

## **Section 2: The effectiveness of the Local Safeguarding Children Board**

### **The effectiveness of the LSCB is inadequate**

#### **Priority and immediate action**

- Ensure all partner agencies are engaged in the delivery of the early help strategy that children and families have equal access to the services they need as early as possible.
- Ensure that agencies take full responsibility for their roles as set out in Working Together to Safeguard Children (Department for Education 2013) and that they commit to multi-agency strategies and working groups, including sharing responsibility and resources where necessary.

#### **Areas for improvement**

- Include an evaluation of the effectiveness of arrangements for children who are missing from home and education in the LSCB annual report. This information should be accompanied by an overview of private fostering in order to help make decisions and plan service improvements.
- Complete and implement a pathway for young people at risk of sexual exploitation, which clearly outlines multi-agency responses and interventions, setting out how risk will be continually reviewed on individual cases.
- Improve auditing activity and focus on evaluating the quality of interventions in order to draw the key lessons for improving management decision-making and oversight on cases.
- Ensure operational staff are included in multi-agency audits to provide the required expertise to ensure rigorous scrutiny. Individual agencies must own the findings of audits and use this information effectively to promote improvement.

#### **Key strengths and weaknesses of the LSCB**

- The LSCB has made clear improvements in the last year from a low starting point. This is particularly the case in the scope of its scrutiny and analysis activities. It is well placed to drive improvements, but as yet there is too little evidence of significant impact in key areas of child protection and early help.
  - Accountabilities between the Independent Chair of the LSCB, the DCS and the Council's Chief Executive are clearly defined. There are formal and informal arrangements in place to ensure dialogue and challenge.
  - Not all key partners are making a full and active contribution to improving the delivery of early help services for children and young people. This inconsistent performance is causing needs to go unmet. Children and families living in the diverse communities of Slough do not have equality of access to support services; their needs are not comprehensively met as early as they should be in order to prevent children's situations deteriorating and avoid children's social care
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involvement. Whilst partnership work is becoming more effective in some areas, increasing the impact of its challenge to partner agencies, so that they cooperate fully in the improvement of early help, is the single most important area for the board to develop.

- Although the LSCB has appropriately challenged poor attendance and variation in different agencies' contributions, this has not been effective in securing improvement in important areas of work. For example, there remains a need to secure the routine involvement of the police at critical stages of the child protection process in order to complete risk assessments at initial child protection conferences.
  - The LSCB has conducted audits of agencies' compliance with requirements in statutory guidance. However, not all partner agencies have complied fully with the audit process. The panel coordinating audits has been poorly attended and has only recently produced an action plan drive improvement.
  - While the LSCB now considers and evaluates a good range of performance information from the partner agencies, its use in quality assurance remains under-developed. It has only recently commenced multi-agency case audits and this is not yet leading to consistent discernible improvements.
  - The LSCB has clearly identified priorities which have been informed by local needs and the performance data provided by both the partner agencies and the Local Authority. However, although the data for missing children is detailed, there has not been sufficient oversight and reporting by the LSCB to determine the effectiveness of arrangements for missing children.
  - The LSCB has taken effective action to address some of the shortfalls and weaknesses in the Board's operation which were identified at the last inspection. For example, it has identified key priorities with all strategic partnership boards across the area and taken decisive action to bring about improvements. However, progress in the key areas of children's services remains in the early stages.
  - The LSCB has clearly identified priorities in the current business plan and regularly reviews its progress. The Executive Board scrutinises these decisions and actions. The LSCB has brought a clear focus to shaping strategy, policy and practice across the partnership; it has revised thresholds and engaged with children and families to improve their involvement and participation across services in regards to domestic violence, child sexual exploitation (CSE) and child trafficking. However, progress on priorities in the LSCB business plan is variable. For example, while the LSCB has been effective in raising awareness of CSE, with a corresponding increase in referrals, it has yet to complete work on a pathway to ensure a safe and consistent response to it. Support for male victims of CSE is not clearly defined and initiatives to tackle and understand the level of need to support victims of female genital mutilation are at a very early stage.
  - The LSCB has been instrumental in ensuring the appointment of a strategic lead for domestic violence. This post is now operational and leads on coordinating both the strategy and delivery of services.
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- Learning from serious case reviews is well established and suitably incorporates lessons from both local and national issues and relevant research. The learning and impact on practice is evaluated through audit activity and, where this is a local serious case review, the board effectively monitors progress. For example, it has tracked and audited progress by health agencies in implementing the recommendations of a 2011 serious case review.
  - Slough LSCB is led by an Independent Chair, appointed in March 2012, who has ensured that the work of the LSCB meets statutory requirements as set out in Working Together to Safeguard Children (Department for Education 2013). The membership of the board now meets requirements following the appointment of two lay members. Although the LSCB has received an annual report on private fostering and subsequently identified actions, this has not been reported on in the LSCB annual report.
  - Partners make appropriate financial contributions to support the business of the LSCB and the members of the board are at a sufficiently senior level to influence change in partner agencies. However, in practice there are shortfalls in sharing responsibilities, with some partners not attending meetings or reluctant to take responsibility for appropriate areas of work which increases the responsibility on the Local Authority.
  - The LSCB ensures policies, procedures and the threshold for access to services are fit for purpose, kept under review and regularly updated to reflect statutory responsibilities and changes. However, although arrangements are in place to disseminate key points of information across the partnership, the threshold for access to service is not yet embedded.
  - The workforce across the partnership is receiving appropriate safeguarding training. A well-defined learning and development strategy supports agencies to identify and address the safeguarding training needs of their workforce on a single and inter-agency basis. The LSCB has funded multi-agency early help training in the last two years. There are good quality assurance arrangements for the delivery of multi-agency training. However, arrangements to evaluate its impact on practice are less developed.
  - Although in the early stages, good progress has been made to establish reflective forums for the multi-agency audit of cases. However, operational staff are not yet fully involved in learning from this experience. Some good examples of audits have identified multi-agency learning points, which have led to improved communication. However, in general, audits remain under-developed and overly focused on process; they do not evaluate sufficiently the quality of interventions. Opportunities to identify learning at key points, particularly in cases relevant to the role of line managers, are not included in audit outcomes.
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## What the inspection judgments mean: the LSCB

An **outstanding** LSCB is highly influential in improving the care and protection of children. Their evaluation of performance is exceptional and helps the local authority and its partners to understand the difference that services make and where they need to improve. The LSCB creates and fosters an effective learning culture.

An LSCB that is **good** coordinates the activity of statutory partners and monitors the effectiveness of local arrangements. Multi-agency training in the protection and care of children is effective and evaluated regularly for impact. The LSCB provides robust and rigorous evaluation and analysis of local performance that identifies areas for improvement and influences the planning and delivery of high-quality services.

An LSCB **requires improvement** if it does not yet demonstrate the characteristics of good.

An LSCB that is **inadequate** does not demonstrate that it has effective arrangements in place and the required skills to discharge its statutory functions. It does not understand the experiences of children and young people locally and fails to identify where improvements can be made.

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