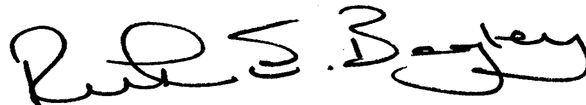
Date of issue: Tuesday 8th March 2016

MEETING	**EDUCATION AND CHILDREN'S SERVICES SCRUTINY PANEL** (Councillors Pantelic (Chair), Abe (Vice Chair), Bal, Brooker, Cheema, Dhillon, Matloob, Morris and Rana) **Education Voting Co-opted Members** James Welsh (Catholic Diocese of Northampton) **Education Non-Voting Co-opted Members** Jo Rockall (Secondary school teacher representative) Maggie Stacey (Head teacher representative) Lynda Bussley (Primary school representative)
DATE AND TIME:	WEDNESDAY, 16TH MARCH, 2016 AT 6.30 PM
VENUE:	VENUS SUITE 2, ST MARTINS PLACE, 51 BATH ROAD, SLOUGH, BERKSHIRE, SL1 3UF
SCRUTINY OFFICER: **(for all enquiries)**	DAVE GORDON 01753 875411

NOTICE OF MEETING

You are requested to attend the above Meeting at the time and date indicated to deal with the business set out in the following agenda.



RUTH BAGLEY
Chief Executive

AGENDA

PART 1

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	APOLOGIES FOR ABSENCE		
	CONSTITUTIONAL MATTERS		
1.	Declaration of Interest *All Members who believe they have a Disclosable Pecuniary or other Pecuniary or non pecuniary Interest in any matter to be considered at the meeting must declare that interest and, having regard to the circumstances described in Section 3 paragraphs 3.25 – 3.27 of the Councillors' Code of Conduct, leave the meeting while the matter is discussed, save for exercising any right to speak in accordance with Paragraph 3.28 of the Code.* *The Chair will ask Members to confirm that they do not have a declarable interest.* *All Members making a declaration will be required to complete a Declaration of Interests at Meetings form detailing the nature of their interest.*		
2.	Minutes of the Meeting held on 28th January 2016	1 - 8	
	SCRUTINY ISSUES		
3.	Member Questions *(An opportunity for Panel Members to ask questions of the relevant Director/ Assistant Director, relating to pertinent, topical issues affecting their Directorate – maximum of 10 minutes allocated).*		
4.	Ofsted - Inspection Of Services For Children In Need Of Help And Protection, Children Looked After And Care Leavers	9 - 60	
5.	Ofsted - Review Of The Effectiveness Of The Local Safeguarding Children Board	61 - 68	
6.	Tackling Child Sexual Exploitation In Slough - An Update	69 - 106	
	ITEMS FOR INFORMATION		
7.	Forward Work Programme	107 - 110	
8.	Attendance Record	111 - 112	
9.	Date of Next Meeting - 21st April 2016		

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AGENDA ITEM	REPORT TITLE	PAGE	WARD

Press and Public

You are welcome to attend this meeting which is open to the press and public, as an observer. You will however be asked to leave before the Committee considers any items in the Part II agenda. Please contact the Democratic Services Officer shown above for further details.

The Council allows the filming, recording and photographing at its meetings that are open to the public. Anyone proposing to film, record or take photographs of a meeting is requested to advise the Democratic Services Officer before the start of the meeting. Filming or recording must be overt and persons filming should not move around the meeting room whilst filming nor should they obstruct proceedings or the public from viewing the meeting. The use of flash photography, additional lighting or any non hand held devices, including tripods, will not be allowed unless this has been discussed with the Democratic Services Officer.

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Education and Children's Services Scrutiny Panel – Meeting held on Thursday, 28th January, 2016.

Present:- Councillors Abe (Vice-Chair, in the Chair at the outset), Pantelic (Chair from minute 29 onwards), Brooker, Cheema, Dhillon, Matloob, Morris, Rana, Rockall and Stacey

Education Non-Voting Co-opted Members

Jo Rockall (Secondary school teacher representative)
Maggie Stacey (Head teacher representative)

Apologies for Absence:- Councillor Bal

PART 1

28. Election of Chair

Cllr Brooker nominated Cllr Pantelic, and was seconded by Cllr Matloob. No other nominations were received.

Resolved: that Cllr Pantelic be appointed Chair of the Education and Children's Services Scrutiny Panel for the remainder of 2015 – 16.

29. Declaration of Interest

(At this point, Cllr Pantelic took the Chair of the meeting).

Cllr Brooker declared his daughter's previous attendance at Burnham Park Academy and his position as Governor at Churchmead School. Cllr Cheema declared her daughter's attendance at East Berkshire College.

30. Minutes of the Meeting held on 3rd December 2015

The following amendments were made to the minutes of the meeting held on 3rd December 2015:

- Page 5 – the reference in the final paragraph to 'SBC's Head of Director of Children's Services' to be amended to read 'SBC's Director of Children's Services'.
- Page 6 – the references in the second paragraph to 'equality and innovation' be amended to read 'improvement and innovation'. The sub group would receive additional funding from the Department for Education, rather than being entirely funded by DfE as implied by the minute.
- Page 7 – The Children's Services Trust would take over some aspects of Cambridge Education's work, rather than the work in its entirety.

Resolved: that, subject to the amendments above, the minutes of the meeting held on 3rd December 2015 be approved as an accurate record.

31. Membership of Panel

The ECS Scrutiny Panel noted that Cllr Bal had tendered his resignation as Chair. They also agreed that his personal circumstances were an extraordinary factor which needed due consideration.

Resolved: that, by unanimous agreement, Cllr Bal's position as a member of the Panel be continued.

32. Member Questions

The Members' questions were circulated. In response to the answers given, it was noted that Burnham Park had been reported as having a 35% rate of GCSE candidates with 5 A* - C grades (including mathematics and English). The ECS Scrutiny Panel requested further details as to how many Slough students sent to Burnham Park Academy and Churchmead School had put these institutions down as first choices, and how many had appealed the decision to send them there.

Resolved: that information regarding student preferences and schools admission appeals be provided for Members in relation to Burnham Park Academy and Churchmead School.

33. Private Finance Initiative Contract for Schools

The PFI contract was an arrangement where the contractor took the risk of designing, building, financing and operating the three schools' buildings. Value for money was recognised as a primary concern, given the length of the contract (30 years from its commencement in 2006) and this was addressed through effective contract management processes. Affordability could in theory be improved by reducing costs but PFI contracts were notoriously inflexible. The buildings were in effect paid for in a similar fashion to a mortgage, and funded by PFI Credits from the DfE, whilst the payments for the facilities management and other operational costs were index linked to inflation. All payments were consolidated in a Unitary Charge.

As a result, the ongoing cost consideration was the contracting of services. An intensive and tight specification was enforced by SBC, which could also use a deductions mechanism to reduce payments to service providers where services had not been provided in accordance with the contract. The Contract Manager held responsibility for this process. However, the length of the contract and the changes in local government funding which had occurred in that period could raise their own difficulties, especially given the relative absence of flexibility in the contract. One method of counteracting this was using the Council's procurement purchasing power to obtain economies of scale in, for example, the purchase of utilities supplies which would reduce the unitary charge. Thus far, SBC had pursued the relatively easier savings

and was now moving to the more challenging methods of reducing costs which would require difficult negotiations with the contractor; the contractor had protections in the contract that could limit these opportunities. The contractual process had caused SBC to pursue, initially at least, a less formal route as the best method of creating the environment for negotiating savings. Initial discussions had been held with equity holders as part of this process, and SBC would take an iterative approach to secure better terms.

In terms of refinancing, the overall cost of designing and building the 3 schools was approximately £45 million. Around 90% of this (£40 million) had been funded by the contractor as a bank loan at a fixed rate of interest. Given that the contract had been taken out prior to the credit crunch, traditional refinancing was not an option as the terms of lending were now more expensive. The debt could in theory be replaced with a Public Works Loan Board arrangement, but this had been investigated and the potential for savings was not deemed worth pursuing. Lower annual payments could be secured by extending the contract of the loan, but this would ultimately make the deal more expensive.

The Panel raised the following points in discussion:

- Top slicing from schools had been discussed, and would be a matter for SBC's Finance Team. However, such a move would require permission from the Schools Forum, who had yet to be asked to consent to this. The Schools Forum had agreed to a request for £200,000 to cover 2015 – 16's short fall in funding, but had concerns that this should not become a standard procedure.
- Should any of the 3 schools in question (Beechwood, Penn Wood and Arbour Vale) become academies, the schools would continue to make payments towards the Unitary Charge and terms would need to be agreed and reflected in a new legal document, a Schools Agreement, which would replace the current Governing Body Agreement. In particular, the school's contribution to contract management services would require clarification.
- The PFI arrangement involved a number of companies, and members expressed concerns that each of these would seek to make a profit and thus add costs to the process. The problems with the PFI model were acknowledged, hence its discontinuation in recent years for public building works.
- Changes to the contract (e.g. an increase in student numbers at one of the schools leading to a need for additional accommodation) would cause the contract to be varied in accordance with an agreed contractual mechanism. The cost would be negotiated at the time of the variation, so the Council would not be tied to the costs of the initial PFI deal, allowing the Council to deal with the potential issue of multiple layers of profit.
- SBC could propose a change of services in the contract, but the provider could veto such suggestions in certain circumstances. As a result, interests had to be balanced and relationships with partners had to be maintained.

- The PFI arrangements had passed over risks to the contractor and SBC would only need to put in place risk management strategies were it to take any of these risks back.
- Contractual obligations would remain with contractors (who would have to ensure the buildings met the same quality standards for the entirety of the contract) until 2036. A comprehensive specification existed in the contract, which was linked to the payment mechanism for non-delivery or unsatisfactory delivery of services.
- Schools bore the costs of energy consumption rather than SBC, and thus should be encouraged to ensure energy efficiency. SBC worked with schools to bring down such costs.
- Every 5 years a benchmarking process took place which could also market test services in certain circumstances. This would occur in the first half of 2017, and would return to the Panel at such a time as the Panel could have an impact on the process.

Resolved: that

1. The ECS Scrutiny Panel would receive a financial statement on schools and any possible top slicing of funding to cover short falls in PFI funding.
2. The ECS Scrutiny Panel receive a report on the benchmarking of services in 2016 – 17.
3. The ECS Scrutiny Panel’s support for increased value for money in PFI contractual arrangements be noted.

34. Assessment and Examination Results for 2014 / 15

The report presented the statistics for attainment in 2014 – 15, although some results had yet to be validated. More analysis was being provided on issues such as results broken down by ethnic grouping, students in receipt of free school meals and other similar issues. The progress of local schools in terms of Ofsted inspections was also reported, with Ofsted now focusing more on classroom activity than in previous years; in particular, the movement of schools out of special measures was welcomed. In addition, all areas of achievement were at or above national averages in local primary schools.

The Panel raised the following points in discussion:

- The gap for students with special educational needs in attainment was taken as their level of attainment as opposed to the overall average (e.g. 20% SEN students gaining 5 A* – C grade GCSEs, where the average was 70%, would be reported as a 50% gap). However, there could be issues with recording this accurately given the absence of standard categorisation of SEN across local authority areas.
- The gap at KS4 for SEN pupils had been reported as falling by 2%; however, the previous and current level of gap had not been reported. This could be provided for the Panel.
- Overall, future reports would be finessed to increase the level of analysis provided. Attainment in some key areas (e.g. 35% of early years pupils not achieving a ‘Good Level of Development’) needed

attention, and improving the ability to interrogate information would assist in this.

