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Mr K McDaniel
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Mr J Lisle, Clinical Commissioning Group, Chief Operating Officer
Mrs H Hall, Local area nominated officer

Dear Mr McDaniel

Joint local area SEND inspection in Windsor and Maidenhead

Between 3 July 2017 and 7 July 2017, Ofsted and the Care Quality Commission (CQC) conducted a joint inspection of the local area of Windsor and Maidenhead to judge the effectiveness of the area in implementing the disability and special educational needs reforms as set out in the Children and Families Act 2014.

The inspection was led by one of Her Majesty's Inspectors from Ofsted, with a team of inspectors including an Ofsted Inspector and a Children's Services Inspector from the CQC.

Inspectors spoke with children and young people who have disabilities and/or special educational needs, parents and carers, local authority and National Health Service (NHS) officers. They visited a range of providers and spoke to leaders, staff and governors about how they were implementing the special educational needs reforms. Inspectors looked at a range of information about the performance of the local area, including the local area's self-evaluation. Inspectors met with leaders from the local area for health, social care and education. They reviewed performance data and evidence about the local offer and joint commissioning.

As a result of the findings of this inspection and in accordance with the Children Act 2004 (Joint Area Reviews) Regulations 2015, Her Majesty's Chief Inspector (HMCI) has determined that a Written Statement of Action is required because of significant areas of weakness in the local area's practice. HMCI has also determined that the local authority and the area's clinical commissioning group(s) are jointly responsible for submitting the written statement to Ofsted.

This letter outlines our findings from the inspection, including some areas of strengths and areas for further improvement.

Main findings

- Leaders across the local area are not implementing the reforms required by legislation in a timely manner. Key challenges, such as changes to the leadership structure at the Royal Borough of Windsor and Maidenhead (RBWM), and continued turnover of administrative staff, have limited the capacity to drive through the reforms. The clinical commissioning group's designated clinical officer (DCO) is under resourced. The time allocated for the role does not reflect the Children's Disability Council guidance and so the DCO's availability to lead the strategic agenda is limited. As a consequence of all these weaknesses, the implementation of the required reforms has faltered and slowed.
- There is too little evidence of leaders' actions resulting in improvements to the experiences and outcomes of children and young people who have special educational needs and/or disabilities and their families. Many initiatives and strategies are very recent or still in the process of consultation. Significantly, this includes the overarching RBWM special educational needs and/or disabilities (SEND) strategy. As a consequence, weaknesses in the processes for applying for and transferring to an education, health and care plan are not being tackled robustly. Parents overwhelmingly report dissatisfaction with their experience of the system and have very little confidence that things will improve.
- There is too much variability in the implementation of the reforms across the local area. Despite pockets of good practice, joint working is not consistent enough. Furthermore, a lack of robust accountability measures means that not enough is being done to tackle these inconsistencies and to hold leaders and services to account. Inequalities in the quality of identification, assessment and meeting the needs of children and young people who have special educational needs and/or disabilities therefore remain. For example, some school leaders make very good use of local area resources to follow up concerns about children and young people's development. However, other schools take a much less proactive approach. Where this is the case, too many children and young people are not properly assessed, their needs not appropriately identified and then not met well enough.
- Joint commissioning is under-developed. Although the child and adolescent mental health service (CAMHS) transformation project is a good example of joint commissioning, there is little other joint commissioning of note. This means that in a period of declining budgets, opportunities to pool resources to tackle areas of need in the local area are under-utilised.

