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Slough Borough Council

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: 24 November 2015 - 17 December 2015

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Children's services in Slough are inadequate		
1.	**Children who need help and protection**	Inadequate
2.	**Children looked after and achieving permanence**	Inadequate
	2.1 Adoption performance	Requires improvement
	2.2 Experiences and progress of care leavers	Inadequate
3.	**Leadership, management and governance**	Inadequate

[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.

Executive summary

Children's services in Slough are inadequate. Leaders in Slough Borough Council have not achieved enough improvement since the previous Ofsted inspections in 2011 and 2013. Important areas of children's social care services are still inadequate and a considerable amount of work is required before services for children can be considered good.

At the direction of the Secretary of State, responsibility for children's services was transferred to Slough Children's Services Trust (the trust) on 1 October 2015. The chief executive of the trust and the council's director of children's services (DCS) have made a firm commitment to work together to achieve the necessary improvements. However, the decision to establish an alternative delivery model and the process of establishing the trust took too long. Although plans are in place to resolve the few remaining areas of responsibility, some arrangements, such as who is to take the lead on commissioning, are yet to be agreed. Much needs to be done to cement relationships between the council and the trust and to secure an unwavering focus on the task of improvement.

Despite efforts to reduce the number of agency social workers and managers, the proportion of these staff in many teams is still too high and not enough permanent appointments have been made. The level and turnover of agency staff continue to hamper progress and impact negatively on some children's experiences.

Partners have not yet developed a truly multi-agency referral hub for sharing information and making decisions about children. Thresholds for action and intervention at all levels are unclear, which means children do not always receive the right help. Services for children and young people on the edge of care and returning home from care lack focus and structure. Although some early help services are making a difference to families, this work is not coordinated well enough or evaluated effectively to inform future planning and service delivery. The quality of early help assessments is far too variable.

The speed and effectiveness of response to children who are referred to children's social care have improved in recent weeks, but many children have been left too long in situations of risk or where their needs have not been met. Children at risk of child sexual exploitation have not been effectively identified or protected. The quality of assessments has improved since the last inspection, but is still too variable. Decisions to look after children are often delayed and legal advice is not always sought early enough. However, once children enter the court process, plans and decisions progress more quickly.

Leaders have not secured sufficient services to meet the needs of children who need help, protection or care. Advocacy support for children and young people is underdeveloped and learning from complaints is weak. Leaders have not ensured that there are enough local foster placements to enable children looked after to live close to their friends, families, schools and communities. Accommodation for care leavers is not sufficient and does not always meet young people's needs. Not enough

young people benefit from remaining with their foster carers into adulthood.

Care leavers receive a disjointed service and they do not have an arena to express their views. They say that they do not feel safe where they live. Too many care leavers have frequent changes of worker and go for long periods without seeing their personal adviser. Pathway plans are not always up to date or useful and managers have not overseen this work well enough. However, some personal advisers and social workers develop helpful and meaningful relationships with young people. Young people's support workers enable care leavers to access and sustain employment, education or training and many more care leavers in Slough are engaged with these activities than in other areas.

Senior and political leaders have not been proactive, interrogative or aspirational enough about the outcomes and achievements of children looked after. The virtual school for children looked after has been ineffective for at least a year. A new head of the virtual school has been appointed very recently and some decisive planning has begun. The young people who are part of the Children in Care Council (CiCC) are keen to make a difference, but leaders have not been proactive or creative enough in helping them to have an influence within the council. The corporate parenting board has not fulfilled its duty to children looked after well.

Independent reviewing officers (IROs) challenge care plans, but they do not make enough difference to children's outcomes. Children looked after say that they have not been able to develop strong relationships with their social workers, although their carers are supportive and helpful to them. Careful thought is given to children's culture and identity when deciding where they should live. The nurses for children looked after undertake regular and high-quality health assessments and reviews.

Children who have a plan for adoption are matched quickly with good permanent families. At the time of the inspection, there were no children waiting for an adoptive family. Child permanence reports are not of a consistently good standard. Social workers do not always have the right skills to write helpful letters for children about their birth families.

Helped by a baseline audit, the trust has quickly established an accurate view of what needs to change. Managers are rightly prioritising workforce, performance management and the management oversight of practice. Under the decisive leadership of the chief executive of the trust, some important areas of poor practice are being tackled and children are already safer as a result. For example, the practice of using administrative staff to filter and prioritise new contacts was appropriately stopped by the trust. Qualified social workers now carry out this task and oversee next steps.

Over the past two years, the council has made some improvements. Members agreed a significant financial injection to the service, which has led to reduced social work caseloads. Newly qualified social workers are better supported. However, the changes have not been fast or wide ranging enough to improve the experiences of children sufficiently. The trust has already taken decisive action in a number of key

areas and the pace of improvement has increased but it is too soon to see the impact of this for children.

Contents

Executive summary 2

The local authority 6

Information about this local authority area 6

Recommendations 9

Summary for children and young people 11

The experiences and progress of children who need help and protection 12

The experiences and progress of children looked after and achieving permanence 19

Leadership, management and governance 32

The Local Safeguarding Children Board (LSCB) 38

Executive summary 38

Recommendations 39

Inspection findings – the Local Safeguarding Children Board 39

Information about this inspection 44

The local authority

Information about this local authority area[2]

Previous Ofsted inspections

- The previous inspection of the local authority's safeguarding arrangements was in November 2013. The local authority was judged to be inadequate.
- The previous inspection of the local authority's services for children looked after was in November 2013. The local authority was judged to be inadequate.
- The local authority's safeguarding arrangements and services for children looked after were also inspected in April 2011. The local authority was judged to be inadequate for its safeguarding arrangements and adequate for services for its services for children looked after.
- The local authority operates two children's homes. Both were judged to be good or outstanding in their most recent Ofsted inspection.

Local leadership

- The director of children's services (DCS) has been in post since January 2015 on an interim basis and is part time.
- The chair of the LSCB has been in post since November 2014.
- The Secretary of State issued a direction in October 2014 appointing a Commissioner to secure improvement in children's social care pending transfer, and requiring the local authority to cooperate with the Commissioner to establish a trust to deliver its children's social care services.
- The local authority was directed by the Secretary of State to establish a trust to run its social care services. The Slough Children's Services Trust was launched on 1 October 2015 and its responsibilities include early help and the virtual school.

Children living in this area

- Approximately 39,867 children and young people under the age of 18 years live in Slough. This is 27.6% of the total population in the area.
- Approximately 21.6% of the local authority's children are living in poverty.
- The proportion of children entitled to free school meals:
  - in primary schools is 12.2% (the national level is 15.6%)
  - in secondary schools is 11.6% (the national level is 13.9%).

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[2] 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 and young people from minority ethnic groups account for 65.5% of all children living in the area, compared with 21.5% in the country as a whole.
- The largest minority ethnic groups of children and young people in the area are Asian and Asian British (44.1%) and Black and Black British (11.8%).
- The proportion of children and young people with English as an additional language:
  - in primary schools is 58.7% (the national level is 19%)
  - in secondary schools is 44.9% (the national level is 15%).

Additional contextual information

- Population density is the 29th highest across England and Wales, at 43.1 people per hectare compared with just 4.1 across England.
- Official population projections predict further population growth in both the numbers of children and young people and the proportion of the total number of residents accounted for by this age group. This increase in numbers clearly has implications for future demands for all services required by this age group.
- About 20% of dwellings are social rented (13.1% from the council, 7.5% from other landlords). About 24% of dwellings are privately rented compared with just 16.3% across South East England.

Child protection in this area

- At 31 October 2015, 1,172 children had been identified through assessment as being formally in need of a specialist children's service. This is a reduction from 1,450 at 31 March 2015.
- At 31 October 2015, 150 children and young people were the subject of a child protection plan. This is a reduction from 234 at 31 March 2015.[3]
- At 31 October 2015, three children lived in a privately arranged fostering placement. This is an increase from two at 31 March 2015.
- Since the last inspection, six serious incident notifications have been submitted to Ofsted; three of these were submitted since 1 October 2015. One serious case review was ongoing at the time of the inspection.

[3] This figure of 150 differs from published data from the Department for Education due to a data processing error in local authority submission to the annual children in need census.

Children looked after in this area

- At 31 October 2015, 183 children were being looked after by the local authority (a rate of 45.9 per 10,000 children). This is a reduction from 196 (49.2 per 10,000 children) at 31 March 2015.
- Of this number:
  - 128 (73%) live outside the local authority area (excluding children placed for adoption)
  - eight live in residential children's homes, of whom six live out of the authority area
  - one lives in a residential special school; this child lives out of the authority area
  - 132 live with foster families, of whom 100 (76%) live out of the authority area
  - three live with parents, of whom one lives out of the authority area
  - 10 children are unaccompanied asylum-seeking children.
- In the last 12 months:
  - 20 children have been adopted
  - 25 children became subject of special guardianship orders
  - 161 children ceased to be looked after, of whom six (4%) subsequently returned to be looked after
  - 37 children and young people ceased to be looked after and moved on to independent living
  - 46 children and young people ceased to be looked after and are now living in houses of multiple occupation.

Recommendations

1. Quality and effectiveness of practice

    - In line with longstanding plans, develop and embed a genuinely multi-agency response to concerns about children. This should be rooted in clear and up-to-date threshold guidance rolled out across the partnership and regularly reviewed in conjunction with the LSCB.
    - Ensure that contingency arrangements and escalation processes are reviewed, monitored and understood at all levels of need and concern. This should include thresholds for step up and step down arrangements.
    - Ensure that all children and young people at risk of significant harm benefit from strategy discussions and meetings that meet minimum statutory requirements.
    - Improve the coordination and quality of support offered to children and young people on the edge of care and returning home from care.
    - Ensure that assessments, care plans and pathway plans for children looked after and care leavers are up to date, relevant to the individual child or young person and based on a thorough analysis of children and young people's needs and aspirations so that consequent action planning is effective.
    - Significantly improve the quality and regularity of contact with and support for care leavers, ensuring that managers oversee the frequency, quality and impact of contact effectively.
    - Ensure that staff have the knowledge and capacity to complete good-quality and timely life story work and letters for later life.

