The Royal Borough of Windsor and Maidenhead

**Inspection of children’s social care services**

Inspection dates: 13 January to 24 January 2020

**Lead inspector:** Maire Atherton
Her Majesty’s Inspector

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Children’s services were judged to require improvement to be good at the inspection in 2015. Subsequently, the quality of services for children in the Royal Borough of Windsor and Maidenhead (RBWM) deteriorated significantly. Frequent changes at all management levels resulted in a loss of focus and direction, and this created considerable instability across the workforce. Leaders recognised this, and, in response, RBWM delegated their statutory children’s social care functions, under Part 1 of the Children and Young Persons Act 2008, to Achieving for Children (AfC). The pace of change was initially slow, as leaders took time to build the foundations of a sustainable and resilient service. The focused visit in 2018 confirmed that leaders’ actions were making a positive impact and that services to children were beginning to improve. The pace has quickened over the past year, particularly for children in need of help and protection. However, further improvement has been hampered by significant staff turnover. The development work has been informed by a detailed understanding of practice and performance and of the needs of children and families. The legacy of poorer practice is still
evident for children in some areas of the service. Learning from audits and management oversight is now implemented well. As a result, the large majority of children now benefit from interventions that improve their quality of life.

Services for care leavers are variable. They have been disadvantaged as they wait for progress on the development of services and platforms to express their views. Work to address this is in its infancy.

**What needs to improve**

- The attendance of community health colleagues at strategy meetings and the provision of accurate health passports to care leavers.

- Support for care leavers, to include ensuring that their voices are heard, both in developing the service and in their pathway plans, as well as guidance when they are not in education, employment and training, and practical advice and preparation for adulthood.

- The quality and consistency of recording.

- The stability of the workforce to reduce the number of changes of social worker for children.
The experiences and progress of children who need help and protection: good

1. Early help services in RBWM are a real strength. An impressive breadth of targeted interventions and services rapidly address the difficulties, needs and challenging circumstances of children and their families. Since the focused visit in December 2018, there has been an improvement in partners’ understanding of thresholds, and the majority are now completing early help assessments well. The early help hub is effective in securing and continually developing multi-agency partnerships. Managers are adept at prioritising and matching the needs of children and their families with the right resource. When concerns increase, children move from early help to statutory services appropriately.

2. Children and families receive a prompt and proportionate response to contacts and referrals, both during and out of office hours. This begins at the front door, with an easily accessible single point of access (SPA) for all families and professionals seeking help and support. Social workers in the multi-agency safeguarding hub (MASH) make sound appraisals of risk and need. They use histories and chronologies to sharpen their early analysis. They also recognise and understand child development across the age spectrum. This results in risks to older children, such as homelessness, being quickly identified and appropriately referred for single assessments. Consent is carefully considered, obtained and overridden when necessary. Management decisions in the MASH are concise and proportionate, and are supported by a clear rationale.

3. Children, including those with disabilities, benefit from timely and appropriate child protection enquiries that are based on coherent initial assessments of risk. Agencies share information effectively, although community health partners are not always present. The formal records of meetings do not always accurately show who participated in strategy meetings or child protection conferences. This has the potential to undermine the accountability of each agency.

4. When an assessment is needed, it is allocated promptly and children are seen quickly. Their views and wishes inform assessments, and care is taken to see them alone. The vast majority of assessments are completed within a timeframe that is in keeping with children’s needs. They feature thorough, and comprehensive information-gathering from involved agencies and make use of family history, identity and research. Persistent efforts are made to engage fathers and are generally successful. The preferred social work model is used well in most, but not all, cases, in order to calibrate risks, strengths and worries that support evaluative analyses. Assessments are updated regularly before timely child protection and child in need reviews, and benefit from management oversight. However, the use of the assessment template to
record the update does not help families to measure their progress against the objectives of the plan.

5. Most child protection plans specify the actions that are necessary to support and safeguard children, outlining the responsibilities of all involved to achieve this. For example, there are strong interventions available to all family members where domestic abuse is a concern. There is also effective co-working with early help agencies that provide additional targeted support. Child in need plans are more variable. In some cases, these plans lack clarity and the actions and measurement of progress are too generic. Not all child protection or child in need plans recognise issues of diversity well enough to inform actions for children. Managers have now tackled the legacy issues for children who had been on plans for too long. Cases have been reviewed and directions for next steps have been provided to ensure that children are receiving the right level of intervention.