- Systems and processes around the application for, and management of education, health and care (EHC) plans are not working well enough. Despite recent improvement in the proportion of new plans completed in the statutory 20-week timescale, the quality of EHC plans and the process for administering them is too variable. Leaders rightly identify that too many EHC plans include too little contribution from health and social care services. As a consequence, the intended outcomes within weaker plans are focused entirely on educational achievement, and so do not support children and young people to achieve better health and social care outcomes. Furthermore, leaders have not tackled effectively the damaging impact of high turnover in administrative staff, which is negatively affecting the application and transfer processes for children and young people and their families. As a result, there are inconsistencies between EHC plans for children who have similar needs. In other cases, families have had to retell their stories on several occasions because their case workers have changed so frequently.
- Co-production is weak. Although there are some effective examples, such as the CAMHS project and effective engagement with parents in some schools, families' experiences remain too varied across the area. Co-production at a strategic level is not as well established as it should be, considering that the reforms were introduced in 2014. The re-launch of the Parents and Carers in Partnership (PaCiP) is very recent and is yet to have an impact. Plans are in place to improve co-production, but currently parents in the local area have little faith that this will lead to an improved situation. Inspectors found some examples of parental feedback influencing the service, such as within the local area's CAMHS project. However, evidence of co-production in health is particularly weak. Outside CAMHS, inspectors heard little evidence of parents, children and young people being involved in influencing services effectively. The clinical commissioning group (CCG) is aware of the need to improve this area of work and a number of health and multi-agency initiatives are being considered to address the shortfall. However, no effective initiatives have been established.
- Some recent developments demonstrate an improving commitment to joint working between services. Though late in the day, leaders are consulting on a new SEND strategy which details how they intend to work together to implement the reforms. Leaders' evaluations of where there are strengths in the area are generally accurate. For example, leaders recognise that local area performance data reflects well on how well children and young people who have special educational needs and/or disabilities achieve compared with the national picture. However, leaders have not recognised that the data masks inequalities in the assessment, provision and outcomes for pupils who have special educational needs and/or disabilities across the local area. Nor have local area leaders fully understood the depth of concern felt among their parents. Leaders have not recognised the limited progress in improving the experience and outcomes for children and young people who have special educational needs and/or disabilities which results from their slow and piecemeal implementation of the reforms.
- Safeguarding arrangements are effective. Agencies rightly prioritise the safety of

children and young people. Children and young people who shared their views with the inspection team feel happy and well cared for. None reported not feeling safe.

The effectiveness of the local area in identifying children and young people's special educational needs and/or disabilities

Strengths

- Strong joint working between a range of services that support children in the early years leads to effective early identification, particularly for children who present with the most complex needs. The strategic decision to maintain children's centres in the RBWM has supported this well. There are strong links between children's centres, pre-schools, nurseries and the child development centre. As a consequence, effective joint working has been established and staff working in the early years know children and families very well. Where needs are identified in the early years, there are appropriate systems to signpost families to relevant services.
- The Child Development Unit has a well-developed integrated team for assessing children aged under five. Over 95% of children are seen within 14 weeks of the initial assessment. The autistic assessment pathway is child- and family focused and is flexible in approach: for example, the system allows for a clinical judgement on the length of the assessment if there are clear indicators of diagnosis. This ensures that children are offered specialist intervention at the earliest opportunity. Children usually have a diagnosis within six months of referral to the service.
- Neonatal screening is a well-established process and undertaken effectively by the midwifery services. The health visiting teams have open access to the child information service to obtain new-born bloodspot results prior to the six- to eight-week contact. This ensures that, if the parents have not received the results directly and an abnormality has been detected requiring further diagnostic investigation, this is followed up in a timely manner to meet the needs of the child.
- Leaders have established effective training for practitioners to identify and understand mental health difficulties in children and young people. The training, which is suitably evidence based, has been designed to help staff in healthcare and education. The training has been delivered well by CAMHS staff, supported by a service user. Together, they have trained school nurses and a number of general practitioner practices, thereby helping to increase the knowledge and confidence of practitioners in assessing and offering early intervention.