2. Oversight and scrutiny by senior and political leaders

    - Through ambitious and innovative means, prioritise the establishment of a stable and skilled permanent workforce.
    - Evaluate the quality and effectiveness of early help processes and services to inform and improve future planning and service delivery.
    - Revise the corporate parenting strategy to ensure that it sets out a clear vision and process for improving outcomes for children looked after and care leavers.
    - Review the terms of reference of the corporate parenting panel to ensure that it includes wider partner representation and provides rigorous scrutiny and challenge.
    - Broaden the range of children and young people who participate in the CiCC and create a care leavers' focus group. Embed consultation processes systematically across the service.

- Strengthen and monitor the effectiveness of the role of IROs in challenging and escalating concerns about children's plans.
- Ensure that learning from complaints, audits and other sources is used effectively to influence service development.

3. Children who go missing or who are at risk of child sexual exploitation

- With key partners, take decisive action to ensure that the local extent of child sexual exploitation is known and understood and that intelligence information is used proactively to inform risk management and disruption activities.
- Be tenacious about ensuring that all children who go missing from home or care are offered a timely return home interview that properly explores and addresses risk and need.
- Take urgent steps to ensure that all children who are identified as being at risk of going missing or being sexually exploited are subject to a risk assessment and are offered responsive and appropriate help.

4. Provision and sufficiency of key services

- Finalise, as a matter of urgency, which body is responsible for commissioning individual functions and services.
- Ensure that children and young people have access to an advocacy service that enables the children and young people to express their views, particularly in important meetings about them.
- Review the range and quality of accommodation for children looked after and care leavers, including staying put arrangements.
- Improve the educational support provided to children looked after and strengthen significantly all services offered by the virtual school.
- Review the effectiveness and organisation of support to care leavers.

Summary for children and young people

- Ofsted previously found that children in Slough do not get help that is good enough. Too many things have still not improved since the last inspection.
- As a result, a year ago, the government decided to find a different organisation to run services for children in Slough. It took too long to sort these arrangements out. The new organisation, Slough Children's Services Trust, took over on 1 October 2015. Most people who worked for the council now work for the trust.
- Social workers do not have as many children to work with, so they can now spend more time with children and get to know them better. Social workers care about the children they are helping and know them well.
- When social workers work with the court to make plans for children, this work is now completed in good time. Most children who need to be adopted move to their new families quickly. Young people's support workers do a good job helping young people with their problems and supporting them to make good choices.
- However, some very important things have not changed enough or at all. A great deal of money has been spent on social workers but too many do not stay in Slough for long enough. This means that children and families have too many different people to get to know. This has made it harder for managers to improve things. Too many children are not getting the right help and some are at risk of harm.
- Since the trust took over, managers have better and more up-to-date information. This is helping them to work out how well children and families are being helped. They are making good decisions about the things that need sorting out first.
- When children run away from home or care, more help is provided by the trust to support them when they return. Better decisions are being made by social workers and managers to protect children who have been neglected by their families. But there are many more things that need to improve before services for children are good enough.
- It is very important that the trust, the council and partners, like the police, work together better. This will help them to understand how many children are being sexually exploited in Slough and to make sure these children are safe. There is a great deal to be done.
- Managers and political leaders need to be better corporate parents to the children and young people in their care. They need to listen to these children more closely and act more quickly to improve their lives. They also need to care more about how well they do at school. They need to find more local foster families so that children do not have to live too far from their families and friends.
- It is good that so many care leavers are in education or have a job, but too many do not feel happy or safe where they live. Not enough personal advisers have good relationships with care leavers. Pathway plans are not helpful enough to care leavers in improving their lives.

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The experiences and progress of children who need help and protection	Inadequate

Summary

Services for children in need of help and protection continue to be inadequate overall, although inspectors found a more positive picture emerging over the past few months. The direction of travel is positive and accelerating. However, over the time period looked at during the inspection, too many cases were seen that had serious weaknesses. When children are at risk of significant harm, they do not always benefit from a strategy discussion. In addition, too many strategy discussions only include the police and children's social care. In some cases, agencies have delayed referring children, leaving them in potentially harmful situations for too long.

The multi-agency safeguarding hub is significantly underdeveloped; the first contact service consists solely of trust staff. Police are co-located but joint working is minimal. Overall, these relationships require improvement. Threshold guidance and referral and assessment pathways are partial and out of date. Understanding and application across the partnership is weak. The out-of-hours service has insufficient capacity to meet local demand.

Arrangements to protect children who go missing or who are at risk of child sexual exploitation are underdeveloped, with many improvements only being made in the few weeks prior to the inspection. Too many risk assessments relating to child sexual exploitation are weak and do not consider the most important risk factors.

The quality of social work assessments, plans, interventions and reviews are too variable, ranging from good to inadequate. Inspectors' findings largely mirror those of a recent audit commissioned by the trust, where half of the cases analysed were found to be inadequate. Where assessments are weak, plans and reviews are less effective and risks for these children do not reduce quickly enough. The quality of plans has improved over the past year, but there is more to do to ensure that they are clear and helpful documents for families. Not enough children are helped to share their views at important meetings, such as child protection conferences. The ethnicity and cultural heritage of children is not considered well enough in too many cases.

Step up and step down arrangements are not consistently robust. Inspectors found that children who should have been assessed by a social worker had been passed to early help services. Some of these children were at risk of potential harm. Some children are stepped down from a child protection plan prematurely. Too many early help assessments are poor and the impact of early help services overall is unclear.

Despite much awareness-raising, there is more to do to ensure that children at risk of female genital mutilation are identified given the diverse population. Such cases, when referred to children's social care, are assessed well.

Inspection findings

5. Children, young people and families who need early help services do not always receive support quickly enough. Additional needs are not consistently identified or met by professionals. The quality and timeliness of referrals from some agencies, including the police, who refer most often, is poor. Too many referrals are hard to understand and miss key information. This means that much remedial action is required by the staff, who screen contacts in order to decide what to do next. This wastes staff time and delays a response in meeting children's needs.

6. Too many early help assessments are inadequate. In some, presenting risk factors warranted an intervention from statutory services; in others the recording of interventions was too poor to measure change. There were examples where the reason for an early help assessment being undertaken was unclear. Records of 'team around the family' meetings were poor overall. Although a range of services are on offer, the overall impact and effectiveness of early help is unknown. (Recommendation)

7. The first contact service has improved very recently. Six weeks before the inspection, there were multiple routes by which agencies could refer children, increasing the likelihood of referrals being overlooked. There is now a single inbox, which is better. The practice of using administrative staff to filter and prioritise new contacts was, quite correctly, ceased by the trust. Qualified social workers now carry out this task and oversee next steps. The timeliness of response to contacts has been poor, although has significantly improved in recent weeks.

8. Thresholds for statutory and early help services are not clear across the partnership, leading to some confusion about how children should be helped. Much work was undertaken by the LSCB in 2014 to launch the threshold guidance but it has not been updated in line with the most recent statutory framework (Working together to safeguard children, 2015). Threshold and single assessment guidance does not reflect current practice arrangements, which leads to further confusion within the partnership. (Recommendation)

9. Multi-agency arrangements to consider contacts and requests for services are significantly underdeveloped, limiting the effectiveness of initial decision making. The first contact service is staffed by agency social workers and managers and is co-located with, but not yet integrated with, the police. There are no other child welfare agencies participating in 'front door' screening arrangements, although for some time discussions have been taking place about how to achieve this. (Recommendation)

10. Joint working between agencies is not always effective, with examples of disagreements about what action should be taken, without evidence of resolution. Social workers do not reliably consult with the right professionals when deciding how to respond to concerns about children, even when parents

have given their consent for information to be shared. This means that decisions about how to help children are not always informed by all the available information. In contrast, in some child protection and 'team around the family' meetings, information sharing between agencies is of better quality. (Recommendation)

11. Children, young people and their families do not get a good enough service outside office hours. This service, jointly commissioned for six neighbouring boroughs, is not always able to meet demand in Slough, particularly at weekends. Cases were seen where the service was unable to undertake important actions, such as checking the whereabouts of a looked after child. There are increasing difficulties in reaching agreement with the police about undertaking welfare checks on vulnerable children out of hours, reducing partners' ability to be assured of children's safety during these times. Children and young people who require urgent accommodation have very little choice, particularly those who are at risk of homelessness. Information sharing between daytime and out-of-hours services is good, with actions being recorded promptly.

12. Too many assessments take too long to complete and this leads to delays in children's needs being met promptly. For the year ending 31 March 2015 few assessments took longer than 45 days, but 21% were completed between days 41 and 45. This is double the rate for comparable local authorities. More recent data are still concerning. Managers do not routinely give clear enough guidance to social workers about how long an assessment should take based on risk and need, although a few good examples were seen. Managers receive regular performance information on assessment timescales but this does not include whether children have been seen and assessed in the right timescale for them.