- Members also requested more information on Ofsted inspections. Issues such as recurrent themes or trends noted in inspections should be available through improved data analysis.
- Issues such as local students who had arrived in the area with English as a second or other language was not used by Ofsted in compiling national data. However, it could be taken into account when undertaking an inspection.
- The Panel also requested for a termly update on Ofsted inspections. In addition to these, a School Action Group report for any inspections by Her Majesty's Chief Inspector (HMCI) under Section 8 of the Education Act 2005 should be included.
- 2 schools which were now 'out of special measures' were in this position as they had become sponsored schools. As a result, these were exempt from the Ofsted system for 18 months.
- Beechwood School's percentage of GCSE candidates with 5 A* - C grades (including mathematics and English) was just over 40%. Their mathematics department had experienced major staffing issues; this had been resolved in September 2015, but Christmas had seen further staff departures. Other schools were offering support to the institution to assist.
- Information Technology had experienced a major shortage of teaching staff. In particular, the recent move to incorporate more coding skills in the curriculum had made recruitment difficult.
- Research into the recruitment and retention of secondary teachers was ongoing and was investigating barriers to working in Slough as part of its remit. The preliminary findings had been completed and published, with the full findings available in approximately 3 – 4 months once interviews had been concluded. In particular, increasing Slough's presence on social media to improve its profile was being investigated; meanwhile, SBC had discussed using key worker housing to improve the situation.

Resolved: that

1. The first termly report on Ofsted inspections should be commissioned and added to the Panel's agenda.
2. The Chair would pursue SBC's progress on using key worker housing to improve teacher recruitment and retention and report the findings to co-opted members.

35. Five Year Plan Outcome 5

The report covered the last 6 months and the alteration of services which had arisen from the creation of the Slough Children's Services Trust (SCST). The work to create a Multi-Agency Safeguarding Hub (MASH) was ongoing, with its completion due in Summer 2016. The Children and Young People's Partnership Board now had a new partnership plan and new sub groups.

Work on quality assurance and auditing of children's social care cases had been the subject of significant efforts. Specific training had been given to social workers on creating SMART plans for cases and also on legal planning. On child sexual exploitation, work was ongoing and included efforts to improve the communications between partner organisations; a report on this would be taken by the Panel at its next meeting. The pressure on school places was an ongoing difficulty, and was being resolved through measures such as bulge classes.

In 2016, the focus of work would be on the areas where it would have the greatest immediate impact. SBC was offering support to SCST to ensure the best results, with the joint meeting of the Panel and Overview and Scrutiny Committee on 12th January 2016 part of this. The meeting had taken a report detailing the findings of SCST's initial audit of services, and those present had pledged their efforts to work alongside SCST. It was now acknowledged that corporate parenting had to improve, with a review of the area having started.

A sub group on female genital mutilation would be led by SBC, holding its first meeting on 9th February 2016. This meeting would agree the strategy and raise awareness of the issue.

As the Cambridge Education contract ended, SCST would take on several aspects of its work. However, school improvement, admissions and other areas would require continued consideration on delivery.

The Panel raised the following points in discussion:

- Children and adolescent mental health services were experiencing long waits for referrals to receive treatment. Work was being undertaken by the Public Health Team to reduce these waiting times, but the fact that the service covered all of Berkshire limited the role of SBC in this. However, the progress on this could be shared with the Panel at a future meeting.
- Whilst changes in SBC's approach to issues of safeguarding had been noted, more efforts were requested. For example, whilst licensing had taken on training taxi drivers on CSE, the extension of this in light of recent lapses in licensed hotels caused concern. In addition, some Members reported the need for more work to ensure that Councillors were covered by up-to-date DBS checks. A report on CSE would be presented to the Slough Local Children's Safeguarding Board (SLSCB) on 11th February 2016, but SBC acknowledged that the lack of information on the matter limited its knowledge on the local situation.
- Members requested 'golden threads' to run through SBC strategy'; for example, concerns were raised over the leisure strategy being aimed at over 14s. However, Members also expressed support for the presence of such consistent themes in the report.
- 17th February 2016 would see the Ofsted report on Children's Services and SLSCB published. SCST, SBC and SLSCB would all attend the next meeting on 16th March 2016 to discuss this with the Panel.
-

Resolved: that

1. The Panel discuss a report on child sexual exploitation on 16th March 2016.
2. The Panel receive a report on looked after children on 16th March 2016.
3. The Panel receive a report on CAMHS level 2 at a future meeting.
4. The Panel receive a report on 2016 milestones at a future meeting.
5. Members should contact Group Offices regarding the completion of DBS checks.

36. Forward Work Programme

Resolved: that, in addition to the resolutions in previous agenda items, the following changes be made:

- The report on SEND services be moved to 13th April 2016.
- The report on Cambridge Education be moved to 13th April 2016.
- The report on teacher recruitment and retention be moved to the first meeting of 2016 – 17.
- The report on the external auditor's report on Slough schools be delayed until clear guidance is given on expected input from the Panel.
- The items scheduled for 13th April 2016 on the published work programme be deferred until 2016 – 17.

37. Attendance Record

Resolved: that the attendance record be noted.

38. Date of Next Meeting - 9th March 2016

Members were reminded that, since the publication of the agenda, this meeting had been moved to 16th March 2016.

Chair

(Note: The Meeting opened at 6.30 pm and closed at 8.25 pm)

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AGENDA ITEM 4

SLOUGH BOROUGH COUNCIL

REPORT TO:	Education & Children's Services Scrutiny Panel
DATE:	16 March 2016
CONTACT OFFICER: **(For all enquiries)**	Krutika Pau (Interim Director of Children's Services) (01753) 875 751
WARD(S):	All

PART I
FOR SCRUTINY

OFSTED INSPECTION OF SERVICES FOR CHILDREN IN NEED OF HELP AND PROTECTION, CHILDREN LOOKED AFTER AND CARE LEAVERS

(November – December 2015)

1 Purpose of Report

1.1 To set out the outcome of the recent Ofsted inspection report published on 17th February 2016 and plans for ensuring improvements are made in the experiences and progress of our most vulnerable children.

2 Recommendations

2.1 That the Education & Children's Services Scrutiny Panel

a) Scrutinise and comment on the detail contained within the Ofsted report
b) Scrutinise and comment on the governance arrangements as set out in paragraphs 5.8 to 5.13, for improvements to service delivery.
c) Scrutinise and comment on the Council's plans for service improvement as set out in paragraph 5.14

3. The Slough Joint Wellbeing Strategy, the JSNA and the Five Year Plan

3a. Slough Joint Wellbeing Strategy Priorities

Priorities:

- Safer Communities
  - Carrying out the statutory role of the local authority to provide services for children in need, to safeguard them and look after children whose parents are unable to do so.

3b. **Five Year Plan Outcomes**

Outcome 5: Children and young people in Slough will be healthy, resilient and have positive life chances
The establishment of the Slough Children's Services Trust aims to make Slough children's services one of the best providers of children's social care in the country, providing timely, purposeful support that brings safe, lasting and positive change.

4 **Other Implications**

(f) Financial

There are no financial implications specific to the recommendations in this report.

(g) Risk Management

There are no specific risks associated with this report.

(h) Human Rights Act and Other Legal Implications

In September 2015, the Secretary of State issued a Direction transferring various children's services to Slough Children's Services Trust ('the Trust). Although the Trust performs services on behalf of Slough Borough Council, the Council retains all its legal obligations for the statutory duties.

On 30 September 2015, the Council entered into a contract with the Trust governing the provision of services by the Trust. The contract with the Trust contains various monitoring powers so that the Council can assure itself that vulnerable children in the borough are receiving the best support possible.

(i) Equalities Impact Assessment

There is no identified need for the completion of an EIA in relation to this report.

5 **Background**

5.1 The four week inspection of services for children in need of help and protection, children looked after and care leavers took place in November and December 2015. Services delivered by Slough Borough Council and the Slough Children's Services Trust were within the scope of the inspection. The report also comments on the contribution of partners, in particular the local police and health services, to the experience and progress made by vulnerable children.

5.2 The full Ofsted report, published on the 17 February 2016, is attached as Appendix A. The Director of Children's Services and the Chief Executive of Slough Children's Services Trust provided a briefing for all members of the council on the day of publication. The report found children's services in Slough to be 'inadequate'.

- Services for children in need of help and protection – **inadequate**
- Children looked after and achieving permanence – **inadequate**
- Adoption performance – **requires improvement**
- Experiences and progress of care leavers – **inadequate**
- Leadership, management and governance – **inadequate**

5.3 This is the third report which has rated Slough Borough Council as inadequate in its provision of services to vulnerable children in the borough. Following the inadequate rating in 2013, the DfE put in place new arrangements to transfer children's services from the council to Slough Children's Services Trust.

5.4 A children's commissioner was appointed by the DfE to secure improvement and oversee the change to the Trust, which took over from the council on 1 October 2015.The council remains under DfE direction and the children's commissioner remains in place. The Ofsted inspection took place between 23 November and 17 December 2015. Due to the timing of the inspection the report largely comments on the quality of services before they were transferred to the Trust.

5.5 The report recognised that some improvements had been made over the past two years (since the last inspection) however; the changes have not been fast or wide ranging enough to improve the experiences of children sufficiently. The inspection report also acknowledges that 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 seethe impact of this for children. The report reflects the findings of the baseline audit undertaken by the Trust during October 2016 and shared with joint Overview & Scrutiny Committee and Education & Children's Services Panel held on12th January 2015.

5.6 The Ofsted report highlighted some areas of improvement since the last inspection in 2013

- Social work caseloads have reduced.
- Newly qualified social workers are better supported.
- Young People's Service has undertaken effective work with care leavers
- Adoptions are matched quickly with good permanent families.
- When care proceedings commence, they are well managed.
- Prevent partnership is developing well.
- Quality of assessments has improved.

5.7 However, there were many areas of concern, including:

- The trajectory of improvement has been too shallow and the pace too slow
- In some cases children left for too long in situations of risk
- Insufficient services to meet needs of children
- Disjointed service for care leavers
- Council leaders have not been proactive or aspirational enough
- Council has not been a good corporate parent
- Ineffective Virtual School
- CSE/missing children
- Ineffective partnerships
- Continuing high number of agency staff

Governance and accountability for improvements to service delivery

5.8 The outcome of the Ofsted inspection will require considerable action by the Trust, Council and the LSCB to address the identified failings in the service within rapid timescales. Given this, all parties recognise the need for robust accountability arrangements to oversee improvement progress. This will require consideration of

how to achieve this in the context of the agreed arrangements for governance and performance monitoring in the contract between the Trust and the Council to ensure that duplication of reporting and excessive meeting schedules are avoided.

5.9 The commissioner appointed by the Secretary of State is required by the Direction to ensure that services specified in the Direction are delivered to the required standard, and to report back to the Minister on this. The Council and the Trust will need to work collaboratively and positively together if services are to improve and outcomes for the most vulnerable children in Slough also improve rapidly. The Trust will be responsible for responding to the majority of the recommendations from Ofsted as they relate to the quality of practise and experience of children in the system. However, the contribution of the wider partnership is critical to how the Trust can deliver those improvements rapidly.

5.10 The Trust Board is responsible for over-seeing the development of services it is delivering. The Board meets monthly and has established a Quality and Innovation Committee which will also meet monthly between Board meetings and will focus on detailed service development and performance monitoring.

5.11 There is a formal contract between the Council and Slough Children's Services Trust which clearly sets out the key outcomes for delivery. This includes 33 KPI's and targets for these will be agreed between the Council and the Trust based on the findings of the baseline diagnostic undertaken by the Trust and the recent Ofsted report. The contract between the Council and the Trust is monitored through the Strategic Monitoring Board (SMB) which meets on a monthly basis. In addition the contract requires the Trust to report to members at least four times a year.

5.12 When an authority is judged 'inadequate' the DFE often require the establishment of a Children's Improvement Board, led by a DFE appointed chair. However, in Slough due to the recent establishment of the Slough Children's Services Trust and the continuing role of the Commissioner an Improvement Board would not be appropriate.

