4 July 2022

Kevin McDaniel, Executive Director of Children's Services, Royal Borough of Windsor and Maidenhead
Sarah Bellars, Executive Director, Quality and Nursing, Frimley Clinical Commissioning Group
Matthew Barber, Police and Crime Commissioner for Thames Valley
John Campbell QPM, Chief Constable, Thames Valley Police
Clare Knibbs, Superintendent Head of Public Protection

Dear Royal Borough of Windsor and Maidenhead Local Safeguarding Partnership

**Joint targeted area inspection of Royal Borough of Windsor and Maidenhead**

This letter summarises the findings of the joint targeted area inspection (JTAI) of the multi-agency response to identification of initial need and risk in the Royal Borough of Windsor and Maidenhead.

This inspection took place from 9 May to 13 May 2022. It was carried out by inspectors from Ofsted, the Care Quality Commission (CQC) and Her Majesty's Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS).

## Headline findings

The safeguarding partnership in Windsor and Maidenhead is effective. This strong partnership works well to help and protect children. It demonstrates care and compassion and a sustained approach to striving to deliver good services. The partnership has a clear understanding of its strengths and areas for improvement and is responsive to challenge. Partners demonstrate mostly effective scrutiny and oversight of frontline practice across all agencies. The partnership is focused on driving improvements to the provision offered to children and young people in need at their first point of contact with services. However, more work is needed to ensure that the engagement of adult services protects children and to further improve information-sharing across partner agencies.

## What needs to improve?

- Monitoring and oversight of safeguarding practice in adult services.
- Consistency and quality of partner contacts and referrals to the single point of access.
- Timely response from partners within agreed timescales to requests for information from the multi-agency safeguarding hub (MASH).
- Quality of the response from the emergency duty service to requests for support and intervention for children out of hours.

- The communication of the outcome to partners when they make contacts to the single point of access or contribute to assessments.
- Appropriate health representation at strategy meetings.

**Strengths**

- Multi-agency safeguarding partners in the Royal Borough of Windsor and Maidenhead have a clear understanding of the needs of children and families in need of help and protection and the prevalence of risk in their area.
- An accurate suite of data helps to give leaders an insight into key performance indicators relevant to meeting the needs of children and families. This enables leaders to challenge any areas where performance does not consistently address children's needs and risks of harm.
- There have been a number of multi-agency audits undertaken to evaluate the quality and impact of practice in response to the identification and initial assessment of children's needs. These audits are undertaken collaboratively, with good representation from partners, including the voluntary sector. Audits have focused on a selection of topics relevant to children's experiences, such as analysis of the quality of referrals, the response to referrals and the appropriateness of decision-making.
- Learning from a range of sources, including local and national safeguarding reviews, has led to improvements in professional practice. For example, the partnership has been proactive in ensuring that all multi-agency practitioners are actively promoting safe sleeping for babies.
- Professional partnerships in the MASH help to protect children from harm. Thresholds for statutory services are understood; professionals mostly work together collaboratively to share information, mitigating risk and ensuring that children receive the right level of help and protection at the right time.
- There are effective systems in place to ensure that children at risk of harm are identified and assessed by a range of partners.
- Partners recognise the importance of addressing children's needs early to support them, avoiding the need for children to be provided with more intensive support at later stages of their lives. A range of provision responsive to need is offered. Escalating risk and harm to children are understood by professionals, and children requiring a statutory service are promptly referred into the MASH.
- Contacts and referrals have appropriate management oversight at different stages of decision-making. This provides staff with a clear direction on what further information is needed to determine a threshold decision and intervention. Managers use the family's history to inform current decision-making.
- Professionals across the partnership explore well children's diverse needs that arise from their culture. This enables professionals to work sensitively with children and families to understand how best to provide support.

## Main findings

Contacts and referrals into the single point of access (SPA) from the partnership are mostly timely, concise and holistic. There is, however, inconsistency in the content and