Windsor and Maidenhead

Inspection of services for children in need of help and protection, children looked after and care leavers

and

Review of the effectiveness of the Local Safeguarding Children Board[1]

Inspection date: 3 March 2015 – 25 March 2015

Report published: 13 May 2015

The overall judgement is that children's services require improvement
The authority is not yet delivering good protection and help and care for children, young people and families. It is Ofsted's expectation that, as a minimum, all children and young people receive good help, care and protection.[2]

The judgements on areas of the service that contribute to overall effectiveness are:		
1. Children who need help and protection		**Requires Improvement**
2. Children looked after and achieving permanence		**Requires Improvement**
	2.1 Adoption performance	**Requires Improvement**
	2.2 Experiences and progress of care leavers	**Requires Improvement**
3. Leadership, management and governance		**Requires Improvement**

[1] 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 Inspections 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.

[2] A full description of what the inspection judgements mean can be found at the end of this report.

Contents

The local authority

Summary of findings

Children's services in Windsor and Maidenhead require improvement because:

Help and protection

- Some children who are helped under child in need plans are stepped down to lower level services before enough progress has been made.
- Not all young people who become homeless or who are privately fostered receive an appropriate response to ensure that they are safe.
- Multi-agency risk assessment conferences (MARAC) do not yet consider all the domestic abuse cases that they could.

Children looked after, care leavers and adoption

- Care planning is not routinely informed by up-to-date, comprehensive assessments, and so does not always reflect children's current needs.
- The local authority is not ensuring that there are enough placements for older children and young people. There are delays in securing permanent homes for some children.
- The independent reviewing service does not provide sufficiently robust challenge when plans for children are not suitable or not progressing.
- Planning to help young people move from care to independence does not fully involve the young person from the outset. Personal advisors for care leavers are not involved early enough to ensure transitions are positive for young people.
- Children are not being matched with adoptive families and placed for adoption quickly enough.

Leadership, management and governance

- Frontline managers do not oversee and manage practice well enough to deliver consistently good standards.
- Commissioning practice is underdeveloped, meaning that the local authority is not able to ensure that there are sufficient suitable placements for all children looked after.
- Although senior managers were aware of many of the areas of development identified during the inspection, and had plans in place to address them, this was not true for all areas. Not all improvements identified and implemented to date by the authority have yet had the desired impact.

What does the local authority need to improve?

Priority and immediate action

Help and protection

1. Ensure that children's cases are only closed or stepped down to targeted or universal services when a full evaluation indicates that enough progress has been made in meeting needs and reducing risk.

2. Undertake assessments of 16- and 17-year-old young people presenting as homeless in line with case law. Initiate appropriate training for managers and staff in respect of this.

3. Visit children who are privately fostered, assess their circumstances within statutory timescales and undertake appropriate safeguarding checks.

4. Together with the LSCB and police, review the effectiveness of MARAC and the appropriate identification of domestic abuse cases to be presented at MARAC so that risk to children is recognised and minimised in all cases where it should be.

Areas for improvement

Child sexual exploitation

5. Improve the understanding and practice of social workers in return interviews for children who have been missing, so that these are always fully recorded and the information gathered can be used to identify trends and patterns.

6. Review and revise the databases used to collect information on children missing education, children receiving alternative provision and children electively home educated, so that they can be cross-referenced with the children's social care electronic recording system.

Leadership, management and governance

7. Review the performance of frontline managers and take action where necessary to make sure that their case oversight and decision making are of a consistently good standard.

8. Develop the Principal Social Worker role to maximise its influence and support of social workers during their assessed and supported year of employment (ASYE).

Help and protection

9. Review the recording of core groups so that the records of these events are placed on the electronic record system as soon as possible after they occur.

Children looked after, adoption and care leavers

10. Consider the full range of permanence options in early planning for all children looked after, and monitor plans to make sure these are progressed within children's timescales.

11. Improve care plans so that these are routinely informed by good quality up-to-date assessments and take appropriate account of the needs of children arising from diversity.

12. Strengthen the pathway planning process so that young people leaving care are fully involved and have the opportunity to develop a meaningful relationship with their personal adviser from an early stage.

13. Track the assessment process for prospective adopters effectively, so that barriers to timely approval are identified and action can be taken to improve timeliness where necessary.

Commissioning arrangements

14. Accelerate progress on the implementation of effective commissioning strategies to ensure that there is a range of placement choice, so that all children looked after can be appropriately placed.

Corporate Parenting

15. Review and refresh the role and practice of the corporate parenting forum to improve its drive of the children looked after agenda. Consider how young people can be better supported to participate in the forum's work.

16. Support the further development of the children in care council, Kickback, to enhance its influence and help it become more representative of all children looked after.

The local authority's strengths

17. The Director of Children's Services (DCS) is a strong, assertive and passionate leader with the vision to deliver good quality services to children and young people and the drive to improve them. The senior leadership team is outward-looking, proactive and ambitious, and services are on an improving trajectory.

18. The local authority has been successful in securing additional resources to support its work, including becoming part of the second phase of the Troubled Families programme and securing funding from central government to support work with specific groups within the community.

19. The Lead Member for children's services is very well engaged with children's services and knowledgeable about their work. Support from elected members has resulted in improved employment terms and conditions for social workers. This is helping to reduce long-standing recruitment and retention difficulties.

20. The views of children are captured well, particularly during child protection investigations. Similarly, social workers for children looked after know them well, visit them regularly, see them on their own and take account of their views.

21. Early help services for children, young people and families are well targeted and coordinated to provide support at the right time.

22. Referrals to social care are appropriate, and thresholds for access to children's social care are widely understood. Social work expertise and advice are available to support other professionals in determining the best way forward.

23. Most assessments contain detailed consideration of issues, some use of research and appropriate analysis. Most reach appropriate conclusions and make appropriate recommendations. Assessments of whether or not brothers and sisters should be placed together when looked after are done well.

24. Managers identify when children looked after go missing and monitor those deemed to be at high risk, especially those vulnerable to child sexual exploitation or criminal behaviour.

25. At Key Stages 1 and 2 the educational attainment of children looked after exceeds that of children looked after nationally, and all children in the local authority.

26. Children who cannot return to the care of their birth families are always considered for adoption where this would meet their needs. The recent transfer of adoption work to the combined Adopt Berkshire service has led to improved tracking to address delay.

27. Transition planning for care leavers with disabilities and special educational needs is done well, and a high priority is given by personal advisors to making sure that care leavers are living in safe and suitable accommodation.

Progress since the last inspection

28. The last Ofsted inspection of Windsor and Maidenhead's safeguarding arrangements was in March 2012. The local authority was judged to be adequate.

29. The last Ofsted inspection of Windsor and Maidenhead's services for looked after children was in March 2012. The local authority was judged to be adequate.

30. The DCS has been in post since June 2013 and since her arrival has built a strong and stable senior leadership team. The pace of change has accelerated since this team has been in place.

31. Although the local authority has clearly identified many areas for improvement and has taken action to address weaknesses, in many instances this has not yet had the opportunity to show impact in the delivery of consistently good practice and outcomes for children and young people.

32. The local authority has taken a lead in strengthening strategic partnerships, including through the LSCB and the Health and Wellbeing Board. This work has resulted in some successes in the development of joint initiatives such as the forthcoming MASH and shared LSCB sub-groups.

33. Although still high, the rate of turnover in the social work workforce has reduced. The recruitment and retention strategy has been supported by elected members resourcing increased salaries and increasing the base budget to support the recruitment of additional social workers.

34. In September 2014 the local authority moved to a 'pod'-based model of working. This model has small teams, or 'pods', of social workers and support staff which undertake all aspects of work for children in need, those with protection plans and those looked after. This significant change in working practices has been successfully implemented, workers are enthusiastic about it and partners comment that it has brought improvements in the timeliness and quality of response to children and their families.

35. Elements of some previous recommendations are repeated at this inspection. In particular, frontline managers are still not always exercising sufficient oversight of practice. The relatively recent move to a 'pod' structure has increased management capacity, but this is not yet having the desired impact on the quality of management oversight. Senior leaders have acknowledged this during the inspection and are clear that it is being addressed. The local authority's commissioning arrangements also still require development, although firm plans are in place to address this.

36. Although the police risk assess referrals in relation to domestic abuse and missing children, it remains the case that not all incident notifications are risk assessed in terms of priority before referral to children's social care. However, this is not having an adverse effect on the ability of children's social care to respond to the demands placed upon it. The forthcoming implementation of a multi-agency safeguarding hub (MASH) is intended to improve practice in this area.