13. Assessments of children, young people and their families are not routinely good enough. Too many do not consider risk factors, such as those relating to adult mental ill health or significant adults, including non-resident fathers. Historical concerns are not consistently taken into account and, overall, there is insufficient attention to children's ethnicity. Too few chronologies summarise the child's journey well enough to inform decisions and plans; many are not up to date or miss key information. Some assessments lack chronologies altogether. Inspectors saw some good assessments, with detailed and careful analysis and clear recommendations. (Recommendation)

14. Not all children who require a strategy meeting to protect them have one; cases were seen where children had been harmed but strategy discussions had not been held. The majority of strategy meetings are telephone conversations between team managers and the police. This does not meet minimum statutory requirements and means that background information from other agencies is not considered. A minority of strategy meetings are held face to face and, those observed, promoted good information sharing. Strategy meetings are recorded but too many lack timescales for actions. (Recommendation)

15. Inspectors identified inconsistencies in practice and decision making at all levels of the child protection process, including the threshold for convening a child protection conference. Some child protection assessments are good, but overall the quality is too variable. Fewer child protection assessments were started in the past 12 months than during the previous year, and a lower proportion led to a child protection conference. As at 31 October 2015, 150 children were subject to a child protection plan. This is 84 fewer than at 31 March 2015. Senior managers have not sufficiently explored the reasons for this reduction in child protection work. The trust's initial analysis is that it is likely be a consequence of inconsistent application of child protection thresholds, as well as plans ending too early.

16. A minority of children have been subject to a child protection plan repeatedly without any evidence of their outcomes improving or of changes being sustained. In other cases, child protection plans are not sufficiently clear about necessary changes and lack contingencies. Risks and concerns about some children have not been responded to early enough, or have not been escalated through legal processes. This is most evident in cases of long-term child neglect, although in recent weeks managers have taken increasingly decisive action to safeguard these children. According to the local authority's own data, neglect was a feature in 43% of child protection plans, emotional abuse in 34%, physical abuse in 10% and sexual abuse in 3%.

17. Some agencies and staff, such as GPs, child and adolescent mental health services (CAMHS) staff, youth offending team workers and the adult community mental health team, do not routinely attend child protection conferences. This reduces the effectiveness of the conference in understanding and addressing risk and need within families. Not all agencies provide reports or share reports with family members before the conference. This makes it difficult to plan for the conference or to prepare family members properly.

18. Child protection plans vary from inadequate to good. Until recently, most plans lacked specificity and were not sufficiently clear about actions or timescales. They did not consistently follow up incomplete actions from previous plans. The introduction of a new plan format in May 2015 has improved this. However, most plans do not set out in plain language what will happen if risks do not reduce or the child's situation does not improve.

19. Minutes of core groups and child protection conferences do not always reflect the voice of the child and children are not routinely supported to attend. Conference chairpersons report that social workers and other professionals do not use creative ways to present children's wishes and feelings often enough. Social workers can purchase advocacy support for children on a case by case basis but this is yet to be embedded across the service. Some good cases were seen where children's wishes and feelings were at the core of meetings and plans because of sensitive practice by individual social workers, but this is not true for the majority of cases. (Recommendation)

20. Children benefit from increasingly timely statutory visits from social workers. The brevity of recording means that it is not always clear whether children have been spoken to and seen on their own when visited by social workers. Inspectors saw good examples of social workers and early help staff being tenacious and creative in developing meaningful relationships with children and families. However, too often children have experienced multiple changes of social worker, reducing the impact of work to help and protect them. This is attributed to the turnover of permanent and agency staff and to children transferring between teams when they need different levels of support.

21. On occasion, decisions have been made to step children down from child protection plans to child in need plans before required changes have been achieved or sustained. The quality of ongoing help provided to them and their families is too variable. Managers are not assured that all children and families receive the right support for long enough once risks and needs are judged to have reduced sufficiently.

22. Children at risk of child sexual exploitation are not effectively identified or protected. Over the past year 'Engage' workers within the Young People's Service have undertaken individual and group work with 75 children at risk of child sexual exploitation. However, this work has not been coordinated well enough, and too many children have not been assessed by social workers using the local risk assessment tool. The service has not received any referrals for boys or young men. The majority of risk assessments include shortcomings such as language that blames children for being in risky situations or do not sufficiently consider risks to boys. Potential risks associated with gang involvement are not sufficiently explored. Currently, there are no specialist post-abuse therapeutic services or parental support groups available to children and families. The role of the child sexual exploitation coordinator has been disjointed and ineffective due to frequent changes of personnel and periods where the post was vacant. Not all post holders have had responsibility for missing children, meaning that these two issues were not consistently cross-referenced. This is now being addressed, but the new coordinator has only been in place for three weeks. Until recently, most children who went missing did not receive a return home interview. Having swiftly identified this important weakness, the trust is now ensuring these interviews take place. Work to map links between children has begun but is overdue. (Recommendation)

23. Links are now being made between the trust and the commissioned provider of education services to consolidate information about children missing education with information about children going missing from other settings. Arrangements to share information with the council team responsible for young people who are not in education, employment or training (NEET) temporarily lapsed during the transition to the new trust arrangements.

24. Arrangements to track children missing from education are effective. The high rate of referrals, approximately 400 per annum, reflects the high mobility of children in and out of the borough. Notifications to the children missing

education coordinator are prompt and appropriate, as are the subsequent actions. The whereabouts of these children are comprehensively recorded and communication with other local authorities is efficient. In the few cases where children are taken abroad, this is investigated in depth.

25. Around 80 children and young people are electively home educated in Slough. Appropriate steps are taken to build positive relationships with educators, although some families choose not to accept this support. Where there are concerns about children's welfare, they are referred to children's social care.

26. Arrangements are developing well to address concerns about female genital mutilation. The NHS acute trust identifies approximately six women per month through the mandatory antenatal reporting system. This route has also identified three children subjected to female genital mutilation before entering the UK, with appropriate use of child protection procedures and good social work assessments. Prevalence mapping has identified the geographical area with the highest risk. Awareness-raising activities have encouraged community engagement. However, no cases have been identified by means other than the antenatal reporting system, suggesting limited impact so far.

27. Appropriate agencies attend regular multi-agency risk assessment conferences (MARACs) where plans to protect children, young people and parents who are at risk from serious domestic violence are considered. In all cases sampled appropriate action had been taken. However, meetings do not benefit from consistent engagement from children's social care, and inspectors were unable to assure themselves of the overall effectiveness of these arrangements as no data or annual reports were provided.

28. The overall impact of services to reduce domestic abuse and to protect vulnerable victims and children has not been sufficiently analysed or understood by partners. Victims and perpetrators have access to a range of local services although there are insufficient perpetrator programmes for the culturally diverse local population. The trust acknowledges that it does not yet have a clear picture of what support is available and how effective this is.

29. Attendance by children's social care at multi-agency public protection (MAPPA) level two meetings has improved in the last 18 months. However, no one children's social care representative attends consistently, leading to delays in some actions being carried out. The MAPPA chair has had to follow these actions up on occasion.

30. In September 2014, the council established a Prevent Partnership. Key staff are in place to meet Slough Council's duty to address the risk of radicalisation in response to its designation as a Tier 2 'Prevent' priority area. Partnership arrangements are developing well and have been strengthened through the appointment of a local 'Prevent' coordinator. Community cohesion work and awareness-raising is ongoing, with two community conferences in 2015. The support of council members has been instrumental in ensuring the need for a

cohesive community is understood. Appropriate training is provided, although to date approximately half of the relevant staff have yet to attend. Appropriate systems and processes are in place and risk assessments are informed by local profiles, but high-level police security considerations mean that assessments are not always complete. During the past year, one young person has been considered through the Channel process, the multi-agency approach used to identify and provide support to individuals who are at risk of becoming involved in terrorism. Since March 2015 there have been nine referrals, none of which required further escalation.

31. Staff within housing and children's services know how to respond to young people aged 16 or 17 who are homeless or imminently homeless. The joint protocol between children's social care and housing has been in place for 18 months and is clear and helpful. However, managers acknowledge that young people are not always supported to understand what being 'looked after' means in terms of where they can choose to live. Managers have not sufficiently analysed or quality assured the level and quality of help and accommodation provided to these young people.

32. Children with disabilities benefit from appropriate early help packages of support or specialist multidisciplinary support from a specialist team. These children receive a consistent service because the team undertakes the full range of social work tasks relating to need, risk and permanence. In cases seen, assessments were analytical, with timely multi-agency strategy meetings leading to appropriate plans including child protection plans. Use of short breaks is appropriate, using a variety of providers.

33. Across frontline services, understanding about the role of the designated officer who oversees referrals about adults working in a position of trust with children needs to be strengthened, although recent work with schools has helped to raise awareness. The police assess all referrals to the designated officer to determine whether a strategy meeting is needed, but this is a solo decision, which should be multi-agency. In the cases sampled, arrangements were operating effectively, with timely responses and appropriate action taken to protect children. Records would benefit from greater clarity about the rationale for some decisions.

34. Efforts to raise awareness about private fostering have not been effective. Currently, the number of privately fostered children remains low, at three. Assessments and DBS checks are not consistently undertaken quickly enough to assure these children are properly safeguarded.

The experiences and progress of children looked after and achieving permanence	Inadequate

Summary

Often, decisions to look after children are not timely or well assessed. Too many children who are now looked after have been left in situations where their needs have not been met or where they have experienced further harm. Decisions to start legal proceedings are often delayed, although once proceedings commence they progress quickly. Very recently, social workers and managers have taken decisive action to protect children who have experienced long-term neglect.

In Slough, there is a lack of targeted multi-agency edge-of-care support to enable children to remain at home or to return home. Where the plan is for a child to return home, the support provided is not consistently robust.

Social workers do not always know children well enough to be able to ensure their needs are met and that their lives improve. Assessments and care plans are often not up to date or do not sufficiently reflect children's individual needs. When children go missing from care or are at risk of being sexually exploited, risks are not comprehensively known, tracked or followed up, leaving these children and young people at risk of further harm.

The virtual school is ineffective and has been for at least a year. The council has not afforded the role of head of the virtual school sufficient status or priority. Children looked after do not receive the support and guidance they need to do well in school.