6. A multi-agency risk assessment conference that considers domestic abuse is well attended and informed by effective information-sharing, both for existing families and newly identified high-risk families. The range of interventions and support, provided locally and tailored to the individual circumstances of each family, are reviewed effectively.

7. The quality of pre-proceedings work and care proceedings has improved. Overall, there is timely and pertinent work before proceedings, and legal surgeries evidence discussions on case history and the rationale for decision-making. Letters to parents before proceedings are clear about the actions that parents need to take to address concerns. This supports some parents to make the changes necessary for children to stay in the family. Some letters could be improved by using plain English and ensuring that actions only relate to the parent to whom they are written.

8. Most social workers convey a strong understanding and knowledge of the children they work with. Skilled and thoughtful direct work is conducted at the right pace for children; social workers use a variety of tools to help them understand children’s experiences and views. However, these are not always captured in case records. Children benefit from the routine provision of advocates, before and at meetings.

9. Inspectors were impressed by the ESTEEM group, which offers support to children receiving early help and statutory social work interventions. Children who spoke to inspectors were enthusiastic about these groups, which help them develop valuable social skills. They said that the people who ran the group were ‘nice, helpful, friendly and happy’ and that outside of the group they had difficulties making friends, but ‘loved coming to the group, where they made new friends’. 
10. There has been a significant turnover of staff in some teams, and some of this has been due to internal promotions. The impact of this has been offset by the knowledge of those staff who have been in post some time. This provides a degree of continuity, as does the regular management oversight, with analysis and a rationale for social work practice and decisions. However, many children and their families have not had the opportunity to build meaningful relationships with social workers.

11. Exploitation and missing risk assessment panels provide a clear, joint-agency approach to collectively managing, grading and reducing the risks to children. Although outcomes and actions from these panels are shared with social workers and managers, this information is not routinely recorded in individual children’s case files. This was remedied during the inspection. Children benefit from additional help, provided by a wide spectrum of services, and informed by well-used screening toolkits. When children go missing, they are all offered a return home interview, and the large majority of these interviews are timely. Children who accept interviews engage well with youth workers. However, the quality of recording of these interviews is variable. Some are not thorough enough to support effective wider analysis of the push and pull factors or to gather important intelligence to identify patterns and trends to effect change.

12. Work with families who choose to educate their children at home has been strengthened. New and effective processes are in place to register and monitor these children.

13. At the time of this inspection, there were no private fostering arrangements. Well-targeted awareness-raising is carried out with schools. Single point of access (SPA) workers prompt referrers to consider whether the child is living in a private fostering arrangement.

14. The response to allegations against adults who work with children is thorough and proportionate. However, the rationale for decision-making is not recorded in every case. A good range of training and awareness-raising activity has been undertaken. Work with independent and boarding schools is resulting in advice being sought more often, and better-quality referrals are being made. There is acknowledgement that there is more to do in certain areas, and work is planned to develop this, for example with faith groups where there is a low referral rate.
The experiences and progress of children in care and care leavers: requires improvement to be good

16. Services for care leavers are variable and have suffered as a result of changes of staff in the small care leavers team, formed in 2018. The consistent manager knows the care leavers well and has provided them with stability. There has been insufficient capacity in the team to develop the service.

17. The vast majority of children enter care appropriately when they require safeguarding outside their immediate families. Decisions are informed by comprehensive assessments, which draw on contributions from other professionals working with the family. Permanence options are considered at an early stage, and in the last six months tight management oversight has resulted in permanence being confirmed for an increasing number of children. However, there is more to do to address the legacy issues to ensure that all children have this security.

18. When children cannot return to their parents, they are supported to live with their extended family or people they already know. This is achieved by timely family group conferences and connected persons assessments. This provides children with security and helps them to maintain their sense of identity. Plans for children to return home are informed by thorough assessments and clear support measures that are signed off by a senior manager.

19. The large majority of children in care live in safe, secure and stable homes that meet their needs. Children and their foster families benefit from a good range of services that are designed to support them. Specialist residential placements are sought to reduce identified risks to children, but some of these are at a distance due to a lack of suitable local accommodation. For some children, the records of formally matching them to long-term foster families, and the rationale for the choice of a residential home were not available. This means that these children may not be able to understand their journey in care when accessing their records in the future.