37. Significant progress has been made in respect of other recommendations. Work on the early help offer has proceeded well, resulting in well-targeted and coordinated services that provide the help and support families need at the right time. All children looked after are now seen alone, and have their wishes and feelings identified and recorded. Advocacy services are now available for children looked after and those subject to child protection plans. There is evidence that learning from complaints now informs service improvement.

38. The inspection of the local authority's fostering service carried out in July 2012 recommended that a strategy be implemented to ensure that the service can respond effectively to current and future needs. There are still difficulties in providing every child with a suitable placement. However, there has been significant progress in the development of the fostering recruitment strategy, and this is beginning to have an impact on the number and range of foster placements which are available.

Summary for children and young people

- The local authority has more work to do to make sure that all the things it does for children and young people are done well. Inspectors think that the Director of Children's Services and her senior managers can do this. The Director wants the very best for every child and young person needing support, care and protection, and is working hard to make sure this happens.
- Social workers always try to help children and their families, but sometimes they reduce help too soon. This could mean that children and their families get into more difficulties because they haven't been given all the help they need.
- When young people have nowhere to live, the local authority does not always do a good enough job of deciding what they might need. This means that some young people do not come into care when they should, which could mean that they are not as safe as they should be.
- The local authority does not always make sure that young people who live for more than a month with someone who is not a parent or close relative (we call this 'private fostering') are safe and well looked after.
- Although social workers act quickly if a young person in care goes missing, they do not pay enough attention to talking to them and writing down what they say when they come back. Information about young people missing from home, care or education is kept in different places, so it is not always shared very well between workers. This could limit how well workers can keep these children and young people safe.
- The local authority has not always had enough foster carers to make sure that all children and young people are placed with someone who is right for them, though this is getting better.
- Children and young people waiting for a 'forever family' sometimes have to wait too long. Sometimes this is because the local authority considers possible families one after another, instead of looking at them all at the same time.
- Children and young people in care do well at school. They do particularly well at primary school, and almost all do as well as or better than the rest of the children who live in the area. Young people in care are doing much better in their GCSEs than children in care in other parts of the country. However, not enough young people go to university or into an apprenticeship.
- A lot of young people leaving care stay with the carers they have been living with until they are ready to move on. They get good support when they set up home or go to university, though some said that more help with budgeting wisely would be useful. Personal advisors help young people get ready to live on their own, and make sure that their new homes are right for them, and safe.
- The local authority listens to what children and young people who are looked after want, and works hard to make sure that the services they provide help them to achieve their wishes.

Information about this local authority area[3]

Children living in this area

- Approximately 33,039 children and young people under the age of 18 years live in Windsor and Maidenhead. This is 23% of the total population in the area.
- Approximately 10% of the local authority's children are living in poverty.
- The proportion of children entitled to free school meals:
  - in primary schools is 8% (the national average is 17%)
  - in secondary schools is 6% (the national average is 15%).
- Children and young people from minority ethnic groups account for 20% 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 Pakistani (8%) and White Other (6%).
- The proportion of children and young people with English as an additional language:
  - in primary schools is 18% (the national average is 19%)
  - in secondary schools is 15% (the national average is 14%).

Child protection in this area

- At 3 March 2015, 656 children had been identified through assessment as being formally in need of a specialist children's service. This is a decrease from 951 at 31 March 2014.
- At 3 March 2015, 75 children and young people were the subject of a child protection plan. This is a reduction from 89 at 31 March 2014.
- At 3 March 2015, three children lived in a privately arranged fostering placement. This is an increase from zero at 31 March 2014.
- Since June 2013, one serious incident notification has been submitted to Ofsted, one serious case review has been completed and one is ongoing at the time of the inspection.

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

Children in care in this area

- At 3 March 2015, 102 children are in the care of the local authority (a rate of 31 per 10,000 children). This is a reduction from 107 (33 per 10,000 children) at 31 March 2014. Of this number:
  - 67 (or 66.7%) live outside the local authority area
  - seven live in residential children's homes, of whom 100% live out of the authority area
  - none live in residential special schools[4]
  - 63 live with foster families, of whom 58.7% live out of the authority area
  - four live with parents, of whom none live out of the authority area
  - nine children are unaccompanied asylum-seeking children.
- Since 1 April 2014:
  - there have been seven adoptions
  - 12 children became subjects of special guardianship orders
  - 41 children ceased to be in care, of whom one subsequently returned to the local authority's care
  - five children and young people ceased to be in care and moved on to independent living
  - no children and young people ceased to be looked after and are now living in houses of multiple occupation.

Other Ofsted inspections

- The local authority does not operate any children's homes.

Other information about this area

- The Director of Children's Services has been in post since June 2013.
- The Chair of the LSCB has been in post since May 2014.

[4] These are residential special schools that look after children for 295 days or less per year.

Inspection judgements about the local authority

Key judgement	Judgement grade
The experiences and progress of children who need help and protection	Requires improvement

Summary

Early help services for children, young people and families are well targeted and coordinated, so that they provide the help and support families need at the right time. Professionals across services are well supported by advice and guidance from social workers and the early intervention support panel.

The Intensive Family Support Programme (IFSP), children's centres and youth workers based in children's social care provide a range of support services for individual young people and whole families, which are often of high quality.

Social workers respond to child protection concerns promptly and take appropriate protective action in almost all cases.

The quality of practice is inconsistent, though better for child protection work than for children in need. Some examples of the work seen showed young people and families making progress. However, some cases have a legacy of poor decision-making and drift, with progress not as good as it should be.

The majority of assessments and plans for children are of good quality and clearly set out objectives and timescales for achievement. Many children make progress as a result.

Children and young people missing from home and at risk of child sexual exploitation are identified by the local authority. Steps taken to minimise risk are tracked to monitor effectiveness, but hindered by the use of different databases. Information from return interviews is not collated to identify patterns.

Some young people assessed as children in need have had their cases closed and stepped down to targeted or universal services too quickly because of poor management decision making. This means that some young people are not getting the services they need.

Some 16- and 17-year-olds who become homeless have not been assessed properly to decide if they should be in the care of the local authority. This means that not all these young people are getting the services and care that they need.

The local authority has not followed good practice requirements in relation to background checks and visits to privately fostered children, meaning it could not be sure that these children were safe. The authority addressed these issues during the inspection.

The multi-agency meeting to review and intervene in domestic abuse cases (MARAC) is not considering enough cases. This means that cases are not being considered where children may be at risk

39. The quality of Common Assessment Framework assessments (CAFs) is improving, but remains variable. In a minority, targets are poorly written and timescales are either too long or are not identified at all. In a small minority of CAFs, the identification of the person to carry out the action was inappropriate. The CAF coordinator provides good support to those who are completing CAFs for the first time, or who have not completed one for some time. Training and support for all partner agencies involved in the CAF process is regular. The impact can be seen through the improvement of the quality in the most recent CAFs.

40. Despite the weaknesses in a minority of CAFs, overall early help services are well targeted and coordinated. Children's centres and schools play a key part in delivering these services for younger children. The youth service provides good, targeted interventions for older children. The Intensive Family Support Programme (IFSP) has been successful in supporting families to make positive changes in their lives, and provides a range of 'whole family' support for complex cases held at the level of targeted or universal services. The Troubled Families programme has turned around 90% of its target families as of February 2015. Due to this success, the local authority has achieved early adopter status for the second phase of the Troubled Families programme, and is aiming to work with a further 470 families over the next five years.

41. A new early help advisory service has recently been established, staffed by three social workers, to support school staff in the completion and use of CAFs, identifying where short, intensive social work interventions might help, and when concerns should be escalated. There is an effective, multi-agency early intervention panel acting as an appropriate filter for social care referrals, and providing guidance and support on complex cases held at the level of targeted or universal services. This range of early help support is ensuring that the need for social care services is reduced.

42. Referrals to social care are appropriate, and indicate that thresholds for access to children's social care are understood by referrers. Social work expertise and advice is available to support other professionals in determining the best way forward. There is a timely response to referrals, with most cases being allocated on the same day. Consent is obtained and considerable efforts are made to ensure that parents and carers are engaged with planning and ongoing work. This includes examples of social workers visiting frequently and repeatedly until parents can be engaged. Disguised compliance is recognised as an issue, and is one of the criteria for seeking advice and guidance through a legal planning meeting.

43. The local authority has not ensured that all children and young people who are subject to a child in need plan have their needs and progress sufficiently considered before being 'stepped down' to targeted or universal services. There was evidence of inappropriate decision making by managers in these cases, with some being too quick to close cases and step them down. This means that some young people are not getting appropriate help at the right time. In

response to this finding by inspectors, the local authority immediately developed plans to implement a system to ensure that the first and last child in need meetings (i.e. that on step-down from child protection and that on step-down from child in need) are independently chaired.