Areas for development

- Comprehensive accurate data to inform healthcare service provision is currently unavailable within the local area. Until the new dataset now being developed by the health visitor and school nursing services is made available, leaders are not able to monitor the effectiveness of the Healthy Child Programme and consider the impact of gaps in delivery of the mandated visits.
- Leaders across education, healthcare and care do not have effective oversight of the number of children and young people who have special educational needs and/or disabilities being supported across services. The RBWM and Berkshire Healthcare NHS Foundation Trust (BHFT) information technology (IT) systems do not identify children who have special educational needs and/or disabilities. Therefore, leaders lack a strategic overview, and the information they do hold is susceptible to errors because it is based upon local knowledge collated by practitioners. Leaders are confident that systems can be modified to support identification, but they have not yet taken effective action to ensure this. Consequently, leaders do not know and cannot manage practitioner caseloads effectively. There is no system in place to identify the complexity of cases, or ensure that there is the capacity to deliver an equitable service or accurately plan for the future. Furthermore, the lack of robust management information means that there are limitations on how effectively leaders and services can be held to account.
- The effectiveness of early identification in schools is too varied. Although there are examples of strong practice, led by special educational needs coordinators and some headteachers, this is not consistent. In some schools, leaders are a barrier to children's and young people's needs being identified. For example, where this is the case, children and young people who have attention deficit hyperactivity disorder and autistic spectrum disorder are not identified quickly enough, because their presentation is assumed to be a behavioural issue rather than a presentation of need. Not enough is being done to enable children and young people, particularly those who are disadvantaged, to have their needs identified in a timely manner. Consequently, there is inequity of opportunity across the local area.
- Leaders are not able to demonstrate that the arrangements for identifying and assessing young people between the ages of 19 and 25 who might have special educational needs and/or disabilities for medical assessment are robust and effective.

The effectiveness of the local area in meeting the needs of children and young people who have special educational needs and/or disabilities

Strengths

- Some schools in the local area are highly committed to the reforms and make excellent provision for children and young people who have special educational needs and/or disabilities. Where this is the case, parents report very positively about how school staff support their children and signpost them to where they can gain support as a family. There are pockets of effective joint working between schools. For example, in one part of the local area, special educational needs coordinators meet regularly to find collaborative approaches to implementing the reforms. Where this is happening, there is better engagement with local area services, which in turn leads to more effective and timely implementation of the reforms. However, this is not consistently the case.
- The independent advisory service is excellent and highly regarded by children and young people and their families. They advocate exceptionally well for children, young people and their parents. The service is very well led. For example, the manager has undertaken a thorough review of the service and can precisely identify where its support is most needed. Consequently, those who work for the service are very well placed to provide what is needed for families. The impact of their work is demonstrated in the feedback they receive from families. As one young person described them: 'They are amazing'.
- School leaders and parents are overwhelmingly positive about the educational psychology, behaviour and well-being services. For example, the behaviour and welfare service provides a range of bespoke support packages that help children and young people who have social, emotional and mental health needs effectively. Some parents report very positively about the impact of such packages, such as nurture groups, on the progress of their children.
- BHFT offer a well-developed Children and Young People's Integrated Service, speech and language therapy (SALT) service, physiotherapy service and occupational therapy (OT) service. Together, the services work collaboratively from the point of referral to identify the most appropriate package of care for each child or young person. Referrals are accepted from both parents and professionals and this supports ease of access to the specialist service and minimises delays between referral and assessment. Helpfully, contact is made with the parent to offer advice and strategies within one week of referral and parents are directed to a comprehensive online toolkit to support them in undertaking focused intervention at the earliest opportunity.

- The SALT service has established strong partnerships with local schools. For example, a named therapist meets with school special educational needs coordinators (SENCOs) at least twice yearly. Together they ensure that support is tailored to the individual child's needs. The SALT service places an appropriate emphasis on increasing skills and knowledge for teachers and other school staff who have the most regular contact with the child. A targeted approach can be offered on a number of topics when a school identifies a particular area of need. For example, recent work has been undertaken on selective mutism and bespoke packages of care are offered to children who have a high level of need, which has been very well received by schools.
- Children and young people in mental health crises are treated effectively by a newly formed crises intervention CAMHS team. Children and young people are seen within 24 hours, after which six weeks of therapeutic care is offered.
- School nurses work collaboratively with youth services to deliver an excellent and well-received life skills course for 15- to 25-year-old young people who have learning disabilities. Young people make a direct contribution to the content of sessions to ensure that these meet their needs. However, leaders' evaluations of the impact of the intervention on young people's outcomes is under-developed.
- Provision at the local area special school is highly flexible and meets the varying needs of the children and young people who attend. Leaders within the school work well with local area leaders to ensure that placements are appropriate and lead to positive outcomes for the children and young people.
- Provision for children and young people who have a hearing or visual impairment is strong. For example, children who have a hearing impairment have greater access to a teacher of the deaf than is typical nationally. The quality of provision is reflected in the views of children and young people who are visually or hearing impaired and their parents. The vast majority reported positively about their involvement in designing their provision, and how this helps to secure strong outcomes.
- There is an effective, coordinated approach to securing an appropriate care pathway for young people who have special educational needs and/or disabilities moving into adult services. BHFT's IT system has a transition template which supports practitioners to work collaboratively when identifying need. The introduction of a 'Ready, Steady, Go' toolkit has also improved how practitioners work with young people and their families in early planning of transition. However, consistency in the use of these new tools is not established, because they are too new in their delivery.