20. Children living with foster to adopt carers benefit from this early opportunity to build and develop new attachments. Inspectors saw some persistent work in placing older children and brothers and sisters together in adoptive families.

21. Child permanence reports are variable in quality, and the completion of life-story work is not consistent. The local authority has identified these as areas for development and is working to improve these.

22. When children are placed at some distance from their home, notifications are made to ensure that host authorities are informed when children move into their area. However, the information does not specify the child’s needs and how the placement will meet these needs, for example their education and/or
health needs. Neither is there consultation with host authorities before children are placed to ensure that the help and support children need will be available in a timely manner.

23. Senior managers oversee and sign off decisions for children to move to unregulated semi-independent living provision. However, in one case there was not sufficient evidence of the decision-making process, or of any consideration of whether the provision requires registration with Ofsted.

24. Child in care reviews are timely but are not consistently of good quality. Children said that they don’t always get to choose who attends their review. There is also variability in the oversight of children’s cases. Some benefit from appropriate consultation and follow up on actions, but others lack timely and robust challenge. Records of meetings are written to children, but not all are sufficiently child-focused or written in simple language.

25. Many children benefit from effective care plans that provide a holistic approach and detail the therapeutic and nurturing care that the children receive. Family time is carefully considered and supported. The plans for a minority of children are a list of detailed case management tasks and fail to focus on the desired outcome for the child. Issues of diversity are not always well recognised in plans. This means that children’s support needs in this area are not always met, for example in their expression of faith or cultural identity.

26. Most social workers know their children well and talk knowledgeably about their experiences, but this is not always captured in children’s records. However, some children experience too many changes of social worker, making it hard for them to invest in building meaningful, trusting relationships with their social worker.

27. Children in RBWM have a strong voice. The children in care council, Kickback, is proactive and very well run. Children spoke joyfully of the range of activities they had done in 2019, including their active participation on the corporate parenting panel. Children have delivered innovative and creative input to their corporate parents, and others working with children, to help them understand the experience of being a child in care. Children said: ‘Kickback gives us a voice to give our opinion and people do listen.’ ‘We can meet, catch up with other children and make a difference.’ ‘The best thing about Kickback is the people.’ The participation of care leavers is not yet established. A new care leavers group has very recently had its first meeting.

28. There is a timely response to children in care who are considered at risk through the multi-agency exploitation and missing risk assessment panels. There is management oversight, but recording could be strengthened to ensure that there is reflection on the progress made and of actions to be undertaken. Children in care placed at a distance who go missing do not
always have timely return home interviews to help understand the reasons and inform future work with them.

29. Work with community health partners has been successful in improving the timeliness of initial health assessments. Health passports are not yet consistently given to care leavers. Those provided are incomplete, and this limits the ability of care leavers to understand their health history, which they should be able to use to make informed decisions about their future healthcare. The use of strength and difficulty questionnaires is applied inconsistently, and so not all children benefit from having their emotional health needs considered. Some children benefit from engagement with the well-being team, either individually or in groups, to address lower level mental health worries. Children have access to mental health services, but care leavers talk of their difficulties in moving to adult services.

30. Under the determined leadership of the virtual headteacher, the virtual school has strengthened provision for children in care. The completion and quality of personal education plans done with children have improved dramatically. The virtual headteacher acts as an advocate for children in care, for example ensuring that children’s educational needs are well met by challenging schools that choose to exclude pupils or do not provide a full-time timetable. Children are attending school more regularly and are achieving more than they were before. Children in care are actively encouraged to develop interests and engage in a wide range of activities, both inside and outside school.

31. The frequent changes of staffing have meant that many care leavers have not had the opportunity to build meaningful relationships with social workers. The local authority has increased the number of personal advisers, which, while positive in the long term, has led to some young people experiencing further changes. Consequently, their voices are limited.

32. Pathway plans vary in quality. Some are not specific; the actions lack clarity, and so the plan is not effective. Care leavers are not always involved in the completion of their pathway plans, but it is not possible to determine this from the way they are written. In the small number where their views are included, their words are not used, so it is difficult to determine which are their own wishes and feelings. Reviews of plans do not always include all key people.