Statutory reviews are regular and detailed, but involvement of children is poor. Independent Reviewing Officers (IROs) are not influential enough in challenging or changing plans for children. Leaders have not helped the Children in Care Council to be as effective as it could be. The views of children looked after are not systematically heard or acted upon and commissioning arrangements for advocacy and the independent visitor service are weak. Local placement choice is very limited and too many children live too far from home.

Although most children move to their adoptive families quickly, some children who are older, have complex needs or who need families together with their brothers and sisters wait too long. Not all child permanence reports are good enough. Some children do not receive life story books at the right time. Letters for later life are detailed but not all are written well. Post-adoption support is a strength.

Support for care leavers is not sufficiently comprehensive or integrated. Too many care leavers do not feel safe, and do not receive the help, advice and guidance they need and are entitled to. This means that they are not consistently safeguarded or empowered to achieve all they are capable of. Pathway planning is weak overall. Care leavers are effectively helped to access employment, education or training.

Inspection findings

35. In the large majority of cases seen by inspectors where children had recently become looked after or legal action had commenced, social workers and managers had waited too long to make these decisions. Although the vast majority of these children are now safeguarded, they had been left in situations where their needs had not been met and risks had not reduced. For too many children facing significant issues, such as chronic neglect, unexplained physical injuries and lack of parental engagement had not been responded to quickly enough. Inspectors found a significant change in response in recent weeks, with legal surgeries agreeing decisive action to safeguard children, particularly those who have experienced long-term neglect. In a small minority of the cases seen by inspectors where children had recently become looked after, good practice was identified. For example, appropriate and valuable respite care was being provided under short break regulations.

36. Outcomes for children looked after are too variable. For the very large majority inspectors found significant shortcomings in assessment and care planning, and delays in achieving permanence. This has impacted negatively on children's lives and experiences. The minority, once placed with longer-term carers, become settled and begin to make progress at school and in other areas of their lives.

37. A small proportion of those children who return home from care subsequently return to care (4%). Inspectors found that where the plan is for a child to return home, the support provided through a child in need plan or subsequent child protection plan is not robust enough. There is a lack of targeted, wraparound and flexible support for children and their families to enable children to stay at home or return home from care. Family group conferences are used effectively in some cases but commissioning arrangements are not robust. Leaders acknowledge that edge of care family support needs to improve and plans are in place to develop and coordinate these services from January 2016. (Recommendation)

38. The effectiveness of the use of the Public Law Outline (PLO), the framework which includes all parts of the pre-proceedings and proceedings process, is too variable. Inspectors saw significant delays in the seeking of legal advice about whether the care threshold had been met. This means that children are not always safeguarded as quickly as they should be. The PLO tracker is a useful tool for managers to oversee plans for children once legal advice has been sought. It is beginning to have a positive impact, leading to appropriate permanence plans for a number of children, and since April 2015, 11 adoption orders and 25 special guardianship orders have been granted. However, for almost third of children whose plans are overseen via the PLO tracker there is still significant delay. There are a range of reasons for this, many of which are preventable, such as delays in making applications to court.

39. When care proceedings commence, they are well managed, with the vast majority accepted by the courts. Unnecessary delay is avoided. In the last 18 months, a case supervising manager has proactively tracked and monitored all children in pre-proceedings and care proceedings. A pre-proceedings protocol, introduced in September 2015, is helping to embed better practice.

40. Social work statements are of good quality. This has contributed to improved timeliness of legal proceedings in 2014–15, where on average this process took 31 weeks to conclude. So far in 2015–16, average timescales have risen to 34 weeks. Once adoption is considered as an option for a child, parallel planning begins, but social workers and managers do not consider adoption early enough for all children. In the majority of cases seen by inspectors, social workers had not waited for one assessment to be completed before starting another. This helps to ensure that plans are progressed in good time. Viability assessments of family and friends carers are undertaken appropriately to minimise delay for children.

41. Children are routinely visited and seen alone by social workers. However, in too many cases, social workers' understanding of children's needs and their relationships with children and young people are not strong enough. For these children, plans are too often not progressed well. Children looked after told inspectors that frequent changes of worker had prevented them from building or sustaining meaningful relationships with them. They said that their views were not always heard and agreed actions were not always carried out. These children and young people were, however, more positive about their carers, saying that they were supportive and helpful to them; some said this had made up for inconsistent social worker relationships. For some children and young people, other professionals are providing good support, and one young person described her youth worker as 'brilliant'.

42. Advocacy services for children and the independent visitor service have not been effectively commissioned. This is now being appropriately addressed by senior managers. Managers and children looked after created a complaints leaflet two weeks before the start of the inspection, but young people told inspectors that they did not know how to complain. Managers have not collated information about complaints from children looked after, so any learning has been lost. (Recommendation)

43. In the majority of cases, assessments of children's needs are either not in place or are not comprehensive, current or of sufficient quality. They do not always include the contributions of children and their families to ensure that the support provided is appropriate for their needs. Most care plans do not comprehensively address the needs of children and young people. This means that carers are unable to check that actions are completed and progress cannot be effectively measured. (Recommendation)

44. Up-to-date case recording and case summaries were seen on the majority of files, accurately reflecting the work being undertaken with children and young

people. Some of these records were warm and thoughtful accounts of the time social workers spend with children looked after. These will be helpful to children who decide to view their files as they seek to understand their care experience in later life.

45. During 2014–15, 92% of statutory reviews for children looked after were held on time. Reviews are comprehensive overall, covering the important aspects of care plans and the key details of children's daily lives. However, approximately half of children looked after do not see their IRO before their review, reducing the likelihood that trusting relationships will be formed. IROs' understanding of children's views and feelings is significantly hampered by the very low rate (15%) of reviews where children and young people's views are formally shared through the consultation booklet designed for this purpose. Too often reports for reviews are not provided in a timely way. When IROs challenge or escalate their concerns about care plans, the resolution of issues is weak leading to little or no change for children. (Recommendation)

46. Risks associated with children who go missing from care or who are at risk of being sexually exploited are not comprehensively known, tracked or followed up, leaving these children and young people at risk of further harm. In the vast majority of cases where children looked after have gone missing, return home interviews have either not been undertaken at all, taken place too long after the young person returned, not included a useful description of what has happened or have not sufficiently analysed risk. This is a serious weakness. Trust managers have recognised the significance of this gap and have very recently put more robust arrangements in place. However, there is still a considerable amount of work to be done before these risks are properly understood and children looked after are effectively safeguarded. (Recommendation)

47. In the past four years the youth offending service has worked with 31 Slough children looked after who have been convicted of or cautioned for an offence. Managers have not sufficiently collated or analysed information about children looked after who may be putting themselves at risk through drugs or alcohol abuse. This limits managers' ability to ensure that these children and young people are effectively helped. Services to support young people with these difficulties lack coordination.

48. Nurses for children looked after provide positive, sensitive and proactive work to ensure that all young people, regardless of their placement address, have their health assessments on time and that actions are progressed in between health reviews. As a result, the vast majority of children looked after benefit from comprehensive and tailor-made health plans, which address their physical, emotional and mental health needs alongside issues relating to relationships and sexual health. Children's emotional needs are understood and responded to through the provision of appropriate services.

49. The virtual school for children looked after has been ineffective for at least a year. The role of the head of the virtual school has not been given sufficient status or priority by the council. Wide-ranging improvement actions identified over a year ago to improve fundamental aspects of the virtual school have not been implemented. The trust has taken some very recent action to deal with the many deficiencies of the virtual school; specifically, appointing a new interim head of the virtual school in November 2015. The newly appointed headteacher has quickly produced a new, well-structured and very specific improvement action plan, but it is too soon for it to have had any impact. (Recommendation)

50. Personal education planning is poor. The majority of personal education plans are sparse in detail; they lack well-defined actions relating specifically to the child’s educational development needs, aspirations or skills. They either do not involve the child at all or do not involve them directly, and most have not been reviewed in a timely fashion. A new online system for personal education planning is not used well. (Recommendation)

51. The educational support for the 70% of children looked after who are educated out of borough is poor and lacks coordination, despite some initiatives to address this. While the vast majority of children looked after who are educated in Slough attend good schools, only around two thirds of children looked after who are educated out of borough are attending good or better schools.

52. The virtual school has no comprehensive data with which to monitor and track the educational performance of children looked after in and out of the borough. This includes data on their attainment at all key stages including GCSE results, their incremental progress, attendance and any interventions offered in support. A narrow dataset on the performance of children looked after in Slough at GCSE shows very poor performance. During 2014, none of the 13 children looked after achieved five A* to C grades. Of these 13 children, 10 achieved at least one pass at grade D to G. In 2015, one of the 10 entered achieved five A* to C grades at GCSE, including in English and mathematics and a further eight children achieved at least one pass at grade D to G. (Recommendation)

53. The virtual school’s administration of the pupil premium, used to fund specific support and initiatives for children looked after, has been slow and too many schools have received only half their full entitlement. The remainder of the funding has been retained for training and awareness-raising sessions; the frequency of such sessions has been limited. (Recommendation)

54. Arrangements for the 139 children and young people in alternative education are good, including for the seven children looked after who have achieved well in their vocational courses and made progress in their personal development, behaviour and well-being. The Children Missing Education service does not track any children looked after, on the assumption that this cohort is dealt with

by social workers or the virtual school, and this is a deficiency. (Recommendation)

55. Within the general curriculum, schools and colleges provide protection and support for children looked after who are being bullied or discriminated against, or who are at risk of being so. Schools report that the virtual school has not been sufficiently involved in this work to promote the needs of children looked after. (Recommendation)

56. Leisure activities are appropriately promoted by IROs and by foster carers, although delegated authority for arrangements for individual children are not always evident on foster carer files. Arrangements for children looked after to spend time with their families are run and managed well by a specific contact service. Sensitive work is undertaken with children and their families, endorsed by positive feedback from foster carers, social workers and children's guardians.

