

Piccadilly Gate T 0300 123 1231
Store Street Textphone 0161 618 8524
Manchester M1 2WD enquiries@ofsted.gov.uk
 www.gov.uk/ofsted

20 December 2018

Mr Kevin McDaniel
Director of Children's Services
Town Hall
St Ives Road
Maidenhead
Berkshire
SL6 1RF

Dear Mr McDaniel,

Focused visit to Windsor and Maidenhead children's services

This letter summarises the findings of a focused visit to Windsor and Maidenhead children's services on 27 and 28 November 2018 carried out by Linda Steele and Donna Marriott, Her Majesty's Inspectors.

Inspectors reviewed the local authority's arrangements for managing contacts and referrals in the multi-agency safeguarding hub (MASH) and thresholds for children in need of help and protection, including the quality of social work practice in the duty and assessment service. Inspectors reviewed a range of evidence, including children's case records, case discussions with social workers, performance management and quality assurance information, and supervision files.

Overview

Children's services were last inspected in 2015, when the overall effectiveness of services was judged to require improvement to be good. Subsequently, frequent changes at senior and managerial levels resulted in a loss of focus and considerable instability across the workforce. This led to a decline in the quality of services for children in need of help and protection.

Since August 2017, as part of a transformation programme to deliver services more efficiently, the council has transferred the delivery of its children's services to an external provider. This resulted in additional resource and the appointment of a

director specifically to oversee the delivery of children's services, as well as a number of reviews to assess the effectiveness of the service.

A stable senior leadership team is now in place. Staff morale has significantly improved in the front door service. Staff describe a more structured framework, in which decisions are more consistent, and visible and approachable leaders and managers.

Senior leaders have an accurate view of the quality of services. An improvement plan is focusing on the right things and encouraging progress has been made in the quality of response to children when they are first referred. The single point of access (SPA) and multi-agency safeguarding hub (MASH) now provides an effective service.

Nevertheless, progress is not as evident in the duty and assessment service, where significant pressures in capacity and workforce churn have resulted in some children receiving poor quality services. Senior leaders had already identified these weaknesses prior to the focused visit and responded by increasing social work capacity. This has had some impact, with a reduction in caseloads. However, weaknesses remain in the quality of assessment and planning.

What needs to improve in this area of social work practice

- the quality and effectiveness of management oversight and supervision in guiding case progression, challenging delay and poor practice and promoting consistently good-quality social work
- the size of caseloads in the duty and assessment service
- the quality of chronologies, assessments and visiting to children in accordance with their needs.

Findings

- The quality of assessment services for children in need of help and protection has deteriorated since the single inspection in 2015. Considerable instability across the workforce has led to inconsistencies in the quality of some services for children that were reviewed during this focused visit.
- An experienced and stable senior leadership team is now in place and is making encouraging progress in tackling the weaknesses across the service. Consequently, the SPA and MASH now provide an effective response when children are first referred to the service.
- When children need statutory intervention, the response from the duty and assessment service is not consistently effective. Some children are not seen quickly enough, and some children wait too long for assessments to start or be

completed, leading to delays in them receiving the help they need. A very small minority of children have remained in situations of unassessed and unknown risk. A lack of consistent management oversight and direction has left poor practice unchallenged.

- The SPA provides an easily accessible single point of contact for all families and professionals seeking help and support. The service provides advice and guidance, access to early help and statutory provision. Managers provide a timely response in reviewing all contacts when children are first referred to the SPA. Referral decisions are mostly appropriate and well recorded, though the rationale for decisions is not always sufficiently clear.
- Social workers and partner agencies understand the need for, and consistently seek, parental consent. Referrers receive feedback on referrals made. Thresholds are appropriately applied by managers in the SPA. Partners' understanding of thresholds is improving, but this is not yet embedded across all agencies. Consequently, social workers are having to undertake unnecessary work to signpost inappropriate referrals. This reduces their capacity for other work.
- Generally, historical information is gathered to inform managers' decision-making. However, chronologies are not always completed, and when they are, they are not always concise enough to be a useful tool for social work staff.
- When referrals require a multi-agency approach, the MASH provides an effective, coordinated response. Daily MASH meetings are well attended by key partners and facilitate timely and effective information-sharing. This leads to effective analysis of risk and appropriate decision-making.
- Early help referrals are proportionate to children's needs, and a wide range of early help support is available. Information-sharing with the early help coordinator is effective. This ensures that children's needs are identified at the earliest opportunity. Although children's needs are well identified, they are not always met at the earliest opportunity, and there are waiting lists for some services. Early help assessments and plans are not all of a consistently good quality and not always in place for all children who need them.
- Senior leaders have recognised that they need to strengthen the effectiveness of early help with the recent introduction of the early help board, a new early help assessment and review documents and a launch of a new early help strategy. Senior leaders understand that they are hampered in progressing some of their early help development by the difficulties with the children's recording system, which does not reliably capture critical performance information.
- Some social work caseloads in the duty and assessment team are too high, and some children have experienced changes of worker, often at short notice. This has impacted on the quality of some casework. The experiences of children are not always adequately described in assessments and case recording. Assessments

are informed by involved partner agencies, but not all are sufficiently analytical, and they vary in quality. Although leaders have taken action to respond to the pressures in the system, providing additional capacity, considerable pressures remain. The impact of this is seen in delays in completing assessments and shortfalls in recording key information, including visits to children and chronologies.

- Decisions to start child protection enquires are appropriate and timely in the vast majority of children's cases. Strategy meetings are timely, with good multi-agency attendance. These important meetings lead to the right outcomes, and children are protected. The recording of these meetings varies in quality, and actions can be too basic and lack specificity.
- The majority of staff feel well supported. However, the quality and frequency of social work supervision is variable. As a result, plans do not always progress at the pace needed and some children experience delay in having their needs met.
- A comprehensive quality assurance framework includes a range of activities to ensure that managers have an overview of service delivery. Regular audits take place but focus too much on process and compliance rather than on quality and impact for children.
- Weekly and monthly performance huddles chaired by the deputy director are used effectively to keep oversight of performance across the service. These are hampered by the limitations of the children's database, which does not provide the right information to easily oversee performance across the service. This results in managers having to keep a range of manual spreadsheets to track and monitor performance, and this takes up their time. Senior leaders recognise this, and plans are well advanced.
- Although some challenges remain in increasing stability in the duty and assessment team, leaders have been successful in securing a more permanent workforce. Staff morale has significantly improved in the front door service. Staff describe a more structured framework, where managers and the decisions they make are more consistent, and leaders are visible and approachable.

Ofsted will take the findings from this focused visit into account when planning your next inspection or visit.

Yours sincerely

Linda Steele
Her Majesty's Inspector