44. The local authority has not ensured that all young people presenting as homeless receive an assessment of their need for services, including whether they should be in care. This means that some vulnerable young people may not be in care when they should be. The authority has recognised this issue and plans to train managers and practitioners.

45. The local authority has not responded well to children who are privately fostered. In two cases open at the time of the inspection, the authority had not done enough to meet need and promote safety. Social workers had not visited often enough, nor had they completed appropriate safeguarding checks. The authority acted quickly to address these issues during the inspection.

46. There is an established Multi-Agency Risk Assessment Conference (MARAC) process and a monthly meeting with a wide range of agencies attending. However, arrangements are not yet strong enough to ensure that all relevant cases are seen and risks considered. The 2014 Coordinated Action Against Domestic Abuse (CAADA) evaluation indicates low performance in relation to cases seen at panel, with data for 2014 showing just 85 cases discussed against a recommendation of 240. The police referral rate to MARAC is low. This may mean that cases of domestic abuse are not being identified or are not considered serious enough to refer to MARAC, potentially placing children and young people at risk. The 2014–15 action plans arising from the CAADA evaluation have not significantly improved performance.

47. Minutes of MARAC meetings are not transferred to the children's social care recording system in a timely manner, with little reference to MARAC appearing in social care case records. This may mean that social workers are not as aware as they should be of risks associated with domestic abuse on their cases.

48. Some children have had too many changes of social worker. This is the result of a legacy of workforce instability. The last year has seen improvements and reduced turnover, and in most cases social workers now know their children well and have good relationships with them. The establishment of a pod system of working is relatively recent, but is having a positive impact on workforce stability and leading to more effective case working.

49. The quality of managerial oversight is variable. There is evidence of oversight and managerial sign-off of decisions, but case supervision is often factual and lacking in analysis and reflection. It is not always clear if progress has been made, as issues are not followed up from one supervision session to the next, and some supervision records are not signed off.

50. The emergency duty service (EDS) provides a timely response to need. However, a small number of referrals to day-time services were insufficiently detailed to demonstrate how risk had been minimised by the EDS's intervention.

51. Responses to child protection concerns are timely, and there is evidence that strategy discussions and meetings are held which result in appropriate actions and outcomes. However, where strategy discussions take place over the telephone, these are often not led by a manager as set out in statutory guidance. Recording of strategy meetings is variable, with examples seen where only the fact of a discussion is recorded together with its outcome. This means that it is not always possible to see the rationale for decisions. In a small number of sampled cases, inappropriate decision making meant that child protection investigations did not occur when they should have done. However, these young people were not at serious risk and other actions had been taken which contributed to their safety.

52. No children were seen who were subject to child protection enquiries unnecessarily.

53. Domestic abuse notifications are triaged by the referral and assessment team. The team identifies situations of risk to children and ensures an appropriate response. Targeted work on domestic abuse has been given high priority, with a commissioned service providing one-to-one support for 75 children aged six to 17 in the last year. A Domestic Abuse Practitioners' Guide produced by the domestic abuse forums in Windsor and Maidenhead and two neighbouring local authority areas provides information about and contact details for support services.

54. Domestic abuse cases demonstrate access to support services, including the Freedom Programme and counselling, together with evidence of minimisation of risk. Families with parental substance misuse or mental health problems receive support through a range of local services.

55. Statutory visits are timely in the very large majority of cases seen. However, recording is not consistent. Some good examples were seen of records which were focused on case objectives, but also other examples where recording lacked detail and relevance. Case records consistently demonstrate that children are seen and, where appropriate, seen alone. Records also provide examples of direct work with children and young people, both by social workers and by pod-based youth workers.

56. Work on chronologies is not consistent. Some are good, but some do not include sufficient history to support assessments and plans, and key events such as home visits are not always listed. A lack of rigour in recording practice means that chronologies may be recorded in a number of different places on the electronic system, and so cannot always be easily accessed, for example, by a new worker taking on a case.

57. Most assessments demonstrate detailed consideration of risks and some use and awareness of research, and include appropriate analysis. Most, but not all, reach appropriate conclusions and recommendations. There is evidence in assessments of the recognition of cultural issues, and these are included in analyses and recommendations.

58. The voices of children are clearly reflected in most assessments and reports. Parents' views are also captured well, and both young people's and parents' views are taken into account in recommendations arising from assessments.

59. Child protection conferences and reviews of child protection plans are timely. Case conferences use the Strengthening Families approach, and conference chairs were seen to engage parents well.

60. The Youth Counselling Service took on responsibility for providing advocacy services in July 2014 and now provides advocates for children subject to child protection plans. To date the service has supported 28 children and young people at child protection case conferences, which represents a substantial minority of those with protection plans.

61. The content of and analysis in child protection plans is variable, but a majority demonstrate clear objectives, actions, timescales and contingency plans. In two cases seen by inspectors, core risk areas were not identified or were minimised, and the assessment of risk factors was poor. Children were not at immediate risk in either of these cases.

62. Challenge from conference chairs over delays in progressing plans is poor. A number of challenges recorded in the chairs' challenge log had received no reply from practice managers, which may indicate that the chairs lack status and influence with frontline managers.

63. Core groups are of inconsistent quality and not all core group meeting minutes are made available on the electronic system in a timely manner. Some were still not on the system after several months, reducing both impact and usefulness. Most core group meetings seen were timely and some evidenced progression of the child protection plan, but a number had poor attendance and were poorly recorded.

64. Children in need plans are variable. A large majority show good progress in objectives and effective work in engaging and diverting young people. Plans offering help and support are set out clearly in these cases. A minority of cases showed some drift and lack of progression. In the disabled children's team, plans for children in need are not completed routinely.

65. Children and young people missing from home and at risk of child sexual exploitation are identified and responded to by the local authority. The steps taken to minimise risk are tracked well to monitor their effectiveness through an operational group led jointly by the local authority and the police. The authority works with the police to identify patterns and take steps to disrupt

activity, including use of the local authority's licencing function where necessary. The use of legal deterrents such as abduction notices is considered and pursued in appropriate cases.

66. A child sexual exploitation risk assessment tool is completed in all cases where there are concerns, and in some cases this is done with the young person. However, social workers and other professionals have not been trained specifically in the use of the tool, potentially reducing its usefulness. In most child sexual exploitation cases seen, there is evidence of effective work to reduce risk and disrupt activity. However, return interviews for children who have gone missing are not systematically recorded and so are not used effectively to inform further planning and actions or identify trends and themes.

67. The local authority maintains a separate database of all children missing education. However, this contains names and dates of birth of children but lists neither their Unique Pupil Number (UPN) nor their number on the children's social care recording system. It is therefore difficult to cross-reference it to children missing from home, those who are electively home educated, in alternative provision or at risk of sexual exploitation. This limits the local authority's ability to identify young people who may be at risk, and thus reduces its effectiveness.

68. In the current academic year, 63 children have been identified as missing education (CME). Of these, only five were not registered as pupils at a school or receiving suitable alternative education at the time of the inspection. Recording on the CME register does not identify well enough in all cases whether a child is being monitored until a new school place has been confirmed. For example, one entry states: '[Other LA] aware the family are on their CME list', and the case is identified as closed. The local authority is not always sure that children are attending a new school before closing the case.

69. A separate database monitors children receiving alternative education provision. This uses the UPN as a reference for the pupil, but again monitoring is made difficult because these numbers do not correlate to the children's social care system. Currently nine pupils are not receiving their full twenty-five hours entitlement. One pupil does not have any hours allocated. The local authority is fully aware of those who are not accessing their full entitlement, and can demonstrate how all of these children and young people are being supported through a range of strategies to increase their participation and engagement.

70. Children who are being electively home educated (EHE) are monitored on a further database, which is incomplete because not all these pupils have UPNs identified on the database and some do not have their ethnicity recorded. These factors hinder the local authority in its ability to offer advice and support and do not provide a sound basis for responding to any concerns that may arise. Where a parent has refused a visit from the EHE team this is recorded.

71. The management of allegations against those who work with children is effective. Cases sampled showed timely and well-attended strategy meetings, with detailed actions allowing progress to be identified. Thresholds for Local Authority Designated Officer (LADO) intervention are appropriate. However, work remains to be done to engage primary schools, health agencies and faith communities fully in understanding and using LADO processes.

Key judgement	Judgement grade
The experiences and progress of children looked after and achieving permanence	Requires improvement

Summary

Care planning is not always informed by up-to-date assessments, so care plans do not routinely support improvements in the experience and progress of children looked after. Management direction is not consistently robust. The Independent Reviewing Officers (IROs) lack status and need to challenge poor progress on plans more consistently and effectively.