33. There is an inconsistent approach to the efforts of staff to maintain contact with vulnerable, disengaged care leavers. Some staff are more determined than others to make sure that they keep in touch with them. The recording on case files does not evidence whether or not personal advisers have made serious efforts to keep in touch with young people, and case records do not support effective handovers when staff leave the team.
34. Care leavers are provided with homes that met their needs, either by remaining with their foster carers into adulthood or in suitable accommodation that enables them to develop their independence. Some have been supported to gain and maintain tenancies when they have been at risk of breakdown.

35. There has been an increase in the number of care leavers engaged in good employment and education opportunities. They are well supported to attend university and college if they choose too. Resources available across AfC in order to support care leavers into education, employment or training are not yet being used. There are plans to introduce workshops and sessions to develop young people’s life skills and preparation for adulthood, but these are not established.

The impact of leaders on social work practice with children and families: Good

36. In response to a significant deterioration in the quality of services for children since the inspection in 2015, RBWM delegated its statutory children’s services to AfC. Governance arrangements and lines of responsibility and accountability between the borough, as commissioner, and AfC, as the provider of services, are clear and work effectively. This results in strong scrutiny and accountability.

37. Since March 2018, there has been a consistent senior leadership team that has worked steadily to identify the deficits, plan for and implement improvements. As noted in the focused visit in December 2018, there are significant limitations in the children’s database. Despite these challenges, good use is made of a wealth of information to regularly assess and evaluate the impact of the work. A reappraisal of how performance information is presented has led to the introduction of a helpful narrative alongside the data, and the lead member for children’s services values this.

38. Leaders and managers are committed to improving outcomes for children by listening to what they, and their families, have to say. The commitment to maintaining investment in early help provision is laudable and provides families with effective resources that they value. On taking up appointment, new councillors are promptly introduced to their responsibilities as corporate parents to children in care with the use of leaflets informed by ‘Kickback’. They take their role as corporate parents seriously and many children know who the senior leaders are. When asked, one child said of the director, ‘He’s the old man who’s in charge of everything; he came here to visit.’

39. The judiciary and Cafcass were positive about the quality of work in RBWM. The judge noted that, in the last 12 months, it has been a steep positive
trajectory. The police also commented on strong partnership-working. Leaders recognise that there is more to do to ensure that housing services have a fuller awareness of their responsibilities, for example to families fleeing domestic abuse, and this is in hand.

40. There is work to do to strengthen commissioning arrangements. For example, there is no framework for the use of unregulated semi-independent provision. A director has been appointed in AfC to lead on this important area, starting in mid-February. Leaders are keenly aware of where there are gaps in the capacity to meet the demand for residential placements, and are exploring how to use their resources to the best effect. An effective recruitment campaign and a reassessment of existing foster carers’ capacity have led to an increase in the availability of foster placements.

41. The established arrangement to be part of Adopt Thames Valley, a regional adoption agency, is working well. Layers of scrutiny and oversight are further developing, and interpersonal relationships between social workers in both teams are effective, providing both support and challenge.

42. Leaders and managers know their service very well, as demonstrated in the accurate self-assessment. Development work is informed by the use of complaints, review systems and actively seeking the views of stakeholders. The extensive range of quality assurance processes have moved from compliance to improving practice and children’s circumstances. These processes are detailed and include learning from a range of perspectives. More recently, children and families’ feedback has been incorporated into the audit process.

43. The development of performance data reports, with a range of individual workarounds to manage the challenges of the information system, enables accurate scrutiny and assessment of management information. Managers talk positively about the frequent performance huddle meetings to focus on areas needing targeted support and improving individual children’s experiences. The decision to move to create a new social work team, to be implemented in April 2020, for children in care has been informed by the views of staff, practice review and evaluation.

44. RBWM has been significantly challenged by the considerable staff turnover. The workforce development strategy and action plan features programmes to tackle both short-term recruitment and retention challenges and longer-term talent and workforce development. Efficiencies of scale across the three AfC boroughs enable collaborative programmes. Vacancies are filled promptly, and the majority of social workers describe manageable caseloads that enable them to visit children at a frequency that is commensurate with their needs. It remains the case that some children have had a number of changes of social worker.
45. Staff are positive about working in RBWM. Actions to improve the quality and effectiveness of first line management oversight are evident, and for many children this is leading to better quality social work intervention. Staff receive support and supervision from readily accessible and available managers. ‘Stop to think’, informal group reflection, is used effectively to consider work with children and inform practice.
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