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Slough Borough Council
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Dear Cate and Andrew

**Monitoring visit of Slough children's services**

This letter summarises the findings of the monitoring visit to Slough children's services on 1 and 2 May 2018. This was the sixth monitoring visit since the local authority was judged inadequate in February 2016. The inspectors were Linda Steele, Nick Stacey and Maire Atherton, Her Majesty's Inspectors.

Based on the evidence gathered during this visit, there continues to be positive improvement in the services for children. Consequently, the service that children in care receive is much better than it was two years ago, but it is still not consistently good enough for a small number of children.

**Areas covered by the visit**

During the course of this visit, inspectors reviewed the progress made in the area of children in care, with a focus on four themes:

- thresholds for care, the quality of support provided to children in care
- assessment, including health assessments, care planning and planning for permanence
- management oversight and recording on children's case files
- the effectiveness of the independent reviewing service.

A range of evidence was considered during the visit, including electronic case records, supervision notes and other information provided by staff and managers. In addition, we spoke to a range of staff, including independent reviewing officers, managers and social workers.

## Overview

Senior leaders have continued to respond to the findings from previous monitoring visits and the recommendations from the single inspection framework in 2016. In particular, leaders have worked purposely and carefully to ensure that early permanence planning is embedded in practice across the children's workforce. The majority of children in care live in stable homes which meet their needs well. Increasingly, the proportion of children visited within statutory timescales is improving. Social workers take time to listen to children, and help them to maintain contact with their families when this is in their best interest. The stability of short- and long-term placements is improving for some children.

Professional relationships between social workers, team managers, and independent reviewing officers are increasingly constructive, strengthening quality assurance and helping to improve practice. Decisions that children should become looked after are mostly timely and appropriate. Nevertheless, for a small number of children action to address escalating risks could have been taken sooner. The quality of management oversight and decision-making remains an area requiring improvement.

## Findings and evaluation of progress

Based on the evidence gathered during this visit, leaders, social workers and managers continue to demonstrate a commitment to improving outcomes for children in Slough. Practice to bring children into care is timelier than it was at the last inspection. Most children who become looked after are assessed appropriately, placed swiftly and make positive progress towards early permanence. Nonetheless, senior managers recognise that there is more to do to ensure that all children who need care are identified early and that authoritative action is taken, as some children still come into care too late.

Leaders have made concerted efforts to improve permanence planning and tracking, but this is not effective for all children in care. Nevertheless, permanency planning meetings are well attended and closely review the progress of previous actions. Children's needs are well documented, and legal plans and timescales confirmed. Parallel and triple planning is prominent.

Chronologies are evident in the majority of children's case records, but some miss important details and are not consistently up to date. Case summaries provide a helpful overview of the child's journey. Care plans are improving in quality, although

not all are consistently good. Stronger plans are generally clear and informed by updated assessments, and thoroughly consider and reflect children's individual and diverse needs. Children's views are usually well represented. Weaker plans are not specific, measurable or time bound.

Independent reviewing officers (IROs) are now having an impact on challenging and guiding children's plans. The use of formal escalation is increasing. IROs meet regularly with children and social workers, both in and outside of reviews. The timeliness of children looked after reviews and the level of participation by children in their reviews are much improved. The minutes of review meetings are child-centred and written directly to the child in plain language; they ensure that children know why they are in care, and who is responsible for making sure that they remain safe. Professional relationships between social workers, team managers and independent reviewing officers (IROs) are increasingly constructive, and are contributing to strengthening quality assurance processes.

Children live in safe and stable placements and have contact with their families, when this is in their best interests. Children who live outside Slough are well supported and there are processes in place to ensure that they receive appropriate services in respect of their health and education. Nearly all children benefit from annual comprehensive health assessments, although there are significant delays in the completion of initial health assessments when children become looked after.

Assessments of family members as friends and family carers and special guardians are increasingly timely. This is supporting more children to have stability and permanence within their extended birth families. The overall quality of assessments is improving, but more work is required to reduce unnecessary description and ensure that assessments are child-focused and analytical.

Management grip has increased at all levels of the service. However, first line management oversight remains variable. Managers regularly oversee plans for children, with some examples of analytical case supervision, including one-to-one and hub supervision. However, this is still not effective enough to ensure that all children's plans are progressed swiftly.

Leaders have strengthened performance management information with an enhanced caseload reporting system. This weekly data set is particularly useful to managers and heads of service in analysing frontline practice and holding staff to account. Core audit activity evaluates the quality of social work practice, and a moderation process is in place. Where deficits in practice are found, action plans are swiftly implemented. Senior leaders recognise and acknowledge that there is still too much practice that is below the required standard, as identified by the trust's own audits.

The workforce is increasingly stable and, consequently, the number of children who have had two or more social workers in the last 12 months has reduced from 38% in February 2017 to 24% in February 2018.

The trust is actively seeking and acting on the views of children to bring about changes in areas that matter to them. One example of this practice is 'hello postcards', created for social workers to introduce themselves to children. This was introduced in response to feedback from children saying they did not always know who their social worker was.

Staff seen by inspectors are positive about working for the trust and morale is good.

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

Yours sincerely

Linda Steele

**Her Majesty's Inspector**