5.13 The commissioner, the Council and the Trust have agreed alternative arrangements for the oversight of the improvement agenda. It has been agreed that following the monthly SMB, the Commissioner will chair a meeting, where the Council and the Trust and less frequently the LSCB, will present the progress being made in line with each organisations improvement Delivery Plan. The DFE will also be represented at this meeting. The Director of Children's Services will provide regular reports to Education and Children's Services Scrutiny Panel on the progress being made by the Trust, the Council, and the LSCB to improve outcomes, for the most vulnerable children in Slough.

5.14 The Council has already started work on making improvements in the following areas of delivery:

- To take action to fulfil its corporate parenting responsibilities effectively.
- To ensure all parts of the Council and in particular the Young People's Service, public health and housing, contribute as required to improving outcomes for vulnerable children.
- To review LSCB arrangements and work with the chair to ensure improvements are made to the functioning of the Board.
- To review and improve the scrutiny of children's services.

- To actively support the LSCB commitment to improve services for children at risk of child sexual exploitation.

5.15 A detailed delivery plan under each of these 5 headings has been developed and will be subject to an internal project management structure.

6 **Appendix**

A - Ofsted Report: 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 (24 November – 17 December 2015)

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Ofsted

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

Report published: 17 February 2016

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

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

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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.

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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.

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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.

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.

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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.

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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.

Ofsted

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.

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.

The inspection team

Lead inspector: Stephanie Murray

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SLOUGH BOROUGH COUNCIL

REPORT TO: Education & Children's Services Scrutiny Panel

DATE: 16 March 2016

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WARD(S): All

PART I

FOR COMMENT & CONSIDERATION

OFSTED – REVIEW OF THE EFFECTIVENESS OF THE LOCAL SAFEGUARDING CHILDREN BOARD

Inspection date: 24 November 2015 - 17 December 2015
Report published: 17 February 2016

1. Purpose of Report

To update the Education And Children's Services (ECS) Scrutiny Panel on Slough Local Safeguarding Children's Board (SLSCB)'s Ofsted Inspection held between November and December 2015 and the LSCB's intended actions to address all recommendations.

SLSCB coordinates the safeguarding work of the individual agencies and monitors and challenges agencies' progress on improving child protection.

2. Recommendation(s)/Proposed Action

The ECS Scrutiny Panel is recommended to take the following actions:

a) That the Panel discusses the report and note the intentions of SLSCB to agree and implement a plan for improvement which will achieve the Ofsted recommendations.

b) During the summer, SLSCB will produce an Annual Report for 2015-16 and it is suggested that this is discussed at a scrutiny panel meeting during Autumn 2016, when the Panel could also receive a report on the progress of SLSCB at that time.

c) Panel members to receive a copy of the agreed SLSCB Business Plan for 2016 -17 outside of the Panel meetings and respond individually to the Chair of SLSCB as appropriate.

3. The Slough Joint Wellbeing Strategy, the JSNA and the Five Year Plan

3a. Slough Joint Wellbeing Strategy Priorities

The recommendations from the Ofsted Inspection and SLSCB's intended actions indirectly impact across several priorities of the Slough Wellbeing Strategy, however; they particularly challenge and contribute to the 'Health' and 'Safer Communities' priorities.

3b. Five Year Plan Outcomes

The SLSCB work supports specific delivery and challenges the Wellbeing Board's progress against the following Five Year Plan outcomes:

- Slough will be one of the safest places in the Thames Valley
- Children and young people in Slough will be healthy, resilient and have positive life chances

4. Other Implications

(a) Financial

Whilst there are no financial implications for the Panel, the Ofsted report highlights the lack of a robust financial arrangement for funding SLSCB. Similar comments have been made by Ofsted during recent inspections of other LSCBs in Berkshire. The partnership needs to develop a more consistent method of partner financial contribution to ensure its effectiveness in the long term.

(b) Risk Management

An effective LSCB provides oversight, support and challenge for services of the Council, its providers and partners. If effective, it is therefore a way of controlling risks that Council services might be insufficiently effective for local children and families.

As LSCBs are partnership bodies, there is a reputational risk for all statutory members of the partnership in having an ineffective LSCB. This is most significant for Slough Borough Council (SBC) as it is the organisation charged with establishing the LSCB and the inspection report for the Board is embedded within the SBC Children's Services Ofsted Inspection report.

The SLSCB Business Plan (2016-17) is being structured to meet the specific risks that have been identified from the recent Ofsted Inspection. By this means it is anticipated that the above risks will be reduced.

(c) Human Rights Act and Other Legal Implications

There are no Human Rights Act Implications of proposed action although the work of the Board contributes to a number of Human Rights such as the right to family life.

(d) Equalities Impact Assessment

There is no requirement for an EIA attached to the proposed action, however the Panel should note the recommendation of Ofsted regarding lay membership of the Board (see below).

5. **Supporting Information**

5.1 Ofsted reviewed the effectiveness of the Slough Local Safeguarding Children Board between 24 November 2015 - 17 December 2015. Its findings, which are incorporated in the SBC Children's Services Ofsted report published on 17 February 2016 (page 38 onwards) and the overall finding was 'Inadequate'.

5.2 Ofsted summarised its findings as:

"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. "

5.3 In addition to its criticism, Ofsted recognised the good work the Board has achieved, particularly in reviewing the deaths of children and its progress on the risks of children being subjected to Female Genital Mutilation (FGM). This shows that partnership work for Slough can work effectively and that it is possible to work with neighbouring areas to achieve improvement.

5.4 The report makes six recommendations for improvement which are set out below. In order to prioritise the recommendations in its work, the Board has agreed to use the six recommendations as the themes around which the 2016-17 SLSCB Business Plan is being structured. The detailed actions and draft timescales are being discussed at the Board on 17 March 2016 for finalisation but key activities are set out below against each theme .

5.5 At the SLSCB meeting there will also be a facilitated development discussion to identify new ways for Board members to work to achieve stronger outcomes. This will include ensuring that activity between meetings is more dynamic. Such a discussion is key to the Board moving forward so that its members have a culture of challenge and improvement which will impact on all aspects of its work, not merely the Ofsted findings. As the draft plan has yet to be agreed it is not provided to the Panel on 16 March 2016, but once agreed it can be circulated to members for their consideration. Any comments or feedback from Panel members at that time will be fully considered by the Board.

The key themes and actions of the SLSCB draft plan are as follows:

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

Actions:

- SLSCB is already revising its Threshold Document to reflect the requirements of statutory guidance.
- The document will be disseminated to all professionals to ensure it is used within their daily practice.
- The LSCB will request a monitoring report to establish the extent to which the Threshold Document is being appropriately applied and respond to any weaknesses identified within the report(s).
- The LSCB will carry out a multi agency audit of cases, examining referrals and initial response to test practice against the agreed approach.

5.7 ***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.***

*(*Section 11 of the Children's Act sets out standards for all statutory partners to achieve if they are to be effective at safeguarding)

Actions:

The Quality Audit Group of SLSCB was already undertaking a multi-agency audit of domestic abuse cases at the time of the Ofsted visit. The report from this audit together with draft actions to improve any areas of weakness in partners work should be received by the Board on 17 March 2016. The SLSCB Admin Unit are putting in place a tracking system to ensure that actions from audits are delivered and any delays are addressed. The 2016-17 Business Plan will include a draft plan for future multi-agency audits.

The Executive of the Board is receiving basic performance information from partners and discussing it. Once the Children's Trust has embedded its own performance management framework, the Trust's Chief Executive has agreed to provide analyst time to SLSCB so that its performance framework can be improved.

SLSCB already works with other Pan-Berkshire Boards to receive Section 11 self-assessments from organisations which provide services across more than one local authority and to discuss them in a Pan Berkshire panel. However, the inspectors identified that this process was not followed up by discussion of any improvement plans in SLSCB meetings and therefore some partners were not aware of the issues. In future the Pan-Berkshire work will be brought to SLSCB meetings.

The inspectors were critical of the Council for not carrying out a self-assessment against Section 11 standards. This had already been addressed by the Board before the inspection and SBC had started a self-assessment of its services. It is anticipated that the results of this will be discussed by the Board in June 2016. The Council has been asked to establish a process for requiring organisations it commissions to also provide regular assurance against the standards.

SLSCB will ensure it provides feedback and challenge to organisations in response to pertinent Section 11 audits.

SLSCB is specifying that all auditing and evaluation reports from partners include analysis of how children are 'heard' in the cases they examine and how this is improving service delivery and outcomes for children.

5.8 ***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.***

This recommendation is closely aligned to the comments in the Children's Services part of the Ofsted report. The Board's role is to oversee progress on Sexual Exploitation and missing Children effectively.

Actions:

At its February 2016 SLSCB Executive meeting, partners agreed to establish a joint operational team to address sexual exploitation and missing cases, similar to the ‘Operation Kingfisher’ team which exists in Buckinghamshire.

SLCSB is requesting clear and relevant data to assure it that strategic coordination of responses to missing children and those at risk of CSE are effective.

An updated CSE and Missing Strategy and Action Plan have been drafted and is to be discussed at the SLSCB Board.

The LSCB Quality Assurance Sub Committee will audit the impact of CSE training and performance in a selection of operational cases during the year.

Slough LSCB is committed to the recently established Pan Berkshire CSE Sub Committee and ensuring appropriate representation.

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

Actions:

Slough LSCB Executive members have discussed partner contributions and are awaiting the National Review of LSCBs which is considering whether there should be a national formula for funding LSCBs. Subject to the outcome of that review, the LSCB will look to establish a longer term funding proposal for the future.

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

Actions:

The Board is working with other Boards to ensure a suitable Training Needs Analysis (TNA) format is available and supporting partner organisations’ to complete the return.

In response to the training needs analysis, a review of the provision of multi-agency training will take place so that future programmes can fulfil those needs. This will include a review of the current approach to e-learning.

SLSCB will ensure the evaluation of training delivery and its impact takes place and is routinely embedded within training practice.

SLSCB will receive relevant reports summarising course evaluation; data analysis and outcomes of related audits to inform future development of the training programme.

5.11 ***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.***

Actions:

The Board ran with one rather than two lay members for over a year. A recruitment process for the second lay member was put in place during the summer of 2015 and interviews were arranged for October. The existing lay member resigned shortly before the interviews took place and therefore we were seeking to recruit two new lay members. This would have brought us up to the level expected by Ofsted. Unfortunately none of the candidates successfully completed the interview process and therefore, when Ofsted visited, the Board had no serving lay members. Understandably they commented on this in their report.

The Board has discussed alternative ways of finding new lay members and has agreed to second one member from local faith communities and a second from the student community of the local college. We are also expecting an interim report of the National Review of Safeguarding Children's Boards this month which may change the expectations of lay members in Safeguarding Boards. The Board will be taking that into account as we go forward.

SLSCB will revise its website to reflect current work and initiatives which are available to access by all members of the community.

6. Comments of Other Committees

To date, this report has not been presented to any other committee.

7. Conclusion and Recommendation

The Ofsted grading of ‘Inadequate’ for the Board is disappointing but a fair reflection on the year leading up to December 2015 when Ofsted visited. The year was a very challenging one for the Board. However, since Slough Children’s Services Trust started in October, partners are much clearer about how services will be delivered and there is new enthusiasm from all Board members to improve its work.

The longer term development of the Board is likely to be affected by the national work fundamentally reviewing the role of LSCBs which is due to report in late March. In improving its competency the Board needs to be prepared to seize any opportunities which that review may bring.

8. Appendices Attached

Please refer to Appendix 1 for agenda item 4, agenda pages 52 - 57.

