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Dear Nicola and Cate

Monitoring visit of Slough children's services

This letter summarises the findings of the monitoring visit to Slough children's services on 14, 15 and 16 June 2017. This was the third monitoring visit since the local authority was judged inadequate in February 2016. The inspectors were Stephanie Murray SHMI and Andy Whippey HMI.

The council and the trust have established stable and increasingly skilled teams to provide help to the children considered during this visit. Senior managers have identified the key areas of weakness highlighted during this visit, and have taken positive steps to build the foundations of good practice. However, practice remains too inconsistent, and there is still some way to go before vulnerable children can rely on a service that meets their needs and reduces the risks that they experience.

Areas covered by the visit

We reviewed the progress made since the last inspection, with a focus on four themes.

- The application of child protection thresholds, in particular whether to create or cease a child protection plan.
- The effectiveness of child in need and child protection work with families, including children who have disabilities.
- How well the voices and experiences of children are captured in child protection and child in need work, including the provision of formal advocacy support.
- The effectiveness of pre-proceedings work with families, where risks to children increase or the change is too slow.

The visit considered a range of evidence, including electronic case files, meetings with social workers and managers, discussions with key senior and political leaders and partners, and analysis of relevant documents and data.

Overview

A comprehensive restructuring of the teams that support children in need of help and protection is beginning to have a positive impact on the quality of service that they receive. Trust and council leaders have continued to work hard to secure a more permanent workforce and, as a result, the number of agency staff is steadily reducing. All of the senior leadership team are permanent members of staff. Seventy per cent of the staff in the new child protection and child in need hubs are now permanent. This is a substantial improvement from the inspection, when over half of these staff were employed by an agency. As a result, the high turnover of staff, which previously caused disruption and instability for children and their families, is reducing.

Leaders within the trust and the council continue to work together cooperatively towards shared goals. They actively seek new opportunities and additional investment to help them to achieve their ambition to deliver good support to children.

Once children are transferred to the child protection and child in need hubs, they receive a better and safer service than at the time of the inspection. However, the practice improvements have largely been achieved in the last two to three months. For some children, the lack of purpose in tackling complex family difficulties and delays in carrying out key actions have led to their circumstances not improving, or even becoming worse.

Findings and evaluation of progress

Based on the evidence gathered during this monitoring visit, we identified some areas of strength, some progress that has been made in key aspects of support to children and a number of areas in which we considered that change has not been achieved as quickly as needed. We found that most practice requires improvement to be good, with some examples of children's outcomes improving because of skilled, consistent and caring support. However, in a number of cases, we identified a lack of progress in meeting children's needs or reducing risks. We saw a marked contrast between the best and worst practice, and the trust's own audits continue to find a significant minority of work to be inadequate, due to weaknesses such as poor management oversight or lack of attention to the voice of the child.

- All staff in the child protection and child in need hubs have undergone a comprehensive induction programme, with high-quality training in the systemic practice provided to social workers, family support workers and line managers. For some staff, this training is very recent and the skills are yet to be fully embedded in practice. Children are regularly discussed in hub meetings, which are chaired by managers and attended by clinicians. Although these analytical discussions are supportive of practitioners, with new hypotheses being considered and actions being agreed in each meeting, in some cases the meetings are not challenging enough to ensure that practice weaknesses are identified and important actions are progressed.