Planning for children to live permanently with families does not always start early enough. The local authority is not yet making sure that there are suitable placements for all children, especially for older children with more complex needs. A small number of children are placed with carers with whom they are not well matched.

The local authority is getting better at bringing the right cases to court at the right time. However, the timeliness of care proceedings declined during 2014–15. Although it is now improving, 33% of care proceedings remain outside the 26-week timescale set out in legislation. The quality of court work is not yet consistently good.

The two virtual school head teachers ensure that there is good pastoral support in schools for children looked after. Attainment of children looked after at Key Stage 2 exceeds that of their peers in Windsor and Maidenhead, which is exceptional. However, not enough is being done to reduce the attainment gap with their peers at Key Stage 4.

Initial health assessments are timely. Most children looked after receive good quality therapeutic support and have access to a wide range of recreational activities.

Children who are unable to return to their birth family are considered for adoption. Where this would meet their assessed needs it is pursued for them. Though the local authority has consistently performed above the national average in the proportion of children leaving care through adoption, children are not placed with adoptive families quickly enough.

Planning for looked after young people as they approach adulthood does not fully involve them. Too few care leavers progress to higher education. Arrangements for apprenticeship provision specifically for care leavers have only recently been developed.

The local authority is in contact with almost all care leavers, and most say they feel safe and are well supported, though they would like more help with budgeting. The range and choice of accommodation for care leavers when they first leave care is too limited. Care leavers with complex needs are well supported with transitions to adult services and have good opportunities to participate in work placements and gain paid employment.

72. On 3 March 2015, 102 children were looked after by Windsor and Maidenhead, the equivalent of 33 per 10,000 of the population. This is below the 39 per 10,000 rate of comparable authorities and well below the national rate of 60 per 10,000. The reasons for this are not fully understood by the local authority, but the impact of targeted services such as IFSP, the use of family group conferences and the placement of children under Special Guardianship Orders, Residence Orders and Adoption Orders all contribute to this position. Inspectors did not see any children or young people entering care who should not have done so, and decisions that children should become looked after are made at an appropriately senior level. The number of children leaving care and subsequently needing to be readmitted is low.

73. Social workers see the vast majority of children looked after on their own and visit them regularly, often more frequently than prescribed by statutory guidance. They talk knowledgeably about the children they support and reflect their views in case records. Youth workers based in the pods make meaningful relationships with children and there is evidence of good quality direct work. The service's new pod structure is designed to promote continuity in social work allocation. However, previous workforce instability has led to frequent changes of social worker for some children. Inspectors spoke to a number of children who expressed their unhappiness about this.

74. The legal gateway panel provides sound advice to social workers who have assessed children as needing to be subject to pre-proceedings work under the public law outline (PLO). The panel automatically considers all children who have been the subject of a child protection plan for more than 18 months, cases where positive change has not been effected due to disguised compliance by parents or carers, and cases where the mother of an unborn child has had a child removed previously. Senior managers now carefully track and monitor children subject to the PLO and care proceedings, but this is too recent to show impact. Court reports and care plans are quality-assured by legal services, and those sampled were good, paying close attention to the contact needs of children with their birth family. However, three of the nine cases currently in care proceedings are outside the 26-week timescale for conclusion. Senior managers acknowledge that this is related to poor quality practice by interim social workers and poor management oversight. This work has now been re-allocated.

75. The local authority is improving its use of family group conferences, offered through an independent service consisting of five workers and one coordinator. In the last 12 months, 36 conferences have been held and nine more are scheduled. The authority estimates that this resource has prevented ten children from coming into care over this period.

76. The local authority is not meeting its sufficiency duty for placements for older children and young people, particularly those with complex needs. Though the majority of children and young people are in placements that meet their needs,

for a small number of children a lack of placement choice has resulted in inappropriate placements with carers to whom they were not well matched. The authority has recognised this, and the recruitment of foster carers is now targeted.

77. Placement stability is improving in 2014–15, with the local authority's own data stating that 10% of children looked after had three or more placements. This is an improvement on 13% for 2013–14 and below the latest figures of 11% for both comparable authorities and nationally. For 2013–14 the percentage of children in care for 2½ years and in the same placement for two years or more was 41%, which compared poorly with the comparable authority figure of 64% and the national figure of 67%. The local authority's data show improved performance in this area of 63% for 2014–15.

78. As at 31 March 2014, 71% of the local authority's children looked after lived in foster care. This compared with figures of 74% for comparable authorities and 75% nationally. At the point of the inspection, local authority data was showing a decline in this performance to 64%. The local authority's Fostering Recruitment and Retention Strategy 2014–17 has set a target of recruiting 20 fostering households each year for the next three years; initial analysis shows improvement, with the first year's target of 20 new carers being met. However, assessment of foster carers is not always timely, with workforce issues impacting upon timely allocation for assessment. The local authority has recognised this issue and has committed a further two full-time posts to the family placement service.

79. Foster carers are approved in line with national standards and regulations, and are reviewed annually by a Foster Carer Reviewing Officer based in the quality assurance team. The fostering panel has an experienced chair, who ensures that reports are quality assured and provides feedback to the assessing social worker. There is a wide range of training available to foster carers, including safeguarding and more specific training on meeting the needs of children and young people, such as health issues for teenagers and bullying. Core training expectations are clear, with almost all foster carers having completed the national Training, Support and Development Standards. The forthcoming 2015–16 training programme offers a wide range of courses, including child sexual exploitation. Foster carers are encouraged to attend training to enable them to meet the needs of the particular children and young people they are caring for.

80. Most foster carers spoken to report that they are usually well supported by the family placement service, though staff turnover has led to frequent changes of supervising social worker for some of them. They have a high regard for the training programme, and have good access to leisure opportunities that include their own children. There is an active support group, that meets with senior managers one month and family placement service managers the next. Two foster carers are members of the corporate parenting forum.

81. Most permanence decisions are made by the time of the second statutory review. However, family finding is too slow and linear in approach, delaying the identification of a suitable placement. The local authority is aware of this and is taking steps to speed up the process. The assessment of whether or not brothers and sisters should be placed together is a strength. These assessments also address the support needs of children.

82. The local authority actively considers placements with 'connected persons' (relatives and friends) as a permanence option. Between 2011–12 and 2013–14, an average of 14% of children who left care did so because they became subject to a Special Guardianship Order (SGO), compared with the national average of 10%. This means the local authority is the 16th highest performing local authority in England in this respect. During 2013–14, 22% of children who left care did so because they became subject to a Residence Order (Replaced by the Child Arrangement Order, CAO, in April 2014), compared with comparable authority and national figures, both 6%. In all cases seen by inspectors, decisions were appropriate and the support provided to carers was good. Where it is the right thing for the child, the local authority funds permanent fostering placements with independent providers, so reducing delay for some harder to place children.

83. Arrangements for children looked after who are placed with parents are appropriately assessed and monitored. Where appropriate, the local authority applies for care orders to be ended, but in a small number of cases inspectors saw evidence of the local authority returning children at home on care orders to care because of re-emerging risk.

84. The resources panel is ensuring appropriate senior management oversight of children who need additional resources or require an independent sector placement. At 31 March 2014, the local authority had 17% of its children looked after living outside the borough and more than 20 miles from home. This compares with figures of 28% for comparable authorities and 17% nationally. When children live in independently provided placements away from the borough, social workers ensure that they have access to local health and education services and more specialist services when required. Processes for monitoring the quality of external providers lack clarity and require strengthening, though notifications received from Ofsted when providers are judged inadequate are acted on appropriately.

85. The timeliness of looked after reviews is good, with local authority data showing 2014–15 performance of 99.6% completed within the statutory timescale. Reviews are appropriately multi-agency, and IROs communicate with children before review meetings. However, the IRO service lacks authority and does not challenge practice as effectively as it should to make sure that care plans are pursued and achieved. This is particularly so where plans are not delivered within timescale or when children are offered placements which cannot meet their needs. IROs have not been actively involved in service improvement, though there are now plans for this to take place. The recently

appointed Quality Assurance Manager is aware of these issues, acknowledges the lack of aspiration shown by the most recent IRO annual report, and has ambitious plans to address these deficits.

86. Managers identify when children looked after go missing, and monitor those deemed to be at high risk, particularly of sexual exploitation or criminal behaviour. Social workers visit children after missing episodes, but do not have a good understanding of what should be addressed during a return interview. Some are not aware of the return form visit template, so opportunities are missed to improve intelligence about the reasons why children go missing and where they have been.

87. As of January 2015, the Youth Offending Service (YOS) was working with 11 children looked after and care leavers, including one in custody. The YOS works closely with social work and youth services to divert young people from offending and to prevent reoffending. There is a dedicated service to help young people who misuse alcohol and drugs. This includes a peer mentoring scheme and a support group for their parents.