Areas for development

- Provision is too variable for children and young people who have special educational needs and/or disabilities across the local area, despite some very strong practice in some schools and services. As a consequence, some children and young people do much less well than their peers across the local area. In particular, where leaders' commitment to the reforms is weaker, access to appropriate processes for identification and assessment are not secure. As a result, some children are not identified accurately and their needs are not met sufficiently.
- The BHFT CAMHS waiting times for routine autism spectrum disorder assessment are too lengthy and have not been sufficiently addressed by leaders. Referral to triage is 24 weeks, followed by an approximate 18-month wait until completion of the full assessment. Despite the CCG setting trajectories for reducing the waiting time, access to some specialist interventions continue to be delayed for the children or young people and their families during this time. Parents are signposted to useful organisations, including ones commissioned by the CCG. For example, Autism Berkshire offer specialist support during the waiting time. Families who have accessed this service are very positive about the support they have been given.
- Children and young people who have special educational needs and/or disabilities wait too long to be seen by the services. Due to the limited capacity of staff caused by a current vacancy, the occupational therapy waiting time for appointments is 24 weeks. Parents are offered strategies to manage the presenting concern and directed to the children and young people's integrated therapy service (CYPIT) toolkit while waiting. However, parents report frustration with their inability to meet the needs of their children while awaiting for approved changes to their living spaces or equipment.
- Too many parents are unaware of the Local Offer. The vast majority of parents who are aware of the Local Offer say that it is too difficult to navigate the portal to find what they want. Nevertheless, the Local Offer presents a range of comprehensive and useful information for parents and professionals.

- The involvement by healthcare practitioners in the education, health and care planning process is too variable. There is not a consistent approach to alerting healthcare practitioners that their contribution is needed, or to completing or quality assuring health information within the EHC plans. Although the local area meets requirements by responding within six weeks to the request for a statutory assessment, a standard template to support the sharing of information has not been developed. Furthermore, practitioners are not contacted consistently as part of the information-gathering process, even when they are directly involved in a child's care. Some practitioners report that they are not consistently provided with a copy of each child's final EHC plan. This is rightly an area identified within the CCG's self-assessment audit for further development. However, weaknesses in the planning process for EHC plans result in too many poor plans that do not reflect the needs or aspirations of children and young people who have special educational needs and/or disabilities and their families. As a consequence, too many outcomes shown in plans are not measurable enough to be meaningful. Too many are focused on educational outcomes, with too little reference to children's and young people's health and care needs.
- The 'tell it once' approach is not embedded within all services outside the CYPIT. Parents report that while communication between the professionals working with their children is often strong and supports joint working, the communication with parents between formal contacts is inconsistent. Consequently, at critical points in assessment processes, there is an increase in parental stress and anxiety due to not feeling fully informed.
- There are weak quality assurance processes for EHC plans within health. For example, the DCO does not currently have sight of EHC plans for quality assurance purposes. Although the CCG has given clear guidance to individual providers about what should be included in EHC plans, there is too little strategic oversight across the local area as a whole. Healthcare leaders rightly recognise that there is a need to undertake more detailed quality assurance of the EHC plans.
- Due to the health visitor and school nursing services now being commissioned by the local authority, healthcare providers across the local area use different record-keeping systems. Consequently, health visitors and school nurses are not able to view BHFT practitioners' care plans, and BHFT cannot view health visitors' and school nurses' records. There are plans in place to develop a 'Connected Care' IT system which will allow 'read-only' access to certain elements of the health records, but this improvement is not yet in place. As a result, children and young people who have special educational needs and/or disabilities continue to have to re-tell their story to practitioners because information sharing remains limited across some services.