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- Innovation funding is enabling the trust to create additional hubs to undertake discrete and specialist work with families. The commitment of senior leaders to increasing the skills of frontline staff is evidenced by the appointment of a clinician to support each hub to work in a systemic way with families and a lead clinician to oversee this work. A recent research project in partnership with a university demonstrated improvements in the helpfulness of social work support, with 16 of the 17 families spoken to saying that this is different and better.
- We found that decisions about whether a child protection conference is needed are proportionate in the vast majority of cases. Some of the cases that we looked at had been appropriately stepped up from early help.
- Work undertaken with children subject to child protection plans is variable. In the majority of cases, children benefit from frequent and purposeful social work visits, regular and well-attended multi-agency core groups and timely reviews. Overall, children's views are captured well through thoughtful direct work. Children's diverse needs are considered, but not always in sufficient depth. However, for some children, key actions are not progressed, core groups do not analyse whether children are safer as a result of the help provided and there is a lack of focused direct work to understand children's complex lives. In these cases, the oversight of consultant social workers and group managers has not been sufficiently interrogative to identify and resolve the issues, leading to drift.
- We identified a number of cases in which the decision to end a child protection plan was not firmly based on evidence of sustained changes in children's lives or the effectiveness of multi-agency interventions, but rather a period of relative calm with no new worries noted. For some of these children, further concerns about their circumstances later led to further harm, subsequent re-referrals and repeat child protection plans.
- At the time of the visit, surprisingly low numbers of children were subject to the pre-proceedings phase of the Public Law Outline. In some cases seen during the visit, managers had not considered legal action early enough in response to escalating or continued risk. Once the decision is made that the pre-proceedings threshold is met, the letters sent to parents do not always provide enough clarity about the changes that they need to make and by when. A routine process to consider whether children who have been subject to repeat or long-standing child protection plans should be escalated to this legal process is not in place.
- Work to support children in need, including those who have disabilities, is effective, overall, based on the cases seen during the visit. Regular and helpful review meetings, meaningful practical help that is provided jointly with family support workers and skilled work to address specific concerns, such as domestic abuse, are evident. As a result, children are happier and their outcomes improve. Social workers say that they have more time to spend with children, particularly to undertake direct work, and they talked to us confidently about using artwork and specific tools and toys, such as puppets,

to encourage children to talk to them through fun activities. Children who have disabilities considered during the visit benefit from up-to-date assessments, regular reviews and helpful packages of support.

- Safety mapping, where this is used, is helpful to social workers, managers and families in crystallising dangers and strengths. Leaders have sourced external support to help practitioners to learn from other local authorities that do this well. Child protection and child in need plans are comprehensive, with key actions clearly recorded. However, outcomes are not described in straightforward enough language to enable families and professionals to understand how they will know when children are happier and safer.
- Quality assurance work is improving, with a busy and well-integrated case audit programme that staff at all levels say is helpful to them in analysing their practice. Senior managers are active in case audit work. A practice development officer, who has been in post for three months, is taking positive steps to accelerate practice improvements. However, the quality assurance and learning cycle requires further development. The oversight and challenge provided by child protection chairs has increased since the inspection, for instance through their midway monitoring of child protection case files. However, the impact of this intervention is not always apparent, and child protection chairs do not have a strong enough voice to enable them to influence wider practice.
- A quarterly quality assurance report is now in place, which includes findings from case audits and helpfully analyses key performance information. The report would be improved by the inclusion of feedback from child protection chairs and a wider range of quality assurance findings, such as those identified through complaints.
- Private fostering numbers are low, and the training of children’s services staff to ensure that they understand their duties towards these children has not been robust enough.
- Meetings to oversee children who are at risk of child sexual exploitation continue to be well attended, and the minutes evidence detailed discussions about the reasons why risks to children are decreasing or increasing. Sometimes, actions are delayed by not having all the available information about children’s circumstances. It is a positive that, since the inspection, the council has taken steps to provide training to almost all – over 800 – taxi drivers and operatives to raise their awareness of child sexual exploitation.
- Progress has been made in response to the recommendations from the last inspection, although in some areas work is not yet complete. For example, much work has been undertaken across the partnership to improve the early-help offer to families and to develop a comprehensive multi-agency early-help strategy. The strategy is due to be launched in summer 2017. Sufficient formal advocacy services are in place, but this support is not yet routinely offered to children who are subject to a child protection plan. The neglect policy is in place, but requires further development, because it includes insufficient detail about how local professionals should identify, assess and

respond to neglect within families. Tools to assess the impact of neglect on children are available, but are not consistently used.

- Performance information is comprehensive and is used appropriately to identify and interrogate trends and potential strengths and weaknesses in practice. During 2016–17, the trust's own data shows a substantial decline in the number of children subject to child protection enquiries and child protection plans. During the same period, the number of children supported through early intervention hubs significantly increased, adding substantial pressure to this service. It is a positive that, although this performance is now more in line with statistical neighbours, the trust continues to explore the reasons for this change, and managers have reviewed all relevant cases to assure themselves that children are receiving the right service to meet their needs.

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

Yours sincerely

Stephanie Murray
Senior Her Majesty's Inspector