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Dear Cate and Nicola

Monitoring visit of Slough children's services

This letter summarises the findings of the monitoring visit to Slough children's services on 20 and 21 September 2017. This was the fourth monitoring visit since the local authority was judged inadequate in February 2016. The inspectors were Stephanie Murray senior HMI and Donna Marriott HMI.

From a low base, leaders have secured improvement in some parts of the children looked after service. However, managers have not ensured that the core elements of social work practice are evident enough in casework. As a result, the support that children looked after receive is inconsistent.

Areas covered by the visit

Inspectors reviewed the progress made since the last inspection, with a focus on five themes:

- The timeliness and effectiveness of the pre-proceeding processes and of care proceedings, and how these affect children's plans for permanence.
- The role of Slough's corporate parenting board, the 'joint parenting panel', in listening to children looked after and improving their experiences.
- The response to children looked after who go missing.
- The quality and consistency of social work relationships with children.
- The effectiveness of planning for children who return home from care.

Inspectors considered a range of evidence, including discussions with social workers and managers, observations of case-related meetings, children's electronic case files, discussions with senior and political leaders and partners and performance data.

Overview

The pace of improvement has not been swift enough in all areas of practice relating to children looked after. For example, key actions within children's plans are not always carried out in good time, and managers do not always identify practice weaknesses quickly enough. For some children, this leads to unnecessary delay in their needs being met, or in plans for children's permanence not being achieved quickly enough.

Leaders have taken effective steps to strengthen some aspects of the children looked after service. Long-term planning for children has improved since the last inspection, with a clearer focus on achieving permanence. Independent reviewing officers (IROs) are much more active and influential in progressing and challenging plans for children than at the time of the inspection. The joint parenting panel hears, and responds to, the views of children looked after.

Findings and evaluation of progress

Inspectors saw some positive changes that have been made since the inspection, but also a number of areas in which insufficient progress has been made.

- All of the children looked after whose cases were considered during the visit have a care plan, and most plans are up to date. However, plans too often falter when a child is allocated to a new social worker. One child was not visited by their social worker for four months; this was not identified and addressed until a new social worker was allocated. For some children, key actions are not carried out in good time, and in a small number of cases this contributes to delays in planning for children's permanent care. Inspectors saw examples of disjointed or confused planning, resulting in a lack of clarity about what needs to happen and when.
- Managers do not always oversee practice effectively to ensure that children receive the right help at the right time. One-to-one case supervision and reflective hub meetings are regular in most cases, but records sometimes lack clear actions and timescales. Within hub meetings, clinicians offer advice to practitioners about children's emotional needs, and social workers consistently told inspectors that these meetings are helpful. However, hub meetings do not always highlight delays or practice deficits, and, where they do, managers do not always act swiftly enough to address these weaknesses.
- The use of legal processes to safeguard children and promote their permanence is too variable. Emergency legal action is taken where children are at risk of immediate significant harm, and a greater number of children are considered through the pre-proceedings phase of the public law outline (PLO) than at the time of the last monitoring visit. Once a decision has been made that this threshold is met, most parents receive a letter outlining the concerns in good time. Inspectors identified some children who had experienced delays because a formal pre-proceedings process had been by-passed, or started too late. When legal processes are halted due to a decision not to go to court, plans are not always formally agreed or recorded.

Examples were seen where key parenting assessments had not been written up, leading to a lack of clarity about what should happen next. Legal planning and PLO meeting minutes are of variable quality, and do not always outline key decisions alongside timescales for actions to be completed. Planning for these children is not rigorous enough, and, overall, joint working between legal services and children's social care needs to improve.

- When children looked after go missing, most are now seen when they return. The accounts of these conversations do not always analyse what should happen to reduce the risk of children going missing again. Inspectors saw a small number of cases in which attempts to speak with children lacked creativity and persistence, reducing opportunities to understand children's experiences and to reduce the risks that they face. Strategy meetings to share information and agree steps to safeguard children looked after are not always convened when they are needed, for example when children go missing for prolonged periods.
- Planning for permanence was more evident in the cases seen during the visit than at the time of the inspection. Leaders have sought external support to help them to embed new permanence planning processes, and these are beginning to make a difference to children. However, some children have waited too long to feel secure and to have a sense of belonging.
- Oversight and challenge by IROs are increasingly evident, including in those cases in which inspectors were most concerned about the progression of children's plans. Children looked after reviews are regular. It is positive that IROs arrange additional reviews when they are worried about potential drift. Review minutes are written directly to children, and, overall, these vibrant accounts of children's lives will be helpful and meaningful to them if they wish to see their files in the future.
- In the cases seen during the visit, multi-agency plans to ensure that the needs of children returning home from care are met were too often not in place. Inspectors saw some positive examples of social workers and IROs visiting children who have returned home, spending time with them to understand their changing lives, but formal planning is weak for some children. Senior managers have identified that this is an area for improvement and they have started a commissioning process to identify an additional service to complement social work support.
- Most children benefit from regular social work visits, and some benefit from additional time with their social worker when this is needed. However, visiting frequency does not always adapt to children's changing circumstances. Inspectors saw some positive examples of direct work with children, such as working with the brothers of a child to understand the difference between exerting control over her and loving protectiveness. When social workers know children well, they talk about them confidently and with affection, but direct work is not always evident, and the contrast between the best and weakest practice is too great.

- Workforce data shows an increase in the number of permanent social workers who are joining Slough Children's Services Trust, and a decrease in those who are leaving. The number of agency social workers continues to decline steadily. However, in a number of cases considered during the visit, children had experienced too many changes of social worker. Senior managers are not able to understand this fully because they do not oversee or analyse the number of changes of social worker each child experiences.
- Overall, the children considered during the visit were well matched with their foster carers. Foster carers who spoke with inspectors demonstrated commitment, care and a strong determination to ensure that children enjoy happy and settled lives.
- In the cases considered during the visit, children's health needs had been well assessed. Following a recent decline in performance, work is underway to develop a more effective system to ensure that health assessments are consistently carried out in good time.
- Children told inspectors that they enjoy their involvement in the children in care council, 'Reach out!'. They feel that their voices are heard and that they are making a difference to the experiences of all children looked after. The attractive and high-quality booklets, videos and prompt cards that these children have designed have substantially improved the information available to children looked after. This promotes children's understanding of what it means to be looked after, and encourages their involvement in decisions about their day-to-day care.
- The engagement of the joint parenting panel with children looked after has improved markedly since the inspection. Using a themed approach, the panel routinely considers progress against the promises to children looked after that are contained within their 'Pledge'. Involvement of partners is good. Children in the 'Reach out!' group have not always enjoyed the format of the joint parenting panel. In response, members of the panel have worked with children to develop a children's scrutiny committee. The committee, which will be chaired by children and participation workers, is due to be launched in October 2017. Children are excited about this new development.

I am copying this letter to the Department for Education. This letter will also be published on the Ofsted website.

Yours sincerely

Stephanie Murray
Senior Her Majesty's Inspector