57. There is an inadequate choice of placements for children looked after in Slough and there are no in-house specialist fostering schemes. The supported lodgings scheme provides just one placement and is significantly underdeveloped. Three quarters of all children looked after live outside Slough and over 29% live more than 20 miles away from their home address. Too many children are living away from their families, friends, schools and communities. (Recommendation)

58. The number of in-house foster carers has decreased to 34, which managers acknowledge is far too few. The council and the trust have identified foster carer recruitment as a key priority and the recently written sufficiency strategy has set ambitious targets to rectify this deficit. Support services for Slough foster carers, such as a support line, have previously been cut back and as a result foster carers feel insufficiently supported. Developments since June 2015 are beginning to address this and foster carer payments have been reviewed.

59. In most cases seen by inspectors, there has been an appropriate focus on diversity when matching children with placements, with consideration of children's ethnic, linguistic and religious needs. Where these placements are trans-racial, social workers and managers have carefully thought about how carers should be supported to meet children's diverse needs. However, because local placement choice is very limited, many children are not initially well-matched. First placements are often emergency arrangements and in these cases, a further placement move is usually needed. Managers acknowledge this is not good enough, but they are restricted by poor placement choice.

60. A dedicated family finder seeks families for children requiring long-term fostering, and for these children appropriate and thorough matching by foster panel is in place.

61. Within the current cohort of children looked after, placement stability has declined in recent months. As at 31 March 2015, 10% had experienced more than three placement moves within a year. This is in line with England figures.

According to the trust's data, in October 2015 this figure had increased to 15%. Longer-term placements for children are stable; in October 2015, 67% had been in placement for more than two years, an improvement from 58% in 2014. Children placed with independent fostering agencies (IFAs) and in residential placements are monitored and RAG-rated monthly for signs of instability and pressures, enabling managers to increase oversight and support where needed. Where providers are found by Ofsted to be inadequate, there is an appropriate process in place to review placements, but inspectors saw examples where this process had not been applied rigorously enough.

62. There is no accurate data to understand unplanned endings of placements or for the separation of siblings, and this requires further work in order to improve future support and matching for children looked after.

63. Fostering practice is not compliant with statutory regulations in all areas. There are delays in completing annual reviews and some records in foster carer files such as placement plans or delegated authority are missing or blank. Foster carer records highlight lapses in the regulatory process for viability and family and friends assessments.

64. The participation of children looked after and opportunities for them to contribute their views to service development are underdeveloped. Insufficient resources and staff are in place to support this. The CiCC is not representative of all children looked after; for example, there is currently no care leavers group or juniors group. Despite this, these young people have worked hard to make a difference. They made an important contribution to the recent successful celebration of achievement and have renamed and rebranded the group.

65. Managers have failed to ensure that the CiCC are empowered to take forward issues that are important for them and in some cases senior and political leaders have been slow to take action. For example, it took a year for funding to be agreed for the CiCC to have a tablet to use in the group; since one has been provided the young people have made very good and creative use of it. The trust has very recently written an action plan outlining how they plan to work with the CiCC to increase their effectiveness. (Recommendation)

The graded judgement for adoption performance is that it requires improvement

66. When children cannot live with their birth families, appropriate consideration is given to other forms of permanence including adoption. However, adoption is not always considered at an early enough stage, where plans for permanence through other options are being explored.

67. The number of children placed for adoption has increased each year over the last three years. In 2015, 23 children were adopted in comparison with 17 in

2014 and nine in 2013. In the year to date, 12 adoption orders have been made and 10 children placed with their prospective adoptive families. Two children have been placed with fostering to adopt carers. At the time of the inspection no children were waiting for an adoptive family.

68. In the three-year period 2011 to 2014, children waited an average of 573 days between entering care and being placed for adoption. Although this does not meet the national threshold of 547 days, it is better than both the England average of 628 days and that of Slough's neighbours at 647 days.

69. In the same period children waited an average of 203 days between the council receiving court authority to place a child and a suitable match being made. This is a better performance than the average for England of 217 days and in line with performance of statistical neighbours, but does not meet the national threshold of 152 days.

70. Too many children with complex needs, who are older or who are part of sibling groups wait too long for adoption. Fewer children, 37%, were placed for adoption within 18 months of coming into care than the average for England of 51% or statistical neighbours at 45%. Seven of this group of children were brothers and sisters with plans to be placed together, which were changed as a result of their complex needs. This indicates that insufficient attention was given to whether these children's needs could be met through adoption if placed together.

71. A small number of children experience delay in applications for an adoption order being made once they have moved to their adoptive families. This is attributed to a lack of social work capacity in the protection and care teams.

72. Since March 2015, the council and trust have taken action to address the number of children whose plans have changed away from adoption but whose placement orders had not been revoked. Twelve children have had their plans changed from adoption, the vast majority having waited for some years, being older or having complex needs. At the time of this inspection, eight children have had their placement orders revoked; three remain with their foster carers under special guardianship orders and five remain in long-term foster care with the carers they have lived with for some time. Plans are in place to revoke orders for the remaining four children. Decisions to change plans are given appropriate consideration by senior managers and confirmed at children's reviews.

73. Nine adopters were approved in 2014–15 and six have been approved so far this year. The timeliness of the approval process of adopters has been significantly hampered by delays in the return of Disclosure and Barring Service (DBS) checks. Inspectors saw examples of delays of up to six months. This means that the target of two months for the completion of stage one of the assessment cannot be met. Adopters and staff told inspectors of the frustration this causes. Once stage one is completed, or where adopters are being

assessed for a second time, assessments are completed promptly. Adopters are appropriately referred to the national Adoption Register and adopters spoken to are positive about the support they receive from social workers while seeking suitable matches with children.

74. Ambitious recruitment targets are in place, which include a focus on recruiting adopters for older children and sibling groups and increasing the number of fostering to adopt carers. A recruitment initiative, including the development of a recruitment microsite, is due to start in January 2016.

75. Berkshire Adoption Advisory Service (BAAS) administers the adoption panel. It serves six local authorities across the county and has appropriate membership. The panel chair is independent and appropriately qualified. The panel meets twice monthly and provides effective scrutiny and feedback on the quality of reports received.

76. Child permanence reports are thorough and contain sufficient detail. Some examples seen by inspectors contained typographical errors and would have been improved by being more engaging and by using less professional jargon. Better examples seen were detailed, used clear language and were balanced in describing birth family circumstances.

77. Prospective adopters' reports seen by inspectors were of a good quality. They are suitably detailed, with all relevant references and checks completed. In one example, good use was made of a family and friends meeting to observe the adopters' interaction with children, discuss the impact of adoption with the wider family and assess the couple's support network. The quality of reports presented to the adoption panel means that the panel has sufficient information to make robust recommendations and there is no delay caused by requests for further information.

78. Agency decision-making has been insufficiently rigorous or prompt. In one example seen by inspectors, there was a delay of almost four weeks between the decision being made and the adopters being informed. Since the establishment of the trust, changes have been made to strengthen the rigour and timeliness of the decision-making processes. Although this is very recent, panel minutes show an increase in detail of assurance given by the agency decision maker before a decision is made.

79. Not all children receive their life story books at the right time to help them understand and support them in moving to their new family. The quality of life story books seen by inspectors was variable. Those produced in the adoption team are more detailed and professionally produced. While some children in long-term foster placements or in special guardianship arrangements have life story books, this is inconsistent and in some cases special guardians are inappropriately expected to produce these books themselves. Children moving to their adoptive home benefit from a 'We wish you well' DVD produced by their

foster carers, which supports their move to their new homes. (Recommendation)

80. Letters for children in their later life are detailed but vary in quality. Language used is not always suitable; some examples were seen where letters were overly sentimental and in others professional jargon was used. Better examples avoided jargon and used simple, clear language that is likely to be understood by a child reading it in the future. (Recommendation)

81. Nearly all adoptive parents spoken to during this inspection were positive about their social workers, who are available and supportive. Post-adoption support is a strength. Children and families benefit from a range of financial, therapeutic and practical post-adoption support. Currently, 14 children are receiving therapeutic help and there have been three successful applications to the adoption support fund. Adopters welcome a new initiative, provided by a social enterprise company sponsored by the Department for Education, which offers a range of pre- and post-approval support. This includes specialist individual support, therapeutic parenting and group training. No children or families are waiting to receive support. Few adoptions break down; there has been only one this year and none in the previous two years.

82. BAAS supports letterbox arrangements between adopted children and their birth families. Thirteen new letterbox arrangements began in 2014–15, with a total of 153 arrangements in place.

83. BAAS is also commissioned to provide support to birth families. The number of birth family members referred increased from nine in 2012–13 to 18 in 2014–15. Support groups are available for birth mothers and there is a separate group for birth fathers.