88. The proportion of children looked after having timely medical and dental assessments and immunisations is high, at 96%. Health assessments are robust. Children's and young people's health needs are addressed quickly and, where concerns are identified, referral to the relevant agency is prompt. Emotional health assessments are part of the annual health assessment. However, where strength and difficulty questionnaires (SDQs) are completed, findings do not inform personal educational plans (PEPs). This means that planning is not as responsive to the needs of individual children as it could be.

89. A specialist team within the Child and Adolescent Mental Health Service (CAMHS) supports the mental health needs of children up to age 18. Although arrangements prioritise the assessment and treatment needs of children looked after, inspectors found evidence of delays in assessments for a minority of children. A range of therapeutic interventions provided by the youth counselling service provides much-needed initial support for those awaiting CAMHS assessments and treatments and those assessed as not meeting the threshold for CAMHS. The two virtual school head teachers make excellent use of pupil premium funding to ensure that those children looked after who need it receive the very best quality therapeutic interventions, including residential therapeutic educational establishments.

90. Children and young people receive excellent support, motivation and encouragement to make the best possible educational progress from the two virtual school head teachers. Almost all children looked after attend good or better schools. A few are in schools requiring improvement, but these judgments are recent and made while the children were already attending the schools. The local authority has reasonably taken the view that moving these children would be disruptive, and the two head teachers monitor their attendance, behaviour and progress particularly closely so that any future

decision to move them will be well informed. For similar reasons, one child remains in an inadequate school; this child is due to move schools in six months and the decision was that educational stability should take priority. There are no significant differences in outcomes between looked after children placed within or outside the authority, which is good performance.

91. PEPs capture well the progress children make, and are reviewed three times a year. They are rigorous wherever in the country the child receives their education. Tracking of pupils by the virtual school is scrupulous in identifying trends and issues. The quality of PEPs is generally good; targets are aspirational, and challenge children to achieve highly. In almost all cases, PEP reviews include the child and their carer, the social worker, the school and the virtual school. In early years and for children with complex needs, excellent use is made of a range of methods, from observations to play and drawing, to capture the voices of children. The virtual school models best practice by continuing PEP reviews and continued monitoring of the performance of a child for at least a year following adoption.

92. Most children looked after enter school from low starting points. At Key Stages 1 and 2 attainment is good, and exceeds that both of children looked after nationally and of all children in the local authority. In 2013–2014, attainment in reading at Key Stage 1 was 29% above the national average for all children looked after, in writing 39% above, and in mathematics 28% above. In the same year, the attainment of children looked after at Key Stage 2 was markedly higher than children looked after nationally. Attainment in mathematics was 39% higher, in reading 32% higher and in writing 51% higher. This high attainment is also reflected in the comparisons with all children in the local authority, where children looked after out-performed their peers by 11% in mathematics, 8% in reading and 12% in writing. This is exceptional performance.

93. Performance in young people achieving GCSE passes is improving. The proportion gaining five or more GCSE grades A*-C including English and mathematics was 12% above that achieved nationally by all children looked after in 2013–2014. However, it was below that of the attainment of all children nationally by 31%.The rate of progress is not yet rapid enough to close the attainment gap.

94. Attendance is much improved. In the current year it is 97.5% for children looked after, higher than the national average of 94.1% for all schools. The rate of persistent absence for children looked after is 5.1%, the same as for all children in the local authority. The educational welfare service liaises well with schools to support those whose attendance is declining. Individual schools use a range of methods to monitor and tackle children who miss part of a school day, though this information is not yet collected and analysed centrally.

95. No children looked after have been permanently excluded since 2004. Although fixed term exclusions of children looked after increased in 2013–14 to 5%

above that of the whole school population, the most current data show that this has declined and, at 3.8%, is almost the same as that of the local authority's wider school population. The virtual school works in close partnership with schools, alternative providers and providers of individual tuition to ensure that all children looked after receive their full educational entitlement. All four children who are not accessing 25 hours of education are receiving targeted and sensitive support to enable them to increase the hours of education they access. Monitoring of these children is thorough.

96. The local authority keeps a record of children and young people for whom they are directly responsible who are accessing alternative provision, and monitors the quality of this provision. All of these children are included in the central register of children receiving alternative education. Until very recently the number of children and young people accessing alternative provision through their schools had not been recorded by the authority. Consequently the authority does not yet have a clear understanding of the extent and quality of this provision across the borough.

97. Children looked after know how to complain. They understand their entitlements, and this is reinforced by a newly-published information pack, which is being sent to all children looked after. Twelve children looked after have an advocate and six have an independent visitor, but the contract with the independent organisation providing these services is relatively new and they are not yet extensively used.

98. There is an active children in care council, 'Kickback', which has been involved in the design and content of an information pack, work on a revised 'pledge' (the local authority's promises to children looked after about the services they can expect to receive), redesign of consultation forms for looked after reviews and the revision of the Letterbox Club scheme, which provides books for children looked after. However, the number of regular members is small and the group is not yet fully representative of the wider population of the local authority's children looked after. The group would benefit from support from the local authority to develop further.

The graded judgement for adoption performance is that it requires improvement

99. All children who are unable to return to the care of their birth family are considered for adoption, and where this would meet their assessed needs it is pursued for them. Adoption is now considered in a timely way alongside other permanence options to ensure that it is the right plan for the child, with good consideration given to children's heritage.

100. The local authority is not performing well in ensuring that children are adopted with the minimum of delay. Performance on the 2011–14 adoption scorecard for the average time between a child entering care and moving in with an adoptive family declined from that for 2010–13, increasing from 647 days to 743 days. This figure was worse than the England average and 196 days over the national threshold target of 547 days for that three year period. Local authority data for the period 1 April 2014 to 16 March 2015 show that seven children were placed with adopters in an average time of 628 days. This is an improvement in performance, but remains outside the expectation for 2012–15 of 487 days.

101. The average time between the local authority receiving court authority to place a child and deciding on a match with an adoptive family improved very slightly between 2010–13 and 2012–14, from 288 to 286 days. This is longer than the England average and 134 days more than the performance threshold. The local authority has been following a linear process for finding families through the National Adoption Register, Berkshire consortium, activity days and local and national media, rather than exploring all options simultaneously. This has resulted in the large majority of children waiting too long to be placed with adoptive families. The authority has recognised that this approach to finding adoptive families for children has meant that children have taken too long to be matched and placed. It has taken action to improve the adoption service through the development of Adopt Berkshire, though it is too early for the full impact of this to be seen. Only two children are currently waiting for adoption, one of whom is in a fostering for adoption placement.

102. The local authority has consistently performed above the national average in the proportion of children leaving care through adoption, with a 2013–2014 figures of 26% against a national average of 17%. This is a result of a high number of groups of brothers and sisters being successfully placed with adoptive families. A very small number of children had their plans for adoption changed. These decisions were based on assessed need and each was appropriate.

103. The local authority is ambitious and successful in placing older children, groups of brothers and sisters and children who have more complex needs. Between 2011–12 and 2013–14 an average of 8% of the children aged five or older leaving the local authority's care were adopted, which compares favourably with the national average of 5%.

104. Child permanence reports vary in quality, with the large majority requiring further detail about the child's needs and personality. Good quality comprehensive assessments identify whether brothers' and sisters' needs would be best met through remaining together or being placed separately. The percentage of children from black and minority ethnic groups leaving care through adoption is representative of the local authority's children looked after population and higher than the national average.

105. Adoption services are now delivered in partnership with three other local authorities through the 'Adopt Berkshire' service, which came into full operation in January 2015. Plans and tracking mechanisms are in place and these have the potential to have a significant impact on the timeliness of adoptions. The service's approach to family finding is proactive, and activity takes place quickly and concurrently. However, it is too soon for Adopt Berkshire to have demonstrated an impact on timescales.

106. The adoption panel is chaired by a suitably qualified and experienced chair, with clear performance measures in place for the chair and panel members. The quality assurance function of the panel is robust. Panel minutes show appropriate scrutiny of the suitability of prospective adopters and adoption matches. The agency decision maker (ADM) demonstrates effective oversight of panel decisions, and exercises timely decision making for children whose plan is adoption.

107. Adopters are not consistently assessed in line with national expectations about timescales, with only one (13%) of the eight adopters approved in 2014–2015 being assessed within six months. There was justifiable delay in a small minority of the assessments not completed within timescales. The large majority of reports on prospective adopters are of good quality, with analysis showing how adopters are able to meet the wide range of children's needs.

