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Jo Moxon, Interim DCS Slough Borough Council
Nicola Clemo, Chief Executive Slough Children's Services Trust
St Martins Place
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Dear Jo and Nicola,

Monitoring visit of Slough local authority children's services

This letter summarises the findings of the monitoring visit to Slough children's services on 2 and 3 November 2016. This was the first monitoring visit since the local authority was judged inadequate in February 2016. The inspectors were Stephanie Murray HMI and Andy Whippey HMI.

Services for children in need of help, protection and care in Slough have been inadequate for many years. In its first year, the trust, under the determined leadership of its chief executive, has improved the effectiveness of contact and referral services and strengthened the operational response to child sexual exploitation. The council and the trust have agreed that safeguarding of vulnerable children is a firm priority and, together, they have stepped up the pace of improvement in these areas. There remains much work to be done to ensure that children are consistently helped and protected.

Areas covered by the visit

During the course of this visit, inspectors reviewed the progress made in the area of help and protection, with a focus on three themes:

- the effectiveness of the first response hub and the multi-agency safeguarding hub (MASH) in responding to concerns about children
- the early response to risk within families, particularly the application and impact of strategy discussions and child protection enquiries
- the effectiveness of operational arrangements to help children at risk of child sexual exploitation, including sexually exploited and missing conferences (SEMRACs).

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The visit considered a range of evidence, including children's case files, observation of staff undertaking contact and referral duties, and discussions with social workers and managers. In addition, we observed key operational and improvement meetings.

Summary of findings

- Since the inspection, a comprehensive multi-agency threshold document has been published and we saw evidence that it is being effectively applied at the front door.

- Social workers and managers in the first response hub make timely and appropriate decisions to ensure that families receive the help they need.

- The recently established MASH provides a timely, considered and proportionate response to children. Consent is well considered. However, there is no education presence in the MASH, which is a notable gap.

- When children are at risk of immediate harm, social workers within the urgent response hub act quickly and decisively to protect them.

- In most cases, strategy discussions take place quickly, with appropriate actions to protect children. However, the availability and analysis of multi-agency information is too variable. The quality of information sharing at face-to-face meetings is better.

- Child protection enquiries are recorded in stand-alone documents, with clear conclusions. This is helpful. Single assessments are increasingly analytical, with the perspective of children considered well in most cases. However, child protection enquiries and assessments do not always include information about all members of the household, particularly information from GPs. As a result, some children have been left without the right support or at risk of potential harm.

- Decisions to convene child protection conferences are sometimes taken too early, before all information has been properly considered.

- We saw examples of sensitive conversations with children who have been sexually abused, and creative direct work with young children. The views of children are evident in most records, supported by observation. In a few cases, however, records simply note that children have been seen.

- In the cases we considered, risk assessments for children at risk of sexual exploitation were thorough and analytical.

- The contributions of professionals who attend SEMRAC are reflective and child focused. Attendees share ideas and solutions as well as information.

Overall, concerns about children who are at risk of sexual exploitation are steadily reducing. However, the minutes of SEMRACs lack detail and analysis. They need to be improved to ensure that they include relevant information, multi-agency risk analysis and agreed actions.

- In-house and commissioned services to undertake interviews with children who go missing from home or care are now in place. The records we reviewed of these interviews included detailed and helpful conversations. However, not enough children who go missing receive a return home interview, and too many are not spoken to within 72 hours of their return.

Evaluation of progress

Based on the focus of the visit and evidence gathered, we identified strengths, areas where improvement is ongoing, and some areas where progress is not yet achieved.

The delivery plan addresses the recommendations from the inspection, although some actions relating to the focus of this visit have not yet been completed. For example, a multi-agency child sexual exploitation training programme is planned, but will not be complete until January 2017.

It is positive that a permanent senior leadership team is in place, and that all but one group manager is permanent. Senior and political leaders are taking steps to establish a permanent workforce, and in the meantime have retained some valued agency staff. In the new hubs, agency social worker rates have reduced to 20%, but overall they remain high at around 50%. This is in the context of supernumerary agency staff being appointed to support a safe transition to the new hub model.

Social work caseloads are manageable and no children's cases are unallocated. The staff we spoke to were positive about working for Slough, and the introduction of social work hubs is having a positive impact on the early response to need and risk within families. These changes will need to be carefully reviewed to ensure that the hubs are fully fit for purpose. For example, in some of the cases we reviewed, the right balance had not yet been achieved between reflective group supervision and decisive management direction and oversight.

Quality assurance, including case auditing by managers, has improved. Themed case audits, such as the recent child sexual exploitation audit, routinely identify good and inadequate practice. Overall, inspectors agreed with the findings of the case audits undertaken by the trust during the monitoring visit. New quality assurance staff have been appointed to audit cases and drive quality assurance work, but it is too soon for this to have had a significant impact. A 'business as usual' auditing programme is not yet properly established. This needs to be embedded alongside a learning and improvement cycle to ensure that leaders have a clear view of help and protection practice. Performance information is comprehensive overall and commentary is useful. It now needs to be more explicit about what 'good' would look like.

I am copying this letter to the Department for Education. The letter will be published on the Ofsted website on 2 December 2016.

Yours sincerely

Stephanie Murray
Her Majesty's Inspector