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

84. The effectiveness of support for care leavers by social workers and personal advisers is inconsistent and too often poor; this accords with the trust’s own audits. It is due, in part, to high turnover among the staff supporting these young people. Managers do not always know whether care leavers’ welfare is safeguarded because the frequency and quality of each social worker or personal adviser’s contact with young people is not routinely monitored. (Recommendation)

85. Inspectors saw a number of cases where care leavers had not had any meaningful contact with a personal adviser or social worker for lengthy periods of up to 10 months, with significant events in their lives going unnoticed. One care leaver had recently been visited by a new personal adviser after a long gap. Inspectors spoke to care leavers in semi-independent accommodation who said that they relied heavily on guidance and emotional support from their

onsite key workers. These young people depend on their keyworkers and on the unmoderated advice of friends for help with life choices, budgeting, staying safe, independence skills and offending. Key workers in semi-independent accommodation, social workers and personal advisers do not routinely share historical or current information about each care leaver and this reduces their ability to work together effectively to meet young people's needs. However, where relationships between young people and their personal advisors are enduring and meaningful these are helpful to care leavers. One young person said, 'I know she's busy but she always makes me feel as if I am her only young person. She has helped me through some really difficult times. She always gets back to me when she says she will. I really need her – she does the stuff that other people's parents do'. (Recommendation)

86. The information, advice and guidance received by care leavers in Slough are too often incomplete and not coordinated well enough. Care leavers are allocated to a personal adviser or social worker in one of the two looked after children's teams. Staff acknowledge that the absence of a dedicated multi-agency service for care leavers is significantly reducing their ability to provide a seamless offer of guidance, advice and support on aspects including housing, careers, finance, employment, education and training. Social workers and personal advisors also say that it is difficult for their teams to prioritise care leavers' needs when they are so busy with the other children on their caseloads.

87. The quality and impact of too many of the old and new-style pathway plans evaluated by inspectors are poor. The summary analysis and action plan do not provide a specific, action-oriented or time-bound evaluation of need, direction or support to care leavers. They do not sufficiently address young people's diverse needs or sufficiently outline how young people will be helped in their journey towards independence. A new system and format for pathway planning has been introduced in recent months; the plans are comprehensive but most care leavers are unimpressed by them. Young people say that they take far too long to finish them and some young people are unwilling to attempt to complete them at all. One care leaver commented that the pathway plans seemed to be based on a presumption of failure rather than aspiration. Inspectors did see examples where pathway plan workbooks were being used interactively, with evidence that this was proving to be helpful to care leavers. The underlying pathway planning software does not support the process well. (Recommendation)

88. The provision of targeted support to prepare care leavers for independence has historically been weak. A 10-week life skills course was piloted in October 2015, with plans to roll this out from February 2016. Although this is a positive step, it is too early to judge the impact of this support.

89. In recent months managers have introduced some new arrangements and initiatives for care leavers, with some positive impact. However, there is still a very long way to go before these arrangements are applied consistently in

practice or are fully effective. For example, a useful new booklet was produced a few weeks prior to the inspection to provide a single source of comprehensive information about care leavers' various entitlements for use by care leavers, social workers, personal advisers and IROs.

90. Support to help care leavers enter and sustain attendance at further and higher education and vocational training programmes is on a case-by-case basis rather than through a planned system of contact. Care leavers receive appropriate financial help to attend university and at the time of the inspection nine of these young people age 18–21 were in higher education, which is in line with comparable local authorities. Only three are in apprenticeships. Care leavers told inspectors that their enrolment onto a course or gaining employment was largely due to their own initiatives rather than as a result of the help they had received from their social worker or personal adviser.

91. Until July 2015, the destinations of care leavers aged 16–25 into education, employment or training (EET), or not (NEET), were not recorded or monitored accurately enough. Since July, the Slough young people's service (YPS) has played an increasingly effective role in ensuring that information about care leavers in and out of the borough is up to date and that care leavers are better informed about the education, training and employment options available to them. Each NEET care leaver has access to a support worker from the YPS who helps them to achieve their goals. These workers provide counselling and support with issues such as relationships with family members and sexuality as well as practical support to enter and sustain work, training or education.

92. However, data and information are not shared routinely or formally between the YPS, social workers and personal advisers. In some cases, the YPS information is better informed and more up to date than social workers' and personal advisers' case notes, and in other cases the reverse is true. There is no common database or formal means of liaison between these professionals to ensure that all relevant information on each individual is aligned and fully current. (Recommendation)

93. According to the most recent YPS data to November 2015, nearly 70% of 16–21-year-old care leavers are recorded as being in EET, predominantly education, including 60% of 19–21 year olds. The proportion of 16–18-year-old care leavers in some form of EET is also high, at over 80%.

94. Some of the care leavers who spoke with inspectors said that they did not feel safe living in Slough or in their accommodation, particularly at night-time. Care leavers are keen to avoid placements in certain semi-independent accommodation. These young people were not confident that the social workers, personal advisers or managers recognised or understood their concerns.

95. The quality and range of supported accommodation for care leavers in Slough are significantly underdeveloped. There is only one supported lodgings carer

within the trust's fostering service and as at November 2015 there were 21 young people who the trust believed would benefit from such provision. The trust recognises the need to urgently recruit at least 20 supported lodgings carers in 2015–16, and 10 each year thereafter. The trust identifies that 88% of care leavers aged 19–21 are considered to be in suitable accommodation including in and out of borough semi-independent, independent council and private accommodation.

96. The trust understands that no care leavers have been accommodated in bed and breakfast accommodation for over a year. A practice manager from the care leavers' team has visited each of the few houses of multiple occupation used and assessed that they are fit for purpose. However, during the inspection, inspectors raised concerns about the location and risks associated with one of the local providers of supported accommodation. The trust agreed to review this provision.

97. Care leavers register on the council housing list at 16 years of age but are, on occasion, allowed only one offer at a time in their life when many are making daunting long-term decisions; the council's housing department is not consistently flexible enough in its dealings with care leavers.

98. The trust recognises that staying put arrangements are significantly underdeveloped, with only three staying on in foster care after their 18th birthday. This is an in-year priority for the trust. (Recommendation)

99. The health history process for care leavers is comprehensive. Each care leaver's health history pack is assessed by the children looked after's nurse and is completed and shared in depth with them before they reach 18 years of age. Pathways into adult mental health are progressed by CAMHS and, where feasible, by the children looked after's nurse. There is no specific transition team in place for disabled young people aged between 18 and 25 or those with complex needs. However, the nurse for children looked after does some follow-up with these young people locally and is available to support the social work team, if needed, for young people placed out of borough.

100. There is no care leavers' focus group in Slough. An action plan to develop the children in care council service was written during the inspection. The vast majority of care leavers that inspectors spoke with reported that their views on the quality of service they had received had not been sought.

101. This year's annual celebration event for children looked after and care leavers was the eleventh of its kind. Children and young people consider it to have been a great success.

Leadership, management and governance	Inadequate

Summary

Leaders have not improved services enough since the last inspection in 2013. Key aspects of children's social care services are still inadequate. The Secretary of State directed the council to enter into a formal agreement with an independent body for the delivery of children's social care. It took a long time for the council and the Department for Education to reach agreement about the precise nature of the arrangements and to implement the changes. Responsibility transferred to the new body, Slough Children's Services Trust, on 1 October 2015. Although plans are in place to resolve the remaining details, some arrangements, such as how commissioning will be done, are still to be agreed.

The intervening period saw some improvement in the quality of provision under the council, particularly in cases involving legal proceedings. However, the pace of change was insufficient overall and not enough children received good enough help. The council acknowledges that it channelled leadership resources into the transition to the trust at the expense of a focus on the necessary practice improvements. A lack of rigour in the use of performance information, and differing internal and external messages about the quality of services for children, meant that the council lacked a clear picture of service quality.

The council has not been a good corporate parent. The Corporate Parenting Strategy lacks ambition and rigour, and the Corporate Parenting Panel has not received and scrutinised comprehensive performance information. Some key aspects of support for children looked after, including the virtual school, have been weak. The views of children looked after and care leavers have not been sought and analysed actively enough, and so they have not influenced the shape and quality of services.

The pace of improvement has accelerated in the short period since the trust began operations. The response to new referrals is now better than at the time of the last inspection. The trust has consolidated and extended the improvements in management oversight of cases that started under the council. Most records show clear management decisions. The trust has a coherent plan to develop a well-trained stable workforce and to reduce its legacy dependence on agency staff. It is establishing a more rigorous approach to performance monitoring and management. It is too early for the trust to have made enough improvement in all areas that need it. However, there are clear signs that it knows what needs to change and early emerging evidence that it can deliver improvements for Slough's children.

Ofsted

Inspection findings

102. Following the 2013 inspection, the Department for Education commissioned an independent review, published in July 2014, to advise on how best to deliver children's social care services in Slough. In October 2014, the Secretary of State intervened under s497A of the Education Act 1996 and directed that an independent trust should be appointed to deliver children's services in Slough.

103. There followed protracted discussions about the precise nature of the trust arrangement, with the council at first proposing a model which the Secretary of State concluded would not put the services in question sufficiently out of council control to secure the necessary improvements. However, the timeframe set by the Secretary of State was achieved, and, on 1 October 2015 an independent children's trust, Slough Children's Services Trust, took over all council-run children's social care services under a contract with the council. This was almost two years after the most recent inspection. Among the functions transferred are the fostering and adoption agencies. These have been established as a registered independent fostering agency (IFA) and voluntary adoption agency (VAA) respectively.

104. The transition to the trust has not been smooth. Improvements did not happen quickly enough. Agreement between the council, the Commissioner and the Department for Education about the shape of the new structures and governance arrangements took a long time to achieve. This was due, in part, to the multiple parties and complexity of the arrangements. Governance is now largely clear, although there are important areas such as commissioning where partners have yet to resolve the detail.

105. The picture since the last inspection is of inconsistent and insufficient improvement on the very low baseline found in the 2013 inspection. There has been progress, both under the council and now under the trust, but the trajectory has been too shallow and the pace too slow. The lengthy discussions about the future of services created uncertainty and impeded progress. The council acknowledges that the need to manage the transition to the trust distracted it from making necessary improvements. In particular, the part-time interim DCS understandably became increasingly involved in the transition project. This left a capacity and capability gap in senior leadership that the council chose not to fill at a time when the transfer to the trust was imminent. This meant that improvements were slight and piecemeal.