108. Through Adopt Berkshire, the local authority has clear plans in place to improve the recruitment, training and support of prospective adopters. The Cornerstone Partnership, a new initiative funded by the Department for Education, starts on a pilot basis in April 2015, and has the potential to improve the pool of adopters for children who are harder to place.

109. A large majority of approved adopters spoken to by inspectors reported extremely positive experiences of assessment and matching for adoption. They had found the local authority welcoming and professional, and the adoption panel welcoming but appropriately challenging. On the whole, they felt well prepared. All were aware of their entitlements and how to access support when needed, and were confident that they would be well supported and advised.

110. Fostering for adoption is considered for all children where appropriate, and is being actively promoted within the local authority and by the adoption panel. Prospective adopters are routinely asked whether they will consider fostering for adoption, both when commencing assessment and again by the adoption panel. This has resulted in two fostering for adoption approvals, with children placed quickly through Adopt Berkshire.

111. Adoption support plans vary in quality, from requiring improvement to good. In 2013–14 there were no disruptions within adoption placements, with the large majority of support plans meeting the needs both of children and their families. There is a wide range of post-adoption support available for adopted children, adoptive families and adopted adults. This includes funding for therapy, direct

support from social workers and youth workers, birth record counselling and birth family tracing services for adopted adults. Post-adoption support through therapeutic services has not been provided soon enough for a small number of children. This has had an adverse impact on the adopters' ability to meet the child's needs in the early days and weeks of the placement. There are 30 ongoing packages of support, with good examples seen. The local authority is also providing 20 adoption allowances and 19 active post-adoption support services to adopted adults.

112. Currently 91 adopted children maintain links with birth relatives through letterbox arrangements, and one child through direct contact. Where adoption is the plan, social workers refer birth parents and relatives promptly for support services. Twelve people were being supported by the birth relative support service in 2013–2014, an increase of 50% on the previous year. Berkshire Adoption Advisory Service reports that it has engaged a large majority of birth parents in counselling services over the last year.

113. When other local authorities end support for adopted children they have placed in Windsor and Maidenhead, the Berkshire Adoption Consortium Consultation Service (BACCS) provides help. This includes access to clinical psychology services, advice and support.

114. Life story work with children is of good quality. Life story books provide children with information to enable them to understand their life experiences and the reasons why they are living with their adoptive families, and information about their birth families. This work is completed in child-friendly language and contains many significant memory prompts for children.

The graded judgement about the experience and progress of care leavers is that it requires improvement

115. Joint planning for young people's transition from care to independence is currently limited to one handover meeting between social workers, personal advisers and care leavers. This means that the process is not inclusive or effective enough. It does not ensure that the young person owns and recognises the pathway identified for them, or understands the pathway plan written for them. Care leavers do not have enough time to get to know their personal adviser and build confidence in them prior to the handover. This impacts negatively on the quality of transition planning. However, once care leavers move to a personal advisor, they report that they feel the pathway plan increasingly belongs to them and reflects their aspirations well.

116. Transition planning for care leavers with disabilities and special educational needs, on the other hand, is collaborative, clear and effective. A particularly broad range of activities, delivered in conjunction with local private, statutory

and voluntary organisations, supports the development of independent living, job search and employability skills. A local voluntary organisation provides a range of realistic work-related opportunities including work placements, voluntary work and, where possible, paid employment.

117. Experienced personal advisers work closely with young people to support them in making decisions about their future goals. All care leavers have an up-to-date pathway plan. Plans scrutinised by inspectors contained an overview of the young person's history and current medical information. Personal advisers know young people well, understand their vulnerabilities, and generally record this well in plans. However, targets and actions do not clearly state what needs to happen and by when, or who will support progress towards targets. Risks relating to drug and alcohol misuse are carefully recorded and, where necessary, actions taken are documented. Although budgeting is covered during pathway planning, care leavers say that they would welcome more practical individual support to develop good budgeting skills.

118. In most pathway plans the voice of the young person is clear, and excellent consideration is given to religious and cultural needs. This thoughtfulness ensures that nearly all young people are living in areas where they can easily access provision and services that are important to them. This includes living close to former foster carers, sporting facilities and places of worship. The recent planned departure of one adviser has resulted in there only being one personal adviser for all care leavers. The local authority has plans in place to recruit to the vacancy. However, although cases have been re-allocated to the remaining personal adviser and to social workers, a few care leavers are uncertain about whom to go to if they have a concern.

119. Almost all care leavers are in suitable accommodation. Care leavers are encouraged and supported to remain with their foster carers after they leave care, and four are currently in 'staying put' arrangements. Good support is also provided for care leavers to access and sustain tenancies in privately-rented accommodation. However, the range of options, particularly when young people first leave care, is limited. The local authority is aware of this, and the sufficiency strategy identifies it as a key priority. Care leavers report that overall they feel safe and know what to do to keep themselves safe, though they do express concerns about groups of people waiting outside one of the housing options. Personal advisers take concerns about safety very seriously and young people who feel unsafe where they are living are supported to move promptly.

120. The most recent data, from February 2015, record that only three care leavers aged 17½ and over are not in suitable accommodation. This means that 85.7% live in suitable accommodation, which is higher than the national figure of 77.8% for 2013–14. Personal advisers understand the circumstances of these three young people, and appropriate plans are in place to ensure that re-housing takes place as a matter of priority. No young people are living in houses of multiple occupancy and none are in bed and breakfast. Risk assessments of accommodation are recorded in pathway plans, and the process

meets the requirements of statutory guidance. However, there is no comprehensive risk assessment checklist to ensure consistency of assessment or allow collation of all risk assessments. Consequently, the local authority does not have a complete overview of the quality and safety of accommodation.

121. The local authority knows the destinations of all of its care leavers. In 2014 all children looked after progressed to further education or employment at the end of Key Stage 4; of the 19 to 21-year-old care leavers, 60% were in employment, education and training, which is higher than the national figure of 45%. Of those between 16 and 19 years of age, 85.7% were in education, employment or training. The local authority has established partnerships with local private, statutory and voluntary organisations to support young people who are not in employment, education or training (NEET) in the development of job search and employability skills. Two apprenticeship opportunities are ring-fenced for care leavers and plans are in place to extend this. A local voluntary organisation provides good employability opportunities, including work placements and permanent employment, for care leavers and young people with disabilities. Its staff spend time with employers to identify potential job opportunities for young and provide structured job coaching to potential employees to help them become job-ready. Only three (8%) of the young people leaving care over the last three years are at university. Although this is above the figure of six percent for all children looked after nationally, it does not meet the aspirations of the local authority for the rate of children looked after attending university to be the same as for all its young people. Those who are attending university receive good financial support, and personal advisers maintain close contact with them.

122. Working with a local voluntary organisation, the local authority has recently agreed to develop and ring-fence some level 1 apprenticeship-equivalent programmes. Two care leavers are currently on these programmes, which will lead to qualifications in sports coaching or health and safety. Plans are in place for these young people to progress to level 2 apprenticeships in the near future.

123. Health advice and support for the health needs of care leavers is too variable. Examples were seen of good support being provided through the youth counselling service to meet mental health and therapeutic needs. However, for a small minority of young people who needed more specialist intervention there was evidence of delays in accessing specialist assessments. The local authority is aware of this and plans are in place to make improvements.

124. Almost all health assessments are completed on time. Care leavers receive appropriate support to access and understand their health histories at their final health review but currently there is no health passport scheme.

125. Care leavers have a good understanding of their entitlements and their right to complain. They also have information on how to access an advocate. Many were involved in the design and production of an accessible booklet informing care leavers and children looked after of these rights. The youth service's

apprentice uses social networking to engage with care leavers and to celebrate success.

Key judgement	Judgement grade
Leadership, management and governance	Requires improvement

Summary

Considerable efforts have been made to deliver high standards, but a legacy of a dysfunctional workforce culture and poor practice predating the appointment of the current DCS has as yet prevented the development of sufficiently consistent good practice. The DCS is a strong, assertive leader with a clear vision who, together with her senior leadership team, has successfully restructured services and laid the foundation for practice and quality standards to improve.

While children are safe and being effectively protected, there is some practice that requires prompt and significant improvement. Frontline management and oversight are not consistently effective. Despite significant coaching and support, some frontline managers are still not performing at an appropriate level. This means that standards of practice and decision making do not ensure that all children receive the right service at the right time.

Elected members are committed corporate parents, and have invested heavily in the growth and development of the fostering service. They have prioritised, secured and increased the financial resources necessary to ensure that children's social care delivers all of its statutory obligations.

At a strategic level, the role and activity of the Local Authority Designated Officer (LADO) requires systematic drive and focus to become good.