9. Background Papers

None

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Slough Children's Services Trust
www.scstrust.co.uk

TACKLING CHILD SEXUAL EXPLOITATION IN SLOUGH – AN UPDATE

Meeting	Education and Children's Services Scrutiny Committee
Date	Wednesday 16 March 2016
Author	Robina Khan, Interim Head of Safeguarding and Operations

1 Introduction

1.1 The purpose of this report is to update the Education and Children's Services Scrutiny Committee on the plans to develop a multi-agency Child Sexual Exploitation (CSE) team in Slough. In addition, this report sets out the newly revised draft CSE Strategy and Action Plan for delivering on improvements to tackling CSE in Slough.

2 Recommendations

2.1 That the Committee note the progress made in the review of CSE and to support the proposal to tackle CSE in Slough through the development of a multi-agency CSE team to enable an effective and robust response.

2.2 That the Committee note the revised draft CSE Strategy and Action Plan and the new draft Missing Children Strategy and Action plan. These plans are in draft and are to be finalised by the LSCB.

CHILD SEXUAL EXPLOITATION UPDATE

1 Purpose of report

1.1 The purpose of this report is update the Education and Children's Services Scrutiny Committee on the establishment of a multi-agency CSE team to enable a more robust response to CSE, trafficking and missing children.

The CSE multi-agency team will provide the following:

- A single point of contact for all CSE concerns – linked to a robust and effective MASH/Front door service.
- Timely response to all children reported missing as well as robust monitoring of absences.
- Timely provision of effective support for all children;
  - who have been reported absent or missing and intelligence sharing with police in order for the disruption of CSE in Slough to be more effective
  - where trafficking has been highlighted as a concern
  - where gang involvement has been highlighted as a concern
- Ensuring guidance is provided to staff around CSE issues and ensure that the risk management plans are reflected in the children's individual plans.
- Regular auditing and CSE self-assessment.

1.2 The interim CSE Co-ordinator has also led the development of a refreshed CSE Strategy and Action Plan. These have been presented to the CSE subgroup of the LSCB on the 2nd March. The strategy sets out the priorities for 2015-17 and the action plan details both timescales and responsible agencies for progressing the plans. The draft Missing Children Strategy and Action Plans are attached as appendix 3 and 4 for information. We have set a deadline of 8th March for members of the sub group to reply with any final amendments. The draft will then go to the SLSCB on 17th March.

2 Background

2.1 Slough Childrens Services Trust identified as an early priority that there was an urgent need to significantly improve the response to CSE and missing children in Slough. A fulltime CSE Co-ordinator was appointed by the Trust and funded by the Safer Slough Partnership until the end of December 2015 when the funding came to an end. The Trust has continued to fund this post but this is a temporary arrangement and is due to finish at the end of March 2016.

2.2 On the 11 February 2016 the LSCB Executive agreed and committed to the establishment of a new multi agency CSE team for Slough. This was

a model that had been successful in Oxfordshire and known as the Kingfisher model. The LSCB have agreed:

- Thames Valley Police will lead this project, which will cover a two year period as a minimum.
- The Trust will fund a CSE and Missing Lead Manager post to manage the team.
- The Trust will contribute and fund two social workers to specialise in CSE within the team.
- The Young People's service, Slough Borough Council will second a CSE Youth Worker.
- Health services will be explored to assist the team including access to sexual health staff resources and school nursing services.
- Links with Education Attendance Officers to be strengthened to ensure that attendance information as education status of all children at risk of CSE is shared and reviewed on a regular basis.

2.3 Drawing on Council resources and Safer Slough Partnership funding, the Council has agreed to recruit a CSE coordinator with effect from 1st April 2016. This appointment will be for a minimum of 2 years and the recruitment process is to begin imminently. The Council and the Trust have agreed to jointly fund the interim CSE coordinator whilst the recruitment process is underway. This is a separate role from the CSE and Missing lead manager role. The CSE coordinator will provide strategic leadership and support and coordinate the delivery of the CSE strategy and action plan

3 Current Arrangements

3.1 From 26 October 2015, the Trust implemented return home interviews for young people who have been reported missing or absent. All children reported missing from Slough now receive an independent return home interview undertaken by Young People's Services. There is however a gap in the service provided i.e.:

- 1:1 work is not always completed with children to address the missing/ absent occurrences – particularly where it is not clear whether this is linked to CSE, gang involvement or trafficking.
- Completion of return home interviews for children placed out of borough are currently completed by social workers who are not always in a position to undertake these in a timely way and are not independent (a requirement of statutory guidance). The Trust has commissioned the National Youth Advocacy Service (NYAS) to address this gap and this should be available in the new financial year.
- Where CSE concerns have been raised about children placed out of borough, there is currently no service providing 1:1 work with the children. Again NYAS will provide for this group of children and work alongside the CSE team.

3.4 The CSE multi-agency team will ensure that all return home interviews

for children in Slough and Looked after Children (LAC) placed out of borough are completed. Where CSE has been identified as a concern, CSE risk indicator tools will be completed and the case presented to Sexual Exploitation Risk Assessment Conference (SERAC) panel or panels in respective local authorities where the children are placed.

3.5 The LSCB Sub-Group has overseen the review of the CSE Strategy and Action Plan as well as development of the Missing Strategy and Action Plan (appendix 3 and 4). These are due to be presented before the LSCB Executive on 21 April 2016.

4 Benefits of the CSE Multi-Agency Team

4.1

- Creating a single point of contact for all CSE concerns to enable increased transparency and consistence in responding to concerns.
- The use and harnessing of existing resources within the Trust and the Borough Council without significantly altering the existing staffing structure.
- Improved outcomes for children.
- Improved seamless transition and continuity of support and help to children at risk of CSE.
- Timely CSE risk assessments (evidencing clear level and nature of risk) completed alongside social work staff.
- Timely intervention where CSE concerns have been identified for children and their families.
- Completion of evidence based CSE risk indicator tools and intelligence shared with police to increase disruption chances.
- Where return home interviews have highlighted concerns, 1:1 work completed with children to reduce missing / absence incidents – this includes children placed out of borough and children not open to Slough Children's Services Trust.
- Improved recording and management information reports.
- Timely presentation of cases at SERAC panels and improved profiling of CSE problem to ensure that models of CSE, patterns and trends are clear in Slough.
- Regular audits to measure impact and highlight areas of improvement in order to reduce prevalence of CSE in Slough.

4.2 Risks and other considerations to be made

- There is further work to be done around supporting survivors of CSE and identifying the most effective way to secure therapeutic interventions. The CSE Co-ordinator will work with agencies in particular Community and Mental Health Service (CAMHS) and voluntary agencies such as Barnardo's who offer a specialist therapeutic service to assess what is required in Slough.
- The recent Ofsted has set out the need for agencies in Slough to provide a better response to CSE as a shared priority. It is clear

that all agencies are under a great deal of budgetary pressures but this is an area that if agencies work together can make a real difference to children and young people in Slough.

5 Project Management Approach

A formal project management approach will be adopted to increase visibility of the CSE work and the decision making process. This means the project will be managed against a clear documented project plan; there will be a communications plan to ensure all stakeholders are kept up to date and a shared and open risk and issues log. The Project Board will meet and agree to review and sign off key deliverables and approve progression to the next stage of the project. This project will run for 18 months subject to review. The project structure will be very flexible to ensure the relevant resources are brought together when they are needed. The evaluation will focus on impact of CSE project Team and inform a longer term sustainable model. This will include monitoring individual children, impact on outcomes and reduce risk.

6 Report conclusions

6.1 The establishment of a specialist multi-agency CSE team in Slough demonstrates agencies' commitment to ensuring our most vulnerable children and young people are protected. It also sends out a clear message that Slough will not tolerate such abuse and that perpetrators will be sought out and prosecuted.

8 Appendices

8.1

- Appendix 1 CSE Strategy and Action Plan (draft)
- Appendix 2 LSCB CSE Action Plan (draft)
- Appendix 3 Missing Strategy (draft)
- Appendix 4 Missing Action plan (draft)

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APPENDIX 1

Slough CSE & Trafficking Strategic Action Plan 2015 – 2017

This Strategic Plan must be read alongside the The SLSCB Multi-Agency CSE Strategy, Multi-Agency Missing Strategy and Action Plan

Key Strategic Priority: Identify

- Develop a comprehensive and accurate 'Problem Profile' to enable identification of locations and individuals or groups who sexually exploit, whilst timely identifying children's vulnerability indicators in order to provide a responsive multi-agency approach
- Ensure that all incidences of children missing from Missing from Home, School, Care or from the sight of Universal Services are reported to police

How we will do it	Who will be responsible	How we will know the action has been completed effectively	Timescale for completion	RAG Rating
Taking decisive action to ensure that the local extent of child sexual exploitation and trafficking is known and understood and that intelligence information is used proactively to inform risk management and disruption activities.	CSE Coordinator/ Young People's Services Education Services	Up to date CSE Tracker Strategy Meeting Records Quarterly monitoring and progress reports to the CSE & Trafficking Strategic Group Up to date CSE Network chart Monthly CSE audit reports	31/03/2016	
Identifying suspected and known perpetrators through SERAC Panel, CSE Panel, CSE Champion meetings, and Strategy meetings.	Children's Social Care	Up to date CSE Tracker SERAC Panel Minutes Updated CSE Network chart	31/03/2016	
Ensure that any intelligence regarding suspected adults is shared with Police. Multi-agency CSE Training including how to share intelligence with Police.	All Agencies Social Workers, Team managers, TFS, YPS Thames Valley Police	Quarterly reports from Police intelligence informing whether intelligence is shared or not Training Impact and Progress Reports	31/01/2016	

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Key Strategic Priority: Identify cont'd

How we will do it	Who will be responsible	How we will know the action has been completed effectively	Timescale for completion	RAG Rating
Ensuring an effective single point of contact for all CSE referrals and missing children. This should be aligned with the Multi-Agency Safeguarding (MASH) soon to be in place	Head of First Contact, Assessment and Children in Need	MASH in place with all agencies signing up to it Management Information Reports	31/03/2016	

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Key Strategic Priority: Prevent

- Raise awareness of the issue through education and training and provision of early help to prevent exploitation, trafficking and missing from home or care incidences.
- Reducing numbers subject to CSE, trafficking and/or running away through 1:1 work with children.
- Identifying and engaging with groups of children and young people who are potentially at a high risk of being exploited
- Being tenacious about ensuring that all children who go missing from home or care are offered timely return home interviews that properly explore and address risk and need

How we will do it	Who will be responsible	How we will know the action has been completed effectively	Timescale for completion	RAG Rating
Multi-agency CSE Training - including how to share intelligence with Police. Bystander Training for children and young people TVP and Licensing Team training to hotels and taxi drivers	Training Coordinator Engage Thames Valley Police	Up to date CSE Tracker; Strategy Meeting Records; Quarterly monitoring and progress reports to the CSE & Trafficking Strategic Group; Up to date CSE Network chart; Monthly CSE audit reports; Evidence that all agencies use the CSE Screening Tool; Training progress report; Measuring impact through number of referrals and reports from licensed premises and taxi drivers.	31/03/2016	
Identifying suspected and known perpetrators through SERAC Panel, CSE Panel, CSE Champion meetings, and Strategy meetings.	CSE Lead Manager – Coordinators Police (TVP)	Up to date CSE Tracker; SERAC Panel Minutes; Updated CSE Network charts	31/03/2016	
Ensure that any intelligence regarding suspected adults is shared with Police.	All Agencies Social Workers, Team managers, TFS, YPS	Quarterly reports from Police intelligence informing whether intelligence is shared or not	31/01/2016	

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Key Strategic Priority: Prevent con'td