106. For example, historical inconsistencies in tackling child sexual exploitation means that there is no profile or mapping of the scale and type of child sexual exploitation in Slough. Effective awareness-raising has been undertaken, and some helpful direct work with young people. However, gaps in coordination and a lack of a coherent strategic approach have significantly hampered progress. (Recommendation)

107. At the same time political leadership, including scrutiny, has not focused enough on the detail of performance and so has been ineffective in driving up standards. The council has not fully discharged its responsibilities for improving services and quality remains too low.

108. The relationship between the DCS and the chief executive of the trust is developing positively. This is aiding the transition and beginning to resolve some of the inevitable uncertainties about boundaries, roles and responsibilities. However, the DCS is interim. The council is considering succession arrangements, but continued uncertainty risks undermining confidence in the new partnership.

109. Some aspects of provision for children in need of help and protection derive from a firm understanding of the local population. For example, there is a broad range of early help provision, though there are delays in accessing it for some children and families, impact has not been sufficiently analysed and provision lacks coordination. However, other areas of work do not reflect an understanding of the levels and range of need. For example, there are not enough in-house foster carers to meet need, and there is no formal structure for the reliable and cost-effective procurement of foster placements in the independent sector. (Recommendation)

110. Trust leaders have sought to understand and shape what is happening at the front line. They are actively overseeing work, identifying strengths and weaknesses and taking action to improve. A baseline audit conducted shortly after the transfer of provision indicated that services were in a worse shape than had previously been understood. In the year prior to transfer, the council commissioned two reviews of services, including a Local Government Association diagnostic. Each of these reported significant progress. It is unclear whether they presented an accurate picture formed at times when quality was at a temporary peak, or whether they were overoptimistic. It is clear, though, that the council did not have a comprehensive and realistic view about quality and consistency.

111. Key partnerships and strategies, such as the joint well-being strategy, Slough five-year plan, Slough Story, children and young people's needs assessment and plan and the clinical commissioning group (CCG) five-year plan, share some priorities. However, other than the children and young people's plan they have little focus on children's social care issues, despite the very high level of concerns from the last inspection. The joint strategic needs analysis (JSNA) uses old data and does not reflect the 2013 inspection. It does address safeguarding and children looked after but is largely narrative, with no comparative or trended data. It is difficult to see how it could inform projections and planning.

112. Slough's children looked after and care leavers do not regard the council as a good corporate parent. Inspectors agree with them. The corporate parenting strategy is a superficial document that uses old data and priorities, and includes

no action plan. The corporate parenting panel has not received comprehensive performance information. This has limited its ability to provide scrutiny and challenge. IROs have not monitored the council's performance as a corporate parent effectively. The council has not provided the CiCC with enough support to be as representative and influential as it should be. Since taking over, the trust has recognised these shortcomings and is taking action with the council to remedy them. (Recommendation)

113. The chief executive of the council meets quarterly with the independent chair of the Local Safeguarding Children Board (LSCB). Until recently there has been no formal written record of these meetings, so it is not clear to what extent the Chief Executive has used them to hold the chair to account for the conduct and activity of the LSCB. There are also quarterly meetings between the Chief Executive, the DCS and the independent chair to discuss the LSCB's work. The chief executive of Slough Children's Services Trust now joins these meetings. Again, there have until recently been no formal minutes, but there is evidence of challenge to the council over a number of issues, including the strategic response to female genital mutilation.

114. The council has not made enough use of feedback from children, young people and families. There has been no detailed analysis of findings from complaints to learn lessons and make improvements. Nor has there been routine collation or analysis of children's views to inform service development, planning and commissioning. It is too early to tell if the trust will be more of a learning organisation, but initial signs are hopeful. Its leaders intend to move to an evidence-based, systemic model of service delivery, and it is already analysing and using performance information. (Recommendation)

115. Under the council, performance information was collated and analysed by the corporate performance team. There was a lack of rigour in the gathering and analysis of this information. Managers and staff below head of service level did not receive regular performance reports. This meant that they did not develop a full comparative picture of organisational performance and their own role in it. The trust has appointed its own Head of Performance, and is revising and refining data collection. It has established clear expectations of staff and managers for accurate, timely and comprehensive data recording. It uses performance information to identify anomalies, trends and patterns and enable corrective action and learning. There are helpful links between performance data and workforce development initiatives such as the new staff recognition scheme.

116. The pace of improvement has accelerated since the trust launched on 1 October 2015. In particular, the initial response to new referrals is now more secure than at the time of the last inspection. Overall, the quality of practice at the time of this inspection was mixed, with some good work but too much that was poor.

117. Very high and costly use of agency social workers and managers compromised the council's ability to recruit a stable workforce. The council recognised that improving recruitment and retention was central to improvement. Senior managers, including the Council DCS, took steps to address this, including the appointment of a workforce lead who ran three national campaigns to attract staff to what was soon to be the trust. Despite these efforts, agency rates remain worryingly high. The trust has an assertive and coherent plan for recruitment and retention. It is revising its relationship with recruitment agencies and is actively seeking to persuade good temporary staff to apply for permanent roles, with a small number of early successes. Its offer to staff includes comprehensive induction and continuing professional development frameworks. Training is available to agency staff, which is a strength. Most staff have caseloads that are manageable, though a small number were too large. There are arrangements in place with universities and independent organisations to help attract staff. Some staff told inspectors that their move to Slough or decision to stay was because of the trust arrangements. Although it is too early to know how successful the trust will be in establishing good-quality provision, it has made a solid start, prioritising workforce, performance management and the management oversight of practice. Inspectors are in broad agreement with the trust about the areas it should prioritise for improvement. (Recommendation)

118. Most existing staff and managers transferred to the trust, although there have been some significant changes in more senior roles. The trust has developed a clear offer to staff and managers that sets out both expectations and professional development opportunities and pathways. Senior trust leaders have invested time in keeping staff informed and there is extensive consultation about the future shape of the organisation. Social workers say that they are excited by the opportunity to work in the new organisation and that senior leaders in the trust listen to their views. Morale is good, which is crucial at this stage, and there is a clear sense of momentum.

119. The trust has opted to have a large number of heads of service initially to enable it to apply a high level of management oversight at senior levels. Case files now show clear evidence of first-line managers making decisions and there are in many cases clear rationales for them. This improvement has clearly accelerated since the trust took over services. Prior to that, while case files did show decisions, the reason for them was not made clear and they were not always acted upon. For example, in one case the failure to follow a management decision led to a seven-month delay in initiating the Public Law Outline.

120. In April 2015, the council introduced a new supervision policy. This established clear expectations and entitlements as well as links with performance frameworks and quality assurance. All social workers asked about supervision by inspectors report that it has been regular and of good quality, with improvements pre-dating the operational launch of the trust. However, supervision files seen do not reflect this. None of the supervision files that

inspectors saw reflected sustained good practice. There were long gaps between staff supervision meetings, actions identified in one meeting were not followed up in the next and there was little evidence of critical reflection and challenge. It is too early to say how effective the trust will be in improving and sustaining this but there are early signs of progress.

121. Trust leaders are consulting staff about possible new models of service delivery. They have a clear intention to move to a systemic model and are currently examining models in successful local authorities.

122. There are effective relationships with the family courts and the local Family Justice Board. The Designated Judge for Berkshire reports improvement in the quality of court work since the last inspection, with good social work statements and no undue delay. The local Children and Family Court Advisory and Support Service (Cafcass) manager describes working relationships between children's guardians and Slough staff as good. This includes the periods before and after the transition to the trust.

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The Local Safeguarding Children Board (LSCB)

The Local Safeguarding Children Board is inadequate

Executive summary

The LSCB has not made sufficient progress against the recommendations from the previous inspection in 2013. The independent chair has brought increased focus and challenge to work of the Board. However, the LSCB has not been sufficiently effective in scrutinising or challenging the significant weaknesses in the delivery of front-line services to children in need of help, protection and care. The poor engagement of some partners has been a barrier to progress. The LSCB has failed to strengthen the review of practice through case audits, has not ensured that thresholds are regularly reviewed and has not developed arrangements to evaluate and report on the experiences of children missing from care, home and education.

The threshold document is no longer compliant with statutory guidance and, significantly, does not reflect the current arrangements in place across the partnership. The Board has not reviewed the quality or effectiveness of threshold decision making.

Although some progress has been made by the LSCB in recent months in developing more effective arrangements to oversee and scrutinise data and audit front-line practice, it is yet to provide rigorous evaluation and analysis of local practice and performance.

The strategic child sexual exploitation subgroup has overseen some proactive work such as awareness raising with local businesses. However, overall, the Board has not been effective in reviewing front-line practice in response to children missing and those at risk of sexual exploitation. As a result, it has not assured itself that these children are effectively safeguarded.

The female genital mutilation task and finish subgroup has made good progress, for example in understanding prevalence, developing a draft strategy and pathways and undertaking an audit of cases.

The Board's training programme has not been formulated based on a needs analysis. Although there is good take-up of training, the Board has not evaluated impact or assured itself that training leads to improvements in practice and service delivery. There are no lay members on the LSCB currently and therefore it is not duly constituted.

The chair is actively seeking a sufficient multi-agency funding arrangement for the work of the Board, but to date a funding formula has not been agreed. This is required in order to ensure that the Board is able to deliver its core functions.

Recommendations

123. Revise and implement multi-agency threshold guidance and scrutinise the application of thresholds at all levels.

124. Establish a programme of effective monitoring and quality assurance of multi-agency safeguarding practice. This should include analysis of performance information, section 11 audits and internal partner agency audits, as well as multi-agency auditing led by the LSCB.

125. Take action to strengthen the LSCB's oversight and scrutiny of the effectiveness of the local multi-agency response to children at risk of sexual exploitation and children who go missing.

126. Develop and implement a funding agreement to ensure that the LSCB has sufficient resources to undertake its core business.

127. Undertake a training needs analysis and regularly evaluate the quality and impact of training (including e-learning).

