. Support for male victims of CSE is not clearly defined and initiatives to tackle and understand the level of need to support victims of female genital mutilation are at a very early stage.
- The LSCB has been instrumental in ensuring the appointment of a strategic lead for domestic violence. This post is now operational and leads on coordinating both the strategy and delivery of services.

- Learning from serious case reviews is well established and suitably incorporates lessons from both local and national issues and relevant research. The learning and impact on practice is evaluated through audit activity and, where this is a local serious case review, the board effectively monitors progress. For example, it has tracked and audited progress by health agencies in implementing the recommendations of a 2011 serious case review.
- Slough LSCB is led by an Independent Chair, appointed in March 2012, who has ensured that the work of the LSCB meets statutory requirements as set out in Working Together to Safeguard Children (Department for Education 2013). The membership of the board now meets requirements following the appointment of two lay members. Although the LSCB has received an annual report on private fostering and subsequently identified actions, this has not been reported on in the LSCB annual report.
- Partners make appropriate financial contributions to support the business of the LSCB and the members of the board are at a sufficiently senior level to influence change in partner agencies. However, in practice there are shortfalls in sharing responsibilities, with some partners not attending meetings or reluctant to take responsibility for appropriate areas of work which increases the responsibility on the Local Authority.
- The LSCB ensures policies, procedures and the threshold for access to services are fit for purpose, kept under review and regularly updated to reflect statutory responsibilities and changes. However, although arrangements are in place to disseminate key points of information across the partnership, the threshold for access to service is not yet embedded.
- The workforce across the partnership is receiving appropriate safeguarding training. A well-defined learning and development strategy supports agencies to identify and address the safeguarding training needs of their workforce on a single and inter-agency basis. The LSCB has funded multi-agency early help training in the last two years. There are good quality assurance arrangements for the delivery of multi-agency training. However, arrangements to evaluate its impact on practice are less developed.
- Although in the early stages, good progress has been made to establish reflective forums for the multi-agency audit of cases. However, operational staff are not yet fully involved in learning from this experience. Some good examples of audits have identified multi-agency learning points, which have led to improved communication. However, in general, audits remain under-developed and overly focused on process; they do not evaluate sufficiently the quality of interventions. Opportunities to identify learning at key points, particularly in cases relevant to the role of line managers, are not included in audit outcomes.

What the inspection judgments mean: 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.

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