How we will do it	Who will be responsible	How we will know the action has been completed effectively	Timescale for completion	RAG Rating
Ensuring an effective single point of contact for all CSE referrals and missing children. This should be aligned with the Multi-Agency Safeguarding (MASH) soon to be in place.	Head of First Contact, Assessment and Children in Need	MASH in place with all agencies signing up to it Management Information Reports	31/03/2016	
Develop a communication strategy to ensure awareness at child, parents/carer and professional level	CSE Strategic Group	Development of Leaflets for children, parents/carers and professionals to increase CSE & Trafficking awareness Development of a Multi-Agency CSE Handbook	31/03/2016	

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Key Strategic Priority: Protect & Support

- Taking urgent steps to ensure that all children who are identified as being at risk of going missing or being sexually exploited are subject to risk assessment (using the CSE Risk Indicator Tool) and are offered responsive and appropriate help.
- Ensure that the needs of parents and families of victims of CSE and Trafficking are considered and appropriate support provided.
- Linking the Age of Care Strategy and the Sufficiency Strategy to the CSE & Missing Strategy

How we will do it	Who will be responsible	How we will know the action has been completed effectively	Timescale for completion	RAG Rating
Prosecuting perpetrators of child sexual exploitation	Head of Safeguarding	Appointment of a permanent CSE Lead Manager Appointment of CSE Youth Workers Evidence of timely response and provision of support including therapeutic support through monthly monitoring reports and case file audits. Regular review of the SLSCB CSE Dataset	31/03/2016	
Ensuring that all children and young people who have experienced sexual exploitation are fully prepared for court and supported throughout the criminal justice process.	CSE Lead Manager to monitor and provide monitoring and progress reports as well as analysis after each SERAC. Training Coordinator to organise training	Findings from monthly case file audit Quarterly monitoring and progress reports evidencing compliance SERAC panel records indicating that CSE Risk Indicator tools are routinely completed, updated and are of high quality Evidence of Impact of Multi-Agency Training on the quality of the response to CSE	31/03/2016	

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Key Strategic Priority: Protect & Support (cont'd)

How we will do it	Who will be responsible	How we will know the action has been completed effectively	Timescale for completion	RAG Rating
Supporting and protecting children and young people, who are at risk of exploitation, experiencing exploitation, or survivors of exploitation and their parents, carers and families through responsive and consistent service provision. Deliver a wide range of specialist therapy and support services to victims of CSE and their families	CSE Lead Manager through the Specialist CSE Team & SERAC Panel Engage CAMHS CCG Targeted Family Support Support through Lead Agencies CSE Lead Police Head of Safeguarding Heads of Service - Slough Children's Services Trust	Monthly and quarterly monitoring reports from all agencies to the CSE & Trafficking Strategic Group evidencing support and impact Regular Progress Reports to the Improvement Board Regular Feedback from parents Regular feedback from children who have received support Regular Monthly audits evidencing impact SERAC panel process evidencing robust support and ongoing risk assessment of individual children – reports of which will be shared multi-agency senior managers and CSE & Trafficking Strategic Group Progress reports from police evidencing disruption and victim support Monthly Progress reports evidencing that children are placed in suitable placements as well as reduction of children in residential units. Regular reports evidence impact of age of care strategy on CSE and missing risks SERAC panel evidencing impact and robust monitoring of individual children Group and 1:1 work with boys to develop awareness of CSE issues in relation to young men and boys.	31/03/2016	

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Key Strategic Priority: Protect & Support (cont'd)

How we will do it	Who will be responsible	How we will know the action has been completed effectively	Timescale for completion	RAG Rating
Improving the function of the CSE & Trafficking Strategic Group, SERAC Panel and CSE Champions Group. Ensure that cross-border safeguarding is effective for children and young people at risk of CSE and other concerns, such as Missing, Trafficked, FGM, Gangs and Radicalisation.	CSE Lead Police Inspector – CSE & Trafficking Strategic Group Chair CSE Coordinator – Lead Manager CSE Lead Inspector For SERAC Panel CAIU – Lead CSE Sergeant Reps from each agency	Reviewed and Ratified CSE & Trafficking Strategy and Action plan Ratified Missing Strategy and Action Plan in Place Evidence of robust monitoring of the Missing or CSE & Trafficking Action Plan by the CSE & Trafficking Strategic Group, SERAC panel and Champions group CSE & Trafficking Strategic Group meeting records Attendance and contribution to the Pan-Berkshire CSE & Trafficking Strategic Group – evidence of scrutiny of cross border safeguarding issues. Monitoring reports to the SLSCB Exec Board evidencing link between CSE &Trafficking Strategy and action plan to FGM, Missing, Gang violence and Radicalising Strategies and action plans.	31/03/2016	

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APPENDIX 1

Key Strategic Priorities: Pursue, Disrupt & Prosecute

A structured and robust approach in place to address offending behaviour, by professional investigations, effective identification, targeting of perpetrators (including potential perpetrators), disruption tactics and robust offender management;

- Use intelligence gathered to disrupt patterns of exploitation & trafficking
- Provide timely and effective interventions to support victims to break free from sexual exploitation & Trafficking
- Take action against those intent on abusing and exploiting children and young people by prosecuting perpetrators.
- To successfully prosecute those who perpetrate or facilitate the exploitation of children & young people

How we will do it	Who will be responsible	How we will know the action has been completed effectively	Timescale for completion	RAG Rating
Prosecuting perpetrators of child sexual exploitation	Thames Valley Police	Feedback on SERAC panels Quarterly progress reports to the CSE & Trafficking Strategic Group Findings from regular audit of investigations will be established to help identify and eliminate any barriers to effective prosecutions.	31/03/2016	
Ensuring that all children and young people who have experienced sexual exploitation are fully prepared for court and supported throughout the criminal justice process.	Thames Valley Police Specialist CSE Workers CAMHS	SERAC Panel Minutes Quarterly multi-agency audits	31/03/2016	
Using intelligence data to develop problem profiles of individuals or groups to assist with prosecutions.	All Agencies sharing intel with TVP Thames Valley Police	Quarterly progress reports to the CSE & Trafficking Strategic Group Updated CSE Network chart – Chart updated quarterly	31/03/2016	

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Key Strategic Priorities: Pursue, Disrupt & Prosecute cont'd

How we will do it	Who will be responsible	How we will know the action has been completed effectively	Timescale for completion	RAG Rating
Supporting the parents/carers and families of children and young people who are witnesses in Court	CSE Specialist workers Thames Valley Police Legal Support and guardians where appropriate Allocated social workers	Findings from Audit reports Progress reports from Police Operations Feedback from children and their families	31/03/2016	
Make best use of child abduction notices, harbourers warnings, and other appropriate legislation where applicable and utilise other forms of litigation.	Thames Valley Police	SERAC Panel Minutes Update Monitoring and Progress reports to the CSE & Trafficking Subgroup	31/03/2016	
Enhance links between cyber-crime based investigations/ intelligence development (e.g. online grooming, social media etc.) and CSE.	Thames Valley Police	Quarterly updated CSE Network Chart	31/03/2016	

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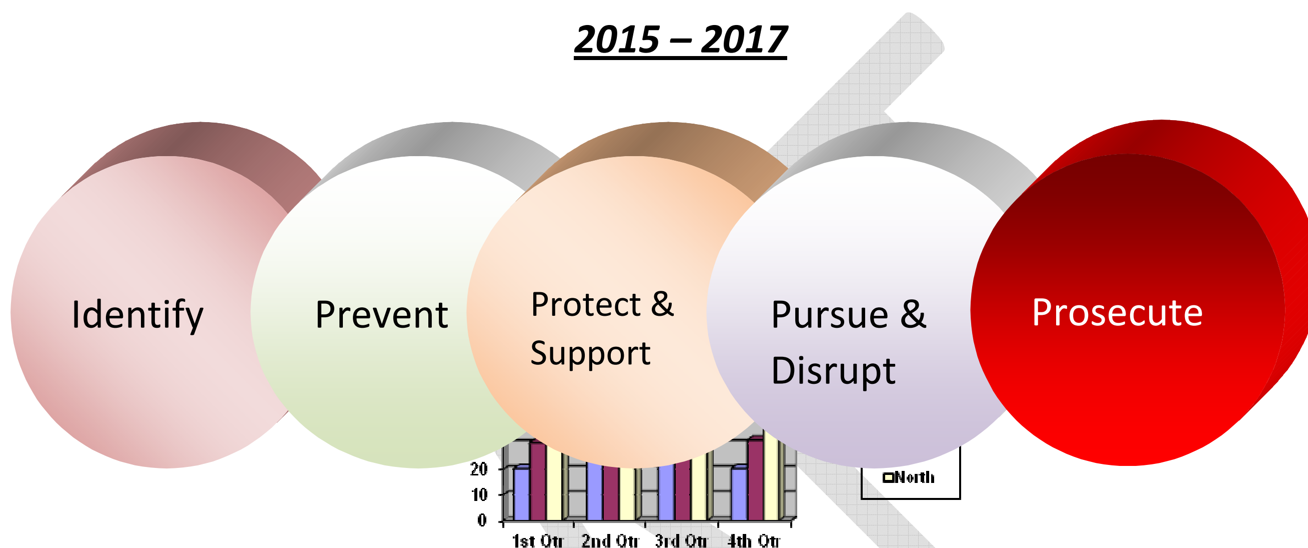
APPENDIX 2

Slough Local Safeguarding Children's Board (SLSCB) Child Sexual Exploitation and its links to Missing & Child Trafficking Strategy

2015 – 2017



Working together to safeguard and promote the welfare of children & young people from Child Sexual Exploitation and Trafficking

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1. Summary

The strategy sets out how Slough Local Safeguarding Children's Board will intervene and prevent child sexual exploitation, child trafficking and missing from home or care incidences through a pro-active, coordinated and multi-agency approach.

We aim to do this under the following key strategic priorities:-

Identify	• Develop a comprehensive and accurate 'Problem Profile' to enable identification of locations and individuals or groups who sexually exploit, whilst timely identifying children's vulnerability indicators in a timely manner, in order to provide a responsive multi-agency approach • Ensure that all incidents of children missing from home, school, care or from the sight of universal services are reported to police
Prevent	• Raise awareness of the issue through education and training and provision of early help to prevent exploitation, trafficking and missing from home or care incidents. • Reducing numbers subject to CSE, trafficking and/or running away through 1:1 work with children. • Identifying and engaging with groups of children and young people who are potentially at a high risk of being exploited • Being tenacious about ensuring that all children who go missing from home or care are offered timely return home interviews that appropriately explore and address risk and need • Continue to promote the use of the police CSE intelligence form and use the information gained to intervene in identified networks and target identified hotspots as well as places of concerns.
Protect & Support	• Taking urgent steps to ensure that all children who are identified as being at risk of going missing or being sexually exploited are subject to risk assessment (using the CSE Risk Indicator Tool) and are offered responsive and appropriate help • Ensure that the needs of parents and families of victims of CSE and trafficking are considered and appropriate support provided
Pursue & Disrupt	• Use information to disrupt patterns of exploitation & trafficking • Provide timely and effective interventions to support victims to break free from sexual exploitation & trafficking
Prosecute	• Take action against those intent on abusing and exploiting children and young people something misomethinby prosecuting perpetrators. • To successfully prosecute those who perpetrate or facilitate the exploitation of children & young people - something missing here?

Fundamental to achieving these objectives is a commitment from Slough LSCB to building a shared understanding of the CSE and trafficking profile in Slough and risk linked to missing from home or care incidences across all agencies as well as sectors of the community to ensure the wellbeing of all children.