Strategic partnership work is not sufficiently mature. The local authority assertively drives the improvement agenda, but has significant challenges in securing the partnership support it needs in all areas. However, child sexual exploitation has had a high priority and demonstrates that the local partnership is working effectively.

Until this inspection the local authority has not been compliant with the Southwark judgement, and was unaware of this. This means young people presenting as homeless have not had the opportunity to benefit from local authority care and accommodation.

The sufficiency duty is not fully met. Senior managers do not have effective performance information to ensure comprehensive oversight of placement, permanence and care planning services. This contributes to children waiting too long to be matched and placed with prospective adopters.

Commissioning practice is underdeveloped, meaning that senior managers are not always able to ensure that the right services to meet assessed needs are available in the right quantity and at the right time.

126. Working arrangements between the LSCB Chair, DCS and interim Managing Director (equivalent to the Chief Executive in this local authority's structure) are in line with statutory guidance and are subject to appropriate governance protocols. Overarching strategic plans demonstrate clear links in objectives and priorities. The Lead Member has a detailed understanding of performance and presenting issues in children's social care, and works effectively with the DCS. The interim Managing Director and Lead Member understand and support the changes to the new pod model of service.

127. Senior managers have a track record of taking assertive action to address poor performance by frontline managers. However, despite significant coaching and support, some frontline managers are still not performing at an appropriate level. In particular, decision making by frontline managers stepping cases down from statutory child in need status to community-based teams is not sufficiently robust. This has the potential to leave some children at risk of harm. Two cases seen by inspectors had not benefited from a multi-agency child protection investigation, and risk had not been appropriately assessed. Senior managers have plans in place to review all cases at this threshold.

128. Commissioning activity has been characterised by insufficient drive and focus, with the result that arrangements are underdeveloped. Work remains to improve systems and practice from what was, until recently, a very low base line. Managers do not yet have a comprehensive understanding of the market, and acknowledge that they are not gaining benefits from cost for volume arrangements in relation to placements. Procurement from the voluntary sector is unsophisticated and small in scale, but delivers effective services such as support for young carers. Good arrangements are in place to support disabled young people's transition to adulthood. This is done through an agency framework contract, developed in conjunction with adult social care, which brings economies of scale and so reduces costs. Close working with a local voluntary organisation is providing good employability opportunities, including work placements and permanent employment, for care leavers and young people with disabilities.

129. Managers have not ensured that sufficient placement choice is available for children looked after. This is particularly the case for those with complex emotional and behavioural needs. As yet, the increase in in-house foster carers has not met the needs of these young people. In addition, the range of options for those over 16 is too limited, and not reflective of the cohort it needs to serve.

130. Strategic partnerships are largely led by children's services and not sufficiently integrated. Some partners have been too slow to commit to the wider development of services for children. For example, the local authority pays its full contribution to the costs of the LSCB, but this represents a disproportionate 70% of the total financial support being provided to the Board. Similarly, the development of the forthcoming borough-based MASH has only been possible due to the local authority's part-funding of police staff. However, agreement

has been achieved to progress an integrated early help offer due to be implemented in 2016.

131. The DCS has driven progress between overarching strategic groups. In February 2015 a joint protocol was agreed between the LSCB, the Health and Wellbeing Board, the Children and Young People's Partnership Strategic Board and the Adult Safeguarding Partnership Board. This sets out the basis for future development and joint accountability. Operationally, there is a good level of multi-agency work in individual cases and, with the agreed transfer of the public health functions for 0-5 year-olds later this year, plans for further improvements are in place.

132. The Principal Social Worker role is not set at an appropriately senior level and has suffered from personnel changes. This has resulted in a lack of any sustained programme of purposeful activity.

133. The DCS and her senior leadership team are outward looking and actively seek opportunities to develop and improve their services further. For instance, a successful bid to the Department for Education's Innovation Fund is intended to increase significantly service provision to specific cultural groups in the community. Senior managers have secured a partnership with an external organisation to provide two units of consultant practitioners and social work students from September this year.

134. The performance management and quality assurance framework has the potential to be a positive tool for driving improvement, and some impact can already be seen. The Performance and Quality group is presently reviewing the current suite of performance indicators to ensure that it will allow the local authority to fully understand and address present deficits. Collection and scrutiny of performance data relating to fostering is particularly poor, and currently depends on manual tracking by a team manager. Regular audit activity is established and showing some positive impact on standards of practice. The routine recording of children's views in their assessments is particularly evident.

135. Good progress has been made to address the issue of child sexual exploitation, and a monthly multi–agency operational group tracks and considers both missing children and those at risk of child sexual exploitation. Prevalence is known and activity to disrupt perpetrators is in place. For example, findings have been used to inform changes to police patrol patterns to disrupt specific activity. Current risk levels and plans are reviewed effectively, and serve as an alert mechanism if risks continue or increase. Currently no specialist services are being delivered for young people and their families affected by child sexual exploitation, but these are prioritised in future commissioning intentions.

136. The Local Authority Designated Officer (LADO) works well operationally but more needs to be done to develop the role strategically. The LADO does not present her own report to the LSCB and thus has never been directly

challenged by the Board. Work with LSCB partners regarding allegations management is not sufficiently well developed. Awareness raising activity is limited, and much work remains to fully engage primary schools, health agencies and faith communities. This means that the local authority cannot be assured that management of allegations is as effective as it could be. Some progress has been made in conjunction with health partners in developing short awareness-raising sessions, but as yet these have not been delivered.

137. The corporate parenting forum is well-established and committed, but does not effectively drive the agenda for children looked after and care leavers. Insufficient priority is given to the full inclusion of young people and the benefits of wider representation from across the authority. Young people are not members of the forum, although their views are represented periodically by members of the children in care council, 'Kickback'. Opportunities to grasp challenges and make improvements to services for children looked after and care leavers are missed due to the limited participation of services such as housing. However, the introduction of free leisure and travel passes for children looked after is positive, and welcomed by children and their foster carers.

138. Senior managers actively look for opportunities to learn lessons and improve practice. They routinely review Ofsted inspection reports to draw on findings and recent good practice. All actions relating to published serious case reviews (SCRs) are complete, and several single- and multi-agency events have disseminated associated learning. As a result, significant changes to practice have been implemented, including safeguarding training for all staff in children's centres and the introduction of a protocol for addressing bruising to infants. Partnership reviews are used effectively in those cases which do not meet the SCR threshold, and lead to practice improvements. For example, management oversight of timescales in accessing specialist resources is now routine.

139. When the present leadership arrived in 2013 no ongoing action plan was in place to address the recommendations from the 2012 Safeguarding and Looked After Children inspection. Since then, most of the recommendations have been acted on effectively. However, commissioning remains underdeveloped, strategic partnership working remains insufficiently robust, and police domestic violence notifications are not yet subject to effective triage prior to being received by the referral and assessment team.

140. Two serious incident notifications have been made since 2012, with one resulting in a serious case review. Procedures for making notifications are clear and understood by relevant officers.

141. Complaints are dealt with well and in a timely way. Representations from children looked after are logged, both in overall complaints records and separately to track their prevalence and to identify trends. Learning from complaints is appropriately linked to practice at monthly performance meetings.

142. The determined leadership of the DCS and her senior leadership team is seen in the fundamental changes made to workforce culture and structure in the last 18 months. Social work staff are very positive about the pod model of working, reporting reduced, manageable caseloads and a more comprehensive service for the children they work with. Training to support this new way of working is in place and being delivered on a rota basis. Retention rates for social workers remain too low, with turnover at over 20%, but this is an improvement from a turnover of 33% 12 months ago. Elected members have resourced increased salaries and increased the base budget to support the recruitment of additional social workers.

The Local Safeguarding Children Board (LSCB)

The Local Safeguarding Children Board requires improvement
The arrangements in place to evaluate the effectiveness of what is done by the authority and board partners to safeguard and promote the welfare of children require improvement.

Summary of findings

The LSCB requires improvement because:

- Not all LSCB member agencies contribute adequately to the costs associated with the delivery of the LSCB's business operation. As a result, the Board's capacity to undertake its full range of business is insufficient and this impedes progress.
- The LSCB does not systematically report on the outcomes of challenges it has made to partners about their work, and there is no log to track this.
- The LSCB is only just beginning to evaluate how well the experiences of children and young people are used to influence the shape of services, and to measure to what extent this has led to improvements.
- The work of the LSCB has been hindered by a number of changes of business manager and consequent delays in progressing work.
- The LSCB has not given sufficient priority to ensuring that information about the role of the LADO and the responsibility of partner agencies to report concerns is widely disseminated.
- Although the LSCB has promoted awareness of private fostering in the community, scrutiny of this area of work does not go far enough to ensure that frontline practice is effective.
- The LSCB does not effectively oversee services for children looked after, the work of the corporate parenting board or multi-agency work to support adoption and care leavers.
- Progress has been made recently to improve attendance by partner members, both at a strategic level and in the operational sub-groups, but representation at board level by the further education sector is poor, as is that of Cafcass, despite the Board's efforts to address their lack of consistent engagement".
- Although a number of audits of practice have taken place over the last year, there has been no systematic monitoring or follow-up of actions. The LSCB is only just beginning to gather the data required to understand the impact and effectiveness of early help services, including those on the edge of care, to help influence decisions on coordinating and targeting services.