128. Engage the wider community in the work of the LSCB by ensuring that the Board has lay member representation and thorough engagement with local faith groups.

Inspection findings – the Local Safeguarding Children Board

129. Appropriate governance arrangements are in place. Links between the LSCB, the Children and Young People's Partnership Board and the Health and Well-being Board are well established. The independent chair is a member of the Children and Young People's Partnership Board. The lead member for children's services is also chair of the Children and Young People's Partnership Board, as well as being a participating observer of the LSCB, which helps to ensure that safeguarding themes are aligned and key strategies communicated. The independent chair of the LSCB meets regularly with the DCS and the council's chief executive. These meetings have included the chief executive of the trust since its launch in October 2015.

130. Despite the appropriateness of the current governance arrangements, partnership working is undeveloped and has not been effective in ensuring sufficient scrutiny and oversight of safeguarding arrangements. The appointment of the independent chair in November 2014 was positive for the Board. However, overall, instability and change in staffing arrangements during 2014 had an adverse effect on the Board's ability to drive progress. This was exacerbated by frequent changes in key appointments across the partnership, particularly the DCS, the council's quality assurance manager and child sexual exploitation coordinator. Consequently, several subgroups have been unable to progress work, contributing to the difficulties the LSCB has experienced in establishing an understanding and analysis of local performance.

131. Partners have not consistently worked collaboratively or demonstrated a shared ownership of the improvement journey since the last inspection. The impact of this is the continued lack of progress in delivering key areas of work. There have been improvements in the level of challenge across the partnership but there is still more work to do to ensure that partners hold each other to account and share ownership of the safeguarding agenda. The independent chair has highlighted to partners that the Board is not sufficiently resourced given the scale of the improvement journey. The previously reduced police funding has been temporarily reinstated by the local police commander, but work is still needed to agree and develop a funding approach, which will enable the Board to deliver its core functions in the future.

132. The Executive Group's decision to dissolve the quality assurance subgroup in September 2014 weakened its ability to ensure effective oversight and analysis of front-line practice. This included a period at the start of 2015 when Berkshire Healthcare NHS Foundation Trust was the only partner submitting performance data and the LSCB undertook no effective performance monitoring. Since this time, all partners have provided the LSCB with performance information, but the quality of this is variable and analysis is not always included. This limits the Board's capacity to analyse what performance data mean for local vulnerable children and this important aspect of the Board's work is still in its infancy. No multi-agency auditing took place during 2014. Only a small number of cases were audited in 2015 and the Board has questioned the quality and reliability of those audits. Partners have not consistently submitted findings from their own internal audits to the LSCB despite requests from the independent chair. As a consequence, the LSCB has failed to fulfil its core statutory function of monitoring and evaluating the effectiveness of front-line practice.

133. In the context of these serious weaknesses, the Board's scrutiny could have been strengthened by using the findings of section 11 audits reviewed as part of the pan-Berkshire arrangement. LSCB partners across the six Berkshire areas provide assurances to a joint LSCB Berkshire-wide section 11 audit panel and subgroup on a three-yearly cycle. However, the feedback loop in respect of this function has not been sufficiently robust, and there has been no section 11 audit of the council for several years. More recently, the LSCB has refreshed planning in respect of section 11 requirements. Schools are currently submitting section 175 audits and the council is in the process of undertaking its audit, with a plan for the trust to complete one in 2016.

134. The independent chair has brought a much needed focus to the Board's performance function, ensuring agencies submit performance data and negotiating the reinstatement of the quality assurance subgroup in September 2015. Although in its infancy, this group provides the foundations for a stronger approach to the Board's scrutiny function in the future. The extent of the difficulties across the partnership at the start of the independent chair's tenure meant that these developments have taken time to achieve. As a result, the LSCB has experienced a considerable period without sufficiently monitoring and evaluating the effectiveness of arrangements to safeguard and promote the

welfare of children. For example, the LSCB still does not have a clear understanding of the extent of child sexual exploitation across the borough. While the child sexual exploitation strategy has been implemented, work to progress the action plan has been slow. The work of the child sexual exploitation subgroup has been hampered by changes in key personnel, and work to map cross-agency data and identify themes and hotspots has not progressed. Earlier in 2015, the LSCB completed a multi-agency audit; however, the sample was not representative and the LSCB does not have confidence in the audit methodology employed. Consequently, the quality or effectiveness of intervention for children and young people at risk of sexual exploitation is not understood.

135. The child sexual exploitation subgroup now operates separately to the sexual exploitation risk assessment conference process (SERAC), which oversees individual children's cases. Governance arrangements are now appropriate and are beginning to strengthen the oversight of child sexual exploitation at a strategic and operational level. However, during the transition period some important systems, processes and practice were not effective. This was exacerbated by periods when child sexual exploitation coordinator post was vacant.

136. The strategic sub group has overseen some proactive work by the licencing group. During 2014–15, this group undertook awareness-raising visits to hotels and bed and breakfasts across Slough, as well as visiting businesses, licenced and fast food premises under the banner of the 'say something if you see something campaign', to raise awareness of child sexual exploitation. In addition, the group ran a taxi driver campaign, with cabs displaying stickers regarding human trafficking. The work undertaken has been featured in a best practice article in an LGA publication.

137. The child sexual exploitation subgroup hosted a Slough LSCB multi-agency child sexual exploitation and female genital mutilation conference in 2014. Subsequent work in respect of female genital mutilation has been driven by the task and finish subgroup. This subgroup has made good progress carrying out scoping work to understand the prevalence of female genital mutilation, identifying potential hotspots, developing a strategy and pathways (currently in draft), as well as undertaking an audit of cases. The LSCB has made progress in moving the female genital mutilation agenda forward after some initial delay by the council. The council has now agreed to lead the next stage of work in implementing the strategy.

138. The LSCB does not understand the effectiveness of the operational response to children who go missing. Performance information relating to missing episodes is being scrutinised by the executive subgroup, but this has not yet resulted in a joined-up response. During 2015, the LSCB became aware that return home interviews were not taking place for all children missing from home or care. Although the LSCB has taken some action to assure itself that the arrangements to protect vulnerable children who go missing are effective, these

steps have not been sufficient. Since the trust came into effect, the trust's chief executive has highlighted to the LSCB that the response to missing children is a significant vulnerability and has put in place a robust action plan, including the need to ensure return home interviews are undertaken for all missing episodes.

139. The draft annual report presents a critical analysis of some aspects of the LSCB's work during 2014–15 has been discussed in public meetings of the Wellbeing Board and Scrutiny Committee but is slow to be published on the Board's website. The report explores key practice areas, but too little consideration is given to the evaluation of the effectiveness of front-line practice. For example, there has been insufficient analysis of the poor partnership response to missing children, particularly in respect of the absence of return home interviews. The revised business plan provides increased focus on core priorities.

140. The LSCB is not duly constituted following the recent resignation of the only lay member. The Board's engagement with the faith community is underdeveloped, as is the involvement of children and young people, and these combined shortfalls limit the LSCB's ability to engage with the wider community. The LSCB has a plan to address these shortfalls, including work to recruit two lay members. The independent chair has begun to engage with children and young people through the Children and Young Person's Partnership Board and plans to use the findings from a recent survey by young people to inform audit planning for the year ahead.

141. The LSCB has had oversight of the council's annual private fostering report. Despite efforts to raise awareness, private fostering notifications remain low. The LSCB has highlighted this as an area of concern and has satisfied itself that there is a plan in place across partner agencies to address this.

142. Multi-agency policies and procedures are commissioned through an online provider and updated through the pan-Berkshire policy and procedures subgroup. The procedures are currently being updated after some delays, due to the complexity of the Pan-Berkshire arrangement. Critically, the threshold document, although extensively rolled out across agencies in 2014, is no longer compliant with statutory guidance and does not reflect current arrangements across the partnership. Combined with the lack of evaluation of front-line practice, this is a key weakness, particularly given that inspectors identified that thresholds for statutory intervention and early help are not fully understood or consistently applied across the partnership. Although the Board has had some oversight of early help, the lack of multi-agency auditing means that it has not reviewed the quality or effectiveness of threshold decision making. This is a significant shortfall given that the need to ensure regular review of thresholds was a recommendation from the previous inspection in 2013.

143. The effectiveness of multi-agency training is not fully understood. A training programme is in place, but this is not yet driven by a training needs analysis. There is good take-up of multi-agency training, which is provided through a

pan-East Berkshire arrangement. This is evaluated at an individual level, but the lack of strategic evaluation of outcomes means that the LSCB is unable to fully understand the impact of the training it delivers. Completion rates of e-learning courses during 2014 were extremely poor (only 21% completed), but no work has been undertaken to address this weakness due to gaps in the capacity of training coordinators who support the Board. The Board recently hosted a well-attended conference with a focus on neglect.

144. The LSCB has initiated one serious case review in the last four years. This review is currently in progress after some delay due to the complexities of running alongside a mental health homicide review. One critical case review has taken place in the last year, which resulted in a learning lessons briefing to a small multi-agency group. A further critical case review, now underway, has been significantly delayed because the council had not provided a chronology. The serious case review subgroup has not been consistently effective in challenging concerns and needs strengthening to ensure that actions are progressed and that progress across the partnership is monitored consistently.

145. Effective arrangements are in place to review child deaths through the pan-Berkshire child death overview panel. The panel is appropriately constituted and well attended. The panel has undertaken some proactive work in seeking to reduce the incidence of preventable child deaths, including awareness-raising regarding safe sleeping; developing a viral wheeze and asthma website; a healthy eating campaign; and significant work in response to the high infant mortality due to genetic issues, which has resulted in a training programme being rolled out to all schools across the area.

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 eight of Her Majesty's Inspectors (HMI) from Ofsted.

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