Expected **outcomes** from this strategy are:

- All professionals have a better understanding of the risk factors and prevalence of CSE in the Slough area
- Children, parents, carers and the wider community have an increased awareness of risks relating to CSE
- There is improved identification of children at risk of sexual exploitation, trafficking and other related risks
- There is increasing evidence of effective prevention of sexual exploitation of those at risk
- Children at risk and victims as well as their parents/carers are engaged in developing support plans and agreeing outcomes
- Victims are effectively supported to exit exploitative relationships during investigations, prosecution and post prosecution
- Activities of perpetrators are either successfully disrupted or result in prosecutions

2. Key principles

Slough Local Safeguarding Children Board is committed to meeting the diverse needs of all children and young people in relation to their health, relationships and emotional health and wellbeing.

All members of the Local Safeguarding Children Board will treat all children and young people with fairness, dignity and respect regardless of age, disability, health status, gender, race, ethnicity, sexuality, family situation, beliefs, religion or economic and social standing in order to meet their identified needs and priorities.

The principles underpinning Slough's multi-agency responses to the sexual exploitation of children and young people are:

- To ensure that anyone who comes into contact with a child or young person who has been or is at risk of being sexually exploited reports the matter to the police;
- To ensure that children are given assistance to ***participate*** as fully as possible in all decisions that are made in respect of them. The involvement of parents or carers is fundamental to this principle.
- Continue to raise awareness that children and young people do not make choices to enter or continue to be sexually exploited, but do so from ***coercion, enticement, manipulation*** and/or ***persuasion***.
- To ensure that all children and young people who are subject to sexual exploitation are treated as ***victims of abuse***.
- To empower children and young people to make realistic choices and to be supported with effective resources for ***"exiting"*** from the circumstances where they are being sexually exploited.

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- Professional judgements regarding levels of risk should be consistently clear and the sources of information should reflect a multi-agency consultative approach.
- ***Prevention, protection, pursuance and prosecution*** should be given equal importance. Timely legal action and disruption strategies are essential to ensure that perpetrators of sexual exploitation are identified and prosecuted.
- Where the police are considering criminal action against children and young people, they should consult with partner agencies through the CSE meetings or appropriate multi-agency routes for other offences to ensure that all alternative and appropriate actions have been considered in line with ensuring adherence to ACPO guidance.
- To ensure that all professionals involved in working with children and young people subject to sexual exploitation show ***professional resilience*** and are committed to taking a pro-active approach in engaging the child or young person as they do not always engage easily. Ongoing training must be provided to increase the skills base and professional resilience of staff working with children at risk of exploitation.

3. Definition of CSE & Child Trafficking

<u>Child Sexual Exploitation</u>

'*Child sexual exploitation is a form of child abuse. It occurs where anyone under the age of 18 is persuaded, coerced or forced into sexual activity in exchange for, amongst other things, money, drugs/alcohol, gifts, affection or status. Consent is irrelevant, even where a child may believe they are voluntarily engaging in sexual activity with the person who is exploiting them. Child sexual exploitation does not always involve physical contact and may occur online'*. (The government is proposing to bring the revised definition into effect on 1 April 2016 and including it within the statutory guidance, 'Working Together to Safeguard Children).

Sexual exploitation of children and young people under 18 years involves exploitative situations, contexts and relationships where the young person (or third person/s) receive 'something' (e.g., food, accommodation, drugs, alcohol, cigarettes, affection, gifts, money) as a result of them performing, and or another or others performing on them, sexual activities. Child sexual exploitation can occur through the use of technology without the children's immediate recognition; for example being persuaded to post images on the internet/mobile phones without immediate payment or gain. Violence, coercion and intimidation are common. Involvement in exploitative relationships is characterised by the child's or young person's limited availability of choice as a result of their social, economic or emotional vulnerability. A common feature of CSE is that the child or young person does not recognise the coercive nature of the relationship and does not see themselves as a victim of exploitation.

<u>Child Trafficking</u>

Child trafficking is the recruitment and movement of children for the purposes of exploitation. Children are most commonly exploited for sexual purposes, exploited to carry out forced labour or criminal activity, or held in servitude. There are three main elements:

- The movement – recruitment, transportation, transfer, harbouring or receipt of children
- The control – threat, use of force, coercion, abduction, fraud, deception, abuse of power or vulnerability, or the giving of payments or benefits to a person in control of the victim child

- The purpose – child sexual exploitation, forced labour, slavery or similar practices, and the removal of organs

4. Models of Child Sexual Exploitation

Slough will use the following models and other emerging patterns, to identify children at risk of CSE as well as the perpetrators. Barnardos definition indicates that child sexual exploitation tends to be a hidden activity and much more likely to take place in private residences than visibly, on the streets. Barnardos has identified different models of activity; they are not exhaustive, but show a spectrum of exploitation, as follows:

Inappropriate relationships model: Usually involves one abuser who has inappropriate power – physical, emotional or financial – or control over a young person. The young person may believe they have a genuine friendship or loving relationship with their abuser. Many cases show the enormity of this problem as girls engage with young men who appear to be genuine but further down the line become aggressive and controlling

Boyfriend model: Abuser grooms victim by striking up a normal relationship with them, giving them gifts and meeting in cafes/ fast food outlets or shopping centres. A seemingly consensual sexual relationship develops but later turns abusive. Victims are required to attend parties have sexual contact with multiple men and threatened with violence if they try to seek help. They may also be required to introduce their friends as new victims.

Organised/networked sexual exploitation or trafficking: Children and Young people (often connected) are passed through networks, possibly over geographical distances, between towns and cities where they may be forced / coerced into sexual activity with multiple men. Often this occurs at 'sex parties' and young people who are involved may be used as agents to recruit others into the network. Some of this activity is described as serious organised crime and can involve the organised 'buying and selling' of children/young people by perpetrators.

The 'party model'; parties are organised by groups of men to lure young people. Young people are offered drinks, drugs and car rides often for 'free'. They are introduced to an exciting environment and a culture where sexual promiscuity and violence is normalised. Parties are held at various locations and children are persuaded (sometimes financially) to bring their peers along. Children are also encouraged to associate with others via Snapchat, Whatsapp kik, Instagram, Facebook, Bebo, ooVoo, etc. The parties may be held some distance from the child's home, enabling the perpetrators to force the child to have sex in return for a lift home. Drugs and alcohol are used to suppress the children's resistance. Images may be taken of them without their clothes for purpose of bribery.

The third model - organised sexual exploitation or trafficking, is the most sophisticated and complex form of child sexual exploitation and those young people involved would be considered at very high risk. However, young people from any of the models described above can be victim to extreme levels of intimidation, and physical and sexual violence. Organised exploitation varies from spontaneous

networking between groups of perpetrators to more serious organised crime where young people are effectively 'sold'.

5. Strategic Priority 1: Identify

Develop a comprehensive and accurate 'problem profile' to enable identification of locations and individuals or groups who sexually exploit, whilst timely identifying children's vulnerability indicators in order to provide a responsive multi-agency approach.

Slough will achieve this by:

- Taking decisive action to ensure that the local extent of child sexual exploitation and trafficking is known and understood and that intelligence information is used proactively to inform risk management and disruption activities.
- Identifying suspected and known perpetrators and ensure that any intelligence regarding suspected adults is shared with police
- Ensuring an effective single point of contact for all CSE referrals and missing children. This should be aligned with the Multi-Agency Safeguarding (MASH) soon to be in place.
- Developing and maintaining a responsive multi-agency map of service provision to:
    - Engender effective multi-agency working
    - Ensure that identified need matches services provided
    - Ensure that service development and commissioning priorities are responsive to the children identified to be at risk and in need of support.
    - Improve multi-agency intelligence sharing and data analysis
    - Problem Profile mapping - i.e. children exploited and potential exploitation networks relating to perpetrators and vulnerable children and young people
    - Identify and monitor geographical places of interest and 'hot spots'

Because of the complexity, these activities receive dedicated police resources to investigate and are described as 'internal trafficking' or 'trafficking for child sexual exploitation'. In these cases, perpetrators may not always be engaging in sexual activity with young people themselves but arranging for others to do so. Under the Sexual Offences Act 2003 (S.58), this is defined as trafficking within the UK[1].

[1] Puppet On A String - reveals the urgent need to cut children free from sexual exploitation.

Barnardo's http://www.barnardos.org.uk/ctf_puppetonastring_report_final.pdf

The Association of Chief Police Officers and Pan Berkshire Safeguarding Board have agreed an operating protocol which includes three levels of risk based on a range of indicators and vulnerability factors. The CSE Risk Indicator Tool, now in place across Pan Berkshire authorities identifies vulnerabilities in children prior to abuse and specific risk indicators to be aware of under each of the three outcomes/ risk categories:-

- **Low Risk** – A vulnerable child/young person, where there are concerns they are being targeted and groomed and where any vulnerability factors have been identified. At this stage, there is no evidence of any offences - (one or more of the following identified);
  - Regularly coming home late or going missing
  - Overtly sexualised dress, sexualised risk taking (including on the internet)
  - Unaccounted for monies or goods
  - Associating with unknown adults
  - Associating with other sexually exploited children
  - Reduced contact with family and friends and other support networks
  - Sexually transmitted infections
  - Experimenting with drugs and alcohol
  - Poor self image, eating disorders, self harm
  - Non school attendance

- **Medium Risk** – Evidence that a child/young person is being targeted for opportunistic abuse through the exchange of sex for drugs, perceived affection, sense of belonging, accommodation (overnight stays), money and goods etc. The likelihood of coercion/control is significant. (two or more of the following indicators) ;
  - Getting into cars with unknown adults or associating with known CSE adults
  - Being groomed on the internet
  - Clipping
  - Receiving rewards of money or goods for recruiting peers in to CSE
  - Disclosure of physical sexual assault and then refusing to make or withdrawing a complaint.
  - Reports of being involved in CSE through being seen in hotspots
  - Having a much older boyfriend / girlfriend
  - Missing school or excluded from school due to behaviour
  - Staying out overnight with no reasonable explanation
  - Breakdown of residential placements due to behaviour
  - Unaccounted for money or goods including mobile phones, drugs, and alcohol
  - Multiple sexually transmitted infections
  - Self harming
  - Repeat offending
  - Gang member or association

- **High Risk** – A young person/child, whose sexual exploitation is habitual, often self-denied and where coercion/control is implicit - any one or more of the following indicators;
  - Child under 13 engaging in penetrative sex with another young person over 15 years

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- Pattern of street homelessness and staying with an adult believed to be sexually exploiting them
- Child under 16 meeting different adults and engaging in sexual activity
- Removed from known “red light” district by professionals due to suspected CSE
- Being taken to clubs and hotels by adults engaging in sexual activity
- Disclosure of serious sexual assault and then withdrawing of statement
- Abduction and forced imprisonment
- Being moved around for sexual activity
- Disappearing from the “system” with no contact or support
- Multiple miscarriages or termination
- Chronic alcohol and drug use
- Indicators of CSE alongside serious self harming

Young people being assessed as being low, medium and high risk will be provided with a range of services from relevant agencies, informed by the specific needs of each case. Cases assessed within medium to high will require specialist police interventions in line with Pan Berkshire CSE Protocols alongside intensive social care intervention in accordance with best practice protocols.

6. Strategic Priority 2: Prevent

- Raise awareness of the issue through education and training and provision of early help to prevent exploitation, trafficking and missing from home or care incidences.
- Reducing numbers subject to CSE, trafficking and/or running away through 1:1 work with children.
- Identifying and engaging with groups of children and young people who are potentially at a high risk of being exploited
- Being tenacious about ensuring that all children who go missing from home or care are offered timely return home interviews that properly explore and address risk and need
- Continue to promote the use of the police CSE intelligence form and use the information gained to intervene in identified networks and target identified hotspots as well as places of concerns.