What does the LSCB need to improve?

Areas for improvement

Capacity to carry out the LSCB business operation

143. Review the financial contributions made by partner agencies to support the implementation of the LSCB business plan, including reviewing the sufficiency of the LSCB business support arrangements to ensure the work of the Board can be delivered. .

Ensuring the effectiveness of multi-agency frontline practice

144. Strengthen the arrangements to quality assure and oversee frontline practice in relation to private fostering.

145. Ensure that information about the role and impact of the LADO is widely disseminated and understood.

Oversight of services for children looked after

146. Increase the scope of the LSCB's scrutiny to provide a basis for effective challenge of services for children looked after.

Monitoring and evaluation of effectiveness

147. Introduce a challenge log to record issues of concern, actions taken, and progress, so that themes can be identified and agencies held to account.

148. Accelerate plans to gather the views of children so that these influence the development of services across the partnership and ensure that the LSCB is held to account for this, with development and progress reported within the LSCB Annual Report.

149. Evaluate the impact of actions taken in response to audits to determine and take any required follow-up action.

Impact of training

150. Improve the evaluation of the effectiveness of training to inform future development.

Inspection judgement about the LSCB

151. The LSCB is increasingly effective, and improving from a low baseline. There remain some gaps where work on the business plan has been deferred. Some areas of work are at an early stage and others are not yet completed. However, the LSCB is challenging agencies effectively in some key areas, including some where it has made a significant difference.

152. Since his appointment in May 2014, the LSCB Chair has worked hard to provide good leadership and challenge. He is experienced at a senior management level and credible with the sector. He runs the business of the LSCB well. He has regular meetings with the Managing Director and the DCS and holds the local authority and other partners to account.

153. Protocols are in place linking the LSCB, Health and Wellbeing Board (HWB) and the Children and Young Peoples Partnership (CYPP). These include the sharing of annual reports and business plans, which feed into the joint strategic needs analysis (JSNA) and other strategic documents, so that key priorities are effectively aligned and the boards are clear about their respective accountabilities. The LSCB Chair also chairs the Adult Safeguarding Board and this, along with a shared business manager, ensures that work streams are joined up to provide continuity.

154. There has been good work on SCRs, leading to some positive learning. The Chair has challenged agencies effectively to ensure that individual management reviews (IMRs) are of sufficient quality. When he was appointed, the Chair quickly prioritised SCR activity to ensure that the serious delay in instigating a review of Child F's case was tackled. Findings from SCRs and two partnership management reports have been widely disseminated. These have made a discernible difference, such as in revised procedures for hospital discharge following concealed pregnancy and the introduction of a protocol for responding to 'bruising in immobile infants'.

155. The LSCB has a logical structure which supports its statutory functions and business priorities. A pan-Berkshire agreement has led to the sensible development of joint sub-groups to build capacity and support some important areas of work, such as training, the child death overview panel (CDOP), policies and procedures, Section 11 audits, and the support of lay members.

156. The LSCB's business plan is focused on core business, including issues such as child sexual exploitation, child trafficking, modern day slavery, child mental health, female genital mutilation, and the need to produce policies and procedures to address these threats. The plan was agreed in April 2014 and endorsed by the LSCB in July 2014. It is a two-year plan with five broad priorities. These are aligned with the HWB and the CYPP outcomes framework. They focus on important areas, such as determining the process for early help assessments. Some work streams are being tracked well and are making a difference, with particular progress on frontline practice in relation to child

sexual exploitation and female genital mutilation. Effective challenge has also been made to drive improvement in areas such as CAMHS provision at tier 3 and 4.

157. The LSCB annual report is closely aligned to statutory requirements, including circulation and publication. Statutory work and priorities and the work of the sub-groups are reported to demonstrate progress, celebrate success and identify what remains to be done. This includes some evaluation of changes which have impacted on frontline practice, such as progress on the recruitment and retention of social work staff, and improvements in morale brought about through the implementation of the pod structure.

158. The outcome framework has improved over the past six months due to focused work by the Monitoring and Evaluation sub-group. There are multi-agency data in the outcomes framework from education, police, health agencies and probation, although more work is needed to secure meaningful data from CAMHS. The outcomes framework tracks some frontline activities and performance, such as work on missing children and child sexual exploitation.

159. The LSCB understands the diverse needs of the community. This is a key role of the Prevention sub-group, and has led to targeted work. There has been particularly good progress on the female genital mutilation agenda and in building resilience for children through work in schools as part of the Prevent strategy to combat extremism.

160. The LSCB has undertaken some themed single- and multi-agency audits to provide the basis for its assessment of the effectiveness of safeguarding. This work is overseen by the Monitoring and Evaluation sub-group, whose collation of actions is a key element of the learning and improvement framework. There is evidence that some findings are being acted on. Children's social care case file audits have identified key issues in the organisation and functioning of core groups. This has led to new modules in the LSCB training programme and a clear practice standard for the circulation of core group minutes within five days.

161. A full Section 11 audit has taken place, with a follow-up mid-term review capturing measurable evidence of progress and providing challenge. The audit identified gaps in agency training and the need for refresher courses, which are being delivered as part of the multi-agency training programme. This has led to clear improvements in participation in training events by health agencies, with a reported 95% compliance.

162. Child sexual exploitation is a key priority for the LSCB. Work is being progressed effectively through dedicated strategic and operational sub-groups. The Missing and Child Sexual Exploitation Strategy 2015–16 is closely aligned to statutory guidance and encompasses children missing from home, care and education. The strategy provides a sound basis for multi-agency work on child sexual exploitation and addresses the 'three Ps' of prevention, protection and

prosecution. Lessons learnt from the recent Oxfordshire SCR have influenced the commissioning strategy to ensure that gaps, such as the need for specialist support services for victims and support for parents, are addressed.

163. Child protection procedures were redesigned in July 2014 to provide a standardised approach to assessment in child sexual exploitation. A child sexual exploitation assessment tool is now used widely by professionals. The LSCB has developed a number of documents relating to child sexual exploitation at both strategic and operational level which are used to further raise awareness, assess risk and determine resource allocation.

164. The threshold for access to services is clear and disseminated across the partnership. Child protection procedures are provided online and are regularly updated.

165. Through a number of workshops in October 2013, and March and April 2014, the LSCB actively promoted the concept of multi-agency work on offering early support to children and families. Staff who spoke with inspectors said that they had attended and this was making a real difference to the way agencies work together.

166. Domestic abuse is effectively prioritised by the LSCB, and this is aligned across the HWB and the CYPP outcome framework. This work has been undertaken by the Domestic Abuse Executive group. There is a robust domestic abuse strategy in place and an action plan which is well-researched, collaboratively drawn-up, and based on an assessment of local need. The plan links to the CYPP to help shape the commissioning of services, and demonstrates a clear commitment to an integrated approach to service delivery.

167. The LSCB has ensured that there is agreement about the early help assessment process. The Common Assessment Framework (CAF) is the main vehicle for assessment, and this work is supported by an early help panel which meets monthly. Staff who spoke with inspectors said the panel is helping to ensure that more children benefit from an assessment.

168. Good provision is made to share resources through pan-Berkshire arrangements, supported by a joint operational learning and development sub-group. This provides more flexibility and choice for multi-agency staff to access training. A comprehensive range of training has been provided to meet local need. The annual programme includes universal and targeted safeguarding training, domestic violence, supervision and appraisal, CAF integrated working and CAF lead professional training. Staff who spoke to inspectors report that they have good access to quality training which is helping them to meet the needs of families.

169. Child death overview panel (CDOP) arrangements are robust. The annual CDOP report is produced in collaboration with the six Berkshire local authorities, which provides a much wider scope to learn lessons from child deaths, and is

presented to the LSCB. The CDOP Panel also uses national data to draw out patterns and trends to determine prevention action. The CDOP process is particularly effective in driving improvement in health service provision and in schools, such as in awareness-raising about children's use of inhalers.

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.

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.

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 local safeguarding children board under its power to combine reports in accordance with section 152 of the Education and Inspections Act 2006.

The inspection team consisted of 7 of Her Majesty's Inspectors (HMI) from Ofsted.

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