- Leaders' lack of strategic planning means that the training of healthcare staff to deliver the reforms is inconsistent. As a consequence, there is an over reliance on individual teams and individual professionals to implement the reforms based on their own knowledge. As a result, there are gaps in some professionals' knowledge of what should be offered and where to signpost families for more information. For example, not all professionals were aware of the Local Offer. The impact of this is that staff are not able to signpost parents effectively to where they can access support or how to access services appropriate for their children's needs.

The effectiveness of the local area in improving outcomes for children and young people who have special educational needs and/or disabilities

Strengths

- Published information about the achievement, attendance and exclusions of pupils identified as having special educational needs and/or disabilities in the RBWM compares favourably with the national picture. There are also higher proportions of these young people who are in education, employment or training.
- Children who have special educational needs and/or disabilities build well on the outcomes they achieve in the early years. There is a strong focus on, and plan of care for children transitioning from early years to school settings. This includes meetings between parents and the SENCos from both settings, as well as planned visits to the new school to familiarise the child and increase staff knowledge of the child and their needs. Consequently, children are well prepared for the transition and do not lose ground as they move into school.

Areas for development

- The positive outcomes achieved overall by children and young people in the local area, reflected in published information, mask significant inequalities in the outcomes achieved overall. For example, those children and young people who have special educational needs and/or disabilities whose needs are not met because of lack of appropriate assessment do not achieve as well as they could. Furthermore, there is too little evidence that outcomes are improving for children and young people who have special educational and/or disabilities as a result of the reforms. In too many cases, children and young people secure strong outcomes because their families pursue and secure what they need, in spite of what is on offer in the local area.

- The experiences for children and young people who have special educational needs and/or disabilities and their families are not improving as a result of the implementation of the reforms. From speaking to around 150 parents with children who have special educational needs and/or disabilities, the very large majority report significant strain and stress as families in having to continue to fight for what they are entitled to. As a consequence, too many children and young people who have special educational needs and/or disabilities find that they only access support when their family is in crisis.
- The high proportion of young people in education, employment or training masks too much variability in appropriate placements being secured for young people who have special educational needs and/or disabilities when they leave school. For example, inspectors met young people who have special educational needs and/or disabilities whose next steps had not been secured, despite being about to leave school within weeks of the inspection. In too many circumstances, securing an appropriate next step for young people who have special educational needs and/or disabilities has been left to parents.
- Children and young people who have special educational needs and/or disabilities are not effectively supported to participate in society. This is because the effectiveness of direct payments is too variable, leading to inequitable outcomes. Some families find that the support offered through direct payments helps them integrate successfully into society. Where this is the case, families typically access personal assistants who also work with their children at school and so understand their needs and the needs of the family. However, many families report difficulty in securing appropriate support. When this is the case, families struggle to secure consistent staff and so relationships are undermined and families are not effectively supported to secure improved integration into society.
- Local area leaders' lack of aspiration to increase the opportunities for independence for young people who have special educational needs and/or disabilities is limiting improvements to their social care outcomes. For example, there are no current plans to increase the number of assisted living spaces in the local area, which remains limited to four beds.

The inspection raises significant concerns about the effectiveness of the local area.

The local area is required to produce and submit a Written Statement of Action to Ofsted that explains how the local area will tackle the following areas of significant weakness:

- tardiness and delay in establishing strategies to implement the reforms effectively
- the lack of leadership capacity across local area services, such as the time given to the role of the DCO
- poor use of management information to secure a robust overview of the local area's effectiveness

- weaknesses in how leaders are held to account across the local area
- the inequality of access to services and variability of experience for children and young people who have special educational needs and/or disabilities and their families
- the wide variances in the quality of education, health and care plans caused by weaknesses in the planning and transition processes
- the lack of effective co-production with parents when designing and delivering services and when planning for their individual children's needs
- poor joint commissioning arrangements that limit leaders' ability to ensure that there are adequate services to meet local area needs.

Yours sincerely

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