7. Strategic Objective 3: Protect & Support

- Taking urgent steps to ensure that all children who are identified as being at risk of going missing or being sexually exploited are subject to risk assessment (using the CSE Risk Indicator Tool) and are offered responsive and appropriate help
- Ensure that the needs of parents and families of victims of CSE and trafficking are considered and appropriate support provided

This will be achieved through:

- Piloting of a police led multi-agency team to support children and young people at risk of, experiencing sexual exploitation to ensure that the response to CSE is well coordinated and effective.
- Undertaking high quality assessments through the use of the Pan Berkshire CSE Risk Indicator Tool for children and young people at risk of or experiencing sexual exploitation.
- Supporting and protecting children and young people, who are at risk of exploitation, experiencing exploitation, or survivors of exploitation and their parents, carers and families through responsive and consistent service provision.
- Improving the function of the CSE & Trafficking Strategic Group, SERAC Panel and CSE Champions Group.

8. Strategic Objective 4: Pursue and Disrupt

- Use intelligence gathered to disrupt patterns of exploitation & trafficking
- Provide timely and effective interventions to support victims to break free from sexual exploitation & trafficking

9. Strategic Objective 5: Prosecute

- Take action against those intent on abusing and exploiting children and young people by prosecuting perpetrators
- To successfully prosecute those who perpetrate or facilitate the exploitation of children & young people

This will be achieved through:

- Prosecuting perpetrators of child sexual exploitation
- Ensuring that all children and young people who have experienced sexual exploitation are fully prepared for court and supported throughout the criminal justice process.
- Using intelligence data to develop problem profiles of individuals or groups to assist with prosecutions.
- Supporting the parents/carers and families of children and young people who are witnesses in court
- Make best use of child abduction notices, harbourers warnings, and other appropriate legislation where applicable and utilise other forms of litigation.

10. Intelligence Sharing and Performance Monitoring

In order to understand the prevalence/scale of CSE in Slough, the necessary data management processes and agreed data set needs to be in place. Referral trends are also crucial in understanding

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which types of agencies tend to refer to police and social care as well as clarifying how well thresholds are being applied. As part of understanding the needs of children at risk/being abused as a result of CSE, the current operational working group (Sexual Exploitation Risk Assessment Conference - SERAC Panel provides a multi-agency oversight and tracking of cases. The SERAC links into the CSE & Trafficking Strategic Sub-group, to enable strategic oversight. Robust partnership working and a programme of the CSE service and practice development is central to achieving improved safeguarding responses and outcomes for children and young people at risk of or experiencing sexual exploitation across the borough.

Child sexual exploitation cannot be addressed by one agency alone or in isolation from other related safeguarding issues. The LSCB has a role and responsibility to have an oversight of safeguarding within Slough Borough Council and the CSE Sub-Group directly reports into it. The action plan directs clearly their role and responsibility in terms of providing an annual report for scrutiny by elected members. All agencies have a responsibility to fulfil their obligations in providing information to inform the annual report. To ensure consistent best practice, the Pan Berkshire CSE Protocol is adopted and applied in conjunction with all Slough CSE documents.

11. CSE & Trafficking Subgroup

The CSE Subgroup is a strategic group to share information and intelligence and additionally receives feedback on operational issues and individual CSE referrals in order to understand the nature and prevalence of CSE in Slough. It aims to reduce the number of children and young people at risk and provide a strategic overview of CSE activity in Slough and monitor the CSE Action plan to ensure effectiveness and timely execution. This helps to ensure agreed common thresholds and categorisation for interventions in response to CSE are consistently adhered to.

The CSE & Trafficking Subgroup is chaired by a senior police officer and mandatory membership includes all agencies across the partnership to promote shared accountability. The CSE & Missing lead manager in social care, reports into the CSE and Trafficking Subgroup in line with the expectations of the LSCB Business Plan and the group will report to the LSCB on progress of specific activity such as CSE investigations, information from SERAC to inform learning and responsive action regarding themes. The CSE & Trafficking Subgroup meets 6 weekly.

CSE is a standing item on the bi-monthly local police area tasking meetings which Safer Slough Partnership (SSP) partners attend. Information from these meetings needs to be relayed to the designated CSE Social Work Lead.

12. The role of Sexual Exploitation Risk Assessment Conference – SERAC

The Sexual Exploitation Risk Assessment Conference (SERAC) in Slough reviews individual cases and provides multi agency risk management oversight. This includes looked after children placed in Slough by other authorities. The panel meets every 4 weeks and is chaired by the safeguarding lead in Children's Social Care. The objective of SERAC is to track the safety plans in place to help tackle issues of child sexual exploitation while increasing intelligence and identifying gaps in data around CSE trends. Representatives attending the conference include Children's Social Care, Targeted Family Support, Engage, Emergency Duty Team, Police, Youth Offending Team, Turning Point, Education,

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Health, CAMHS & Education Safeguarding Lead and Early Help. Information from this conference will feed into CSE Subgroup data reporting for LSCB.

13. CSE Awareness Champions

The role of the CSE Awareness Champion is crucial to enabling the coordination of activity and raising awareness regarding CSE. All agencies/organisations have nominated a professional within their organisation to act as a champion for CSE. The purpose of the role is to keep up to date with CSE activities, developments, policy and procedures in relation to CSE, to act as a focal point within their organisations and to provide advice and signposting in relation to individual cases.

The CSE Awareness Champion Group continues to ensure that:

- All agencies fully understand the nature of CSE
- They are up to date with the policy and procedures that relate to CSE
- They act as a focal point within their organisation to promote awareness of CSE
- They disseminate information relating to CSE within their organisation
- They provide advice and signposting in individual cases where CSE is suspected
- They submit any information/intelligence received to the police for collation
- The action plan activities are progressed in a timely manner.

Document Control

17/02/2016	CSE Strategy Revised by Jes Mupombi and sent to Robina Khan – Interim Head of Safeguarding, Inspector Sarah Cook – TVP Slough CSE Lead Inspector, Jayne James – LSCB Business Manager and Sandra Davies – Head of QA and Performance.
22/02/2016	Robina Khan amendments returned to Jes Mupombi.
22/02/2016	Further amendments made following feedback from Inspector Sarah Cook. V6.1 Sent out to Robina Khan, Sarah Cook, Jayne James and Sandra Davies.
26/02/2016	Final Amendments to the Strategy and Action Plan made – following feedback from DI Richard Cow – Force Intelligence Detective Inspector. Strategy and Action Plan discussed with Inspector Sarah Cook and Phil Picton – LSCB Chair.

29/02/2016	Final Draft Strategy and Action plan send to Nicola Clemo, Slough Children's Services Trust Chief Executive and Robina Khan.

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Slough Local Safeguarding Children's Board (SLSCB)
Multi-Agency Missing Strategy
2015 – 2017

Working Together to Safeguard Children who go Missing from Home or Care, including children reported missing during school hours.

Identify, Prevent, Protect and Provide Support

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APPENDIX 3

This strategy relates to Slough children missing from home or care who are under 18 years old. The strategy also addresses reported patterns of absences from home or care. Where another local authority child is placed in Slough, there will be collaborations with the respective local authorities to ensure that intelligence is shared.

Children and young people missing from home or care is a safeguarding issue; although the majority of children and young people who go missing return or are found quickly, all children and young people who go missing irrespective of the amount of time that they are missing for, are at risk.

The reasons behind why children and young people go missing are varied and complex, these *push-pull* factors, may include the child or young person running away because of problems at home or school, such as abuse, neglect, or bullying, or they may be pushed out of their home by parents /carer. Alternatively a child or young person may go missing because they want to be somewhere other than their home, or because they want to be with someone they are unable to be with, unless they run away. Moreover a child might be coerced to run away and go missing by someone who has power or control over them; Whatever the reason, at the time, children and young people often feel that they have no choice other than to run away.

Children and young people whilst missing from home or care may experience physical and /or emotional abuse, additionally they are more likely to engage in risk taking and self-harming behaviour, and they may find themselves sleeping rough, often committing crime in order to survive, whilst also feeling fear and loneliness. As a consequence of being missing, their education, family and social relationships and life chances often suffer. Missing children and young people are particularly vulnerable to trafficking, violent crime, drug and alcohol misuse and exploitation, including sexual exploitation, as either a cause or consequence of going missing. Significant evidence highlights that children and young people who go missing from home or care are at increased risk of being at risk of, or experiencing sexual exploitation. It is therefore essential that all partner agencies act rigorously to reduce incidents of children going missing, to locate a missing child ensure that they return the child to a safe environment. Agencies must ensure that they have processes in place to assess why a child / young person went missing, what they experienced whilst missing and how any future risk of that child /young person going missing could be reduced.

Children in care are over represented in the statistics for children reported missing and are considered particularly vulnerable; especially in terms of being vulnerable to grooming and exploitation. Whilst children in care go missing for a variety of reasons, it is important for professionals to understand the reasons why, in order to assist with minimising risk and frequency, effectively safeguard, and achieve placement stability. Information gained from return interviews is therefore invaluable.

The majority of children and young people, who go missing, do so from their family home, these children and young people are equally vulnerable, and require the same level of protection and response from professionals and service as children looked after. Whilst there are recognised difficulties in the reporting of the exact number of children and young people who actually go missing each year, current research suggests that approximately 100, children go missing annually. However many children remain hidden from professionals, and the Children's Society notes that only a third of children who go missing are reported as such to the police. Whatever the push or pull factors are that

influence a child or young person to go missing from home or care, approximately one quarter of those who do, are believed to be at risk of serious harm.

The issue of missing children is therefore significant, and to ensure that children and young people in Slough can live free from the feeling they have no other choice other than to go missing, and also live free from the risks associated with being missing, this strategy has focused on three overall strategic objectives; prevention, protection and provision, which demand child-focused, co-ordinated, and effective multi-agency responses.

How we will achieve our objectives?
The SSCB Child Sexual Exploitation and Missing Strategic Subgroup will monitor progress against the strategic objectives, by working in accordance with an agreed detailed action plan, taking into account new legislation, research, policy and guidance.

The lead officers for this group are the dedicated Child Sexual Exploitation and Missing Co-ordinator and the Neighbourhood Policing Inspector, whose roles are to support the multi-agency work required. The strategic planning and collaborative multi-agency working will enable effective leadership and progress our understanding and practice, which in turn will improve the lives of children and young people at risk of harm from going missing from home or care.

The missing strategy will be reinforced by local practice guidance and a LSCB Missing action plan, will complement the Pan Berks Procedure for Children Missing from Home and from Local Authority Care. This Strategy will be driven by the CSE & Trafficking Strategic Group. Progress and impact will be measured through the SLSCB Multi-Agency Action Plan. Progress and Impact Reports will be presented to the CSE & Trafficking Strategic Subgroup on a quarterly basis

This strategy should be read in conjunction with:

- LSCB Child Sexual Exploitation Strategy, procedure, policy and protocols, and the Pan Berkshire procedures for safeguarding children who may have been trafficked.
- Reference can also be made to the Pan Berkshire joint procedure for forced marriage.
- For guidance relating to children missing from education, children who are home education and children with attendance issues, please refer to the Safeguarding Protocol: Children not in School
- Statutory guidance on children who run away or go missing from home or care. Department of Education, 2014

Key Strategic Priority: Identify and Prevent

Objective
To reduce the number of children, who go missing whilst also ensuring that children and young people understand the risks associated with going missing.

We are going to achieve this by:
- Ensuring effective information sharing, and promoting the importance of intelligence sharing with the police amongst partner agencies, including arrangements for information sharing between different local authorities when a child runs away to another area.

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- Complete a CSE screening tool on every child who has been reported missing or absent overnight or 3 times in 90days. This should commence at the point the Return Home Interview is completed.

- Creating systems to effectively collate and analyse data relating to children who go missing, to provide an understanding of the 'picture' and context of 'missing in Slough and identify patterns that indicate particular concerns. Including analysing patterns and monitoring outcomes and of children placed in the area by other local authorities and for Slough children placed in other local authority areas, who go missing from care or are away from placement without authorisation.

- Implementing clear referral and assessment processes, which identify children and young people at risk at an early stage across all partner agencies, ensuring children have full assessment and referrals to relevant services for intervention and support are made.

- Proactively raise awareness of the risks associated with children going missing, with children, young people, parents, carers, local communities and businesses. Including providing child friendly materials and undertaking a wider public facing campaign.

- Train front line practitioners to identify risk factors associated with children going missing and to provide a knowledgeable, consistent response to assessment , intervention and risk management

- Develop young people's participation groups, with children who have experienced being missing so that children's voices inform knowledge, understanding and future service delivery

- Signing up to the Children's Society Missing Children Charter and the Barnardos 'Cut Them Free' Campaign'

- Establishing professional links with national agencies such as CEOP, UKHTC, UKBA, Missing People, Missing Person's Bureau and NWG.

Key Strategic Priority: Protect and Provide Support

Protect

Objective

To reduce the risk of harm to those children and young people who go missing from home or care and during school hours.

We are going to achieve this by:

- Developing an agreed inter-agency framework for assessing and classifying the degree of risk for when a child goes missing from home or care, or when a missing child comes to agency attention.

- Ensuring that robust multi-agency risk assessments and management plans, that involve specialist support services, are in place for all children for children and young people who have been missing from home or care, whilst also ensuring that risk assessments and management plans are coordinated, effectively executed and link to other formal child protection processes.

- Making sure that children in care who are placed out of the county receive the same response and level of intervention to instances of going missing, as those placed within Slough.

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- Offering all children and young people who go missing high quality independent return interviews in a timely manner, undertaking quality assurance audits of these to cater for on-going service development that take into account the voice of the child.

- Providing a high quality training programme to care providers, to assist their understanding of what actions they can do to reduce escalation and manage risk related to children missing from care or those who are away from placement without authorisation.

- Working with parents whose children are reported missing/ absent and providing support, to enable their understanding of the risks associated

Provide Support

Objective
To provide children and young people who go missing and their families and carers with high quality response, support and guidance**.**

We are going to achieve this by:

- Providing high quality relevant multi agency risk assessed plans and interventions for children, carers and families, which are child-focused and ensure that the safety and wellbeing of the child is paramount.

- Providing a quality assured, local independent return interview programme for children known to social care and children not known to social care.

- Establishing an effective independent service(s) to respond to missing notifications for including children who do not have a social worker or other statutory worker.

- Working with national and local third sector partner agencies, to provide children, young people, parents, carers, families and communities with information about how to keep children safe, report missing children and access local and national missing services.

- Endeavouring to train all local frontline staff to communicate effectively with children and young people in a positive and supportive way with children and young people.

- Providing an annual report outlining the 'picture' and context of 'missing in Slough, to identify what we are doing well, outstanding challenges and to inform future service delivery response.

- Creating agreed multi agency common risk assessment process, and referrals pathways; allowing for established and consistent responses to both missing and absent classifications.

- Create a missing resource and educational materials to notify, inform and signpost children young people and their families to local and national missing resources and helplines.

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APPENDIX 3

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APPENDIX 4

Missing Strategy Action Plan 2015/2016

Key Areas	What we will do	How we will do it	Who will be responsible	How we will know the action has been completed effectively	Timescale for completion	RAG Rating
Prevention	Reduce the number of children, who go missing whilst also ensuring that children and young people understand the risks associated with going missing.	Ensuring effective information sharing and promoting the importance of intelligence sharing with Police and other LAs when a Slough child is reported missing in other areas	CSE Coordinator/ Young People's Services	Multi-agency Missing/CSE Audit Reduction of missing absent episodes	31st December 2015	
		Complete a CSE screening tool on every child who is reported missing or absent. This should be done at the point the Return Home Interview is completed.	Children's Social Care/ Young People's Services	Early identification of CSE and other risks	31st December 2015	
		Creating systems to effectively collate and analyse data relating to children reported missing or absent between all key agency partners	CSE & Missing Coordinator	Clear recording systems that enable up to date Management data and management information.	01/02/2016	
		Proactively raise awareness of the risks associated with children going missing	Young People's Services	Regular multi-agency training and awareness raising. Production of leaflets	01/04/2016	
		Train front line practitioners to identify risk factors associated with children going missing and to provide a knowledgeable, consistent response to assessment , intervention and risk management	CSE & Missing Coordinator/ SSCB Training Coordinator	Trained Staff Quicker response to concerns around missing and associated risks Multi-agency audits	01/02/2016	

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Key Areas	What we will do	How we will do it	Who will be responsible	How we will know the action has been completed effectively	Timescale for completion	RAG Rating
Prevention	Reduce the number of children, who go missing whilst also ensuring that children and young people understand the risks associated with going missing	Develop young people's participation groups, with children who have experienced being missing so that children's voices inform knowledge, understanding and future service delivery	CSE & Missing Coordinator/ Young People's Services	Multi-agency audits Participation progress reports	01/03/2016	
		Signing up to Children's Society Missing Children Charter and the Barnardo's 'Cut Them Free' Campaign'	CSE & Missing Coordinator	Evidence that Slough have signed up and that resource information is accessed and used appropriately to raise awareness	31/12/2015	

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Key Areas	What we will do	How we will do it	Who will be responsible	How we will know the action has been completed effectively	Timescale for completion	RAG Rating
Protection	Reduce the risk of harm to those young people who go missing from home or care.	Developing an agreed inter-agency framework for assessing and classifying the degree of risk for when a child goes missing from home or care. This includes CSE screening and risk assessment.	Police CSE Lead/ Police Missing Coordinator/ CSE Coordinator	Multi-agency Audit Tools SERAC Panel records	01/02/2016	
		Ensuring that robust multi-agency risk assessments and management plans, that involve specialist support services, are in place for all children for children and young people who have been missing from home or care	Young People's Services/ Children's Social Care/ CSE Coordinator/	Multi-agency Audit Tools Evidencing robust risk assessments & CSE risk assessments as well as evidence of risk management in children's plans.	01/02/2016	
		Providing quality assured Return Home Interviews to all children and young people who go missing high quality independent return interviews in a timely manner, undertaking quality assurance audits of these to cater for on-going service development that take into account the voice of the child.	Young People's Services/ Children's Social Care	Management information reports Multi-agency audits Updated Tracker indicating that RHIs have been undertaken time	Ongoing – Starting 26/10/2015 to be reviewed by 31/03/2016	
		Providing a high quality training programme to care providers, to assist their understanding of what actions they can do to reduce escalation and manage risk related to children missing from care or those who are away from placement without authorisation	CSE Coordinator/ Fostering Service/ Regulated services	Multi-Agency audits evidencing improved understanding of risk and actions to reduce missing incidences. Placement plans evidencing missing strategy for young people.	Training by 31st March 2016 Impact measured by 31/03/2016	
		Working with parents whose children are reported missing/ absent and providing support, to enable their understanding of the risks associated	Targeted Support Services Children's Social Care Police – when Safe & well checks are undertaken	Multi-Agency Audits	To be evaluated by 31/03/2016	

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Key Areas	What we will do	How we will do it	Who will be responsible	How we will know the action has been completed effectively	Timescale for completion	RAG Rating
Provision	Provide children and young people who go missing & their families and carers with high quality response, support and guidance.	Providing an annual report outlining the 'picture' and context of 'missing in Slough, to identify what we are doing well, outstanding challenges and to inform future service delivery response.	CSE & Missing Coordinator	Annual Report presented to the CSE & Trafficking Subgroup, SSCB Exec Board.	Yearly by 20/03/2016	
		Creating agreed multi agency common risk assessment process, and referrals pathways; allowing for established and consistent responses to both missing and absent classifications	CSE & Missing Coordinator	Weekly, monthly and Quarterly reports of children reported missing evidencing a clear referral pathway and consistent response	31/01/2016	
		Establishing an effective independent service(s) to respond to missing notifications for including children who do not have a social worker or other statutory worker, including children placed out of borough.	CSE & Missing Coordinator	Weekly, monthly and quarterly reports. Multi-agency audits	31/01/2016	

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SLOUGH BOROUGH COUNCIL

REPORT TO: Education & Children's Services Scrutiny Panel

DATE: 16th March 2016

CONTACT OFFICER: Dave Gordon – Scrutiny Officer
(For all Enquiries) (01753) 875411

WARDS: All

PART I

TO NOTE

EDUCATION & CHILDREN'S SERVICES SCRUTINY PANEL 2015/16 WORK PROGRAMME

1. Purpose of Report

1.1 For the Education and Children's Services Scrutiny Panel (ECS Scrutiny Panel) to discuss its current work programme.

2. Recommendations/Proposed Action

2.1 That the Panel note the current work programme for the 2015/16 municipal year.

3. The Slough Joint Wellbeing Strategy, the JSNA and the Five Year Plan

3.1 The Council's decision-making and the effective scrutiny of it underpins the delivery of all the Joint Slough Wellbeing Strategy priorities. The ECS Scrutiny Panel, along with the Overview & Scrutiny Committee and other Scrutiny Panels combine to meet the local authority's statutory requirement to provide public transparency and accountability, ensuring the best outcomes for the residents of Slough.

3.2 The work of the ECS Scrutiny Panel also reflects the priorities of the Five Year Plan, in particular the following:

- Children and young people in Slough will be healthy, resilient and have positive life chances

4. Supporting Information

4.1 The current work programme is based on the discussions of the ECS Scrutiny Panel at previous meetings, looking at requests for consideration of issues from officers and issues that have been brought to the attention of Members outside of the Panel's meetings.

4.2 The work programme is a flexible document which will be continually open to review throughout the municipal year.

5. Conclusion

5.1 This report is intended to provide the ECS Scrutiny Panel with the opportunity to review its upcoming work programme and make any amendments it feels are required.

6. Appendices Attached

A - Work Programme for 2015/16 Municipal Year

7. Background Papers

None.

EDUCATION AND CHILDREN'S SERVICES SCRUTINY PANEL
WORK PROGRAMME 2015/16

Meeting Date
Wednesday 16th March
• Ofsted inspection – results for Children's Services • Ofsted inspection – results for Slough Local Safeguarding Children's Board • Child Sexual Exploitation update
Thursday 21st April
• Cambridge Education Annual Report and an update on the educational contract • Looked After Children • Corporate Parenting • Ofsted Inspections – Term Update

To be programmed:

- Teacher recruitment and retention (reference from Council – September 2015) – first meeting of 2016 - 17
- Slough Local Safeguarding Children's Board
- Benchmarking of PFI contract – follow up from 28th January 2016
- Termly updates on Ofsted inspections – to be programmed throughout 2016 – 17
- CAMHS Level 2
- Five Year Plan – Milestones for 2016
- Children's Services Trust – SEND services

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MEMBERS' ATTENDANCE RECORD

EDUCATION AND CHILDREN'S SERVICES SCRUTINY PANEL 2015-16

	MEETING DATES							
COUNCILLOR	**14/07/2015**	**21/10/2015**	**03/12/2015**	**12/01/2016**	**28/01/2016**	**09/03/2016 Cancelled**	**16/03/2016**	**21/04/2016**
Abe	P*	P	P	Ap	P			
Bal	P	Ap	Ap	Ap	Ap			
Brooker	P	P	P	P	P			
Cheema	P	Ap	P	P	P			
Dhillon	Ab	Ab	P*	P	P			
Matloob	P	P	P	P	P			
Morris	P	P	Ap	Ap	P			
Pantelic	P	P*	P	P	P			
Rana	P	P	Ap	P	P			

P = Present for whole meeting
Ap = Apologies given
P* = Present for part of meeting
Ab = Absent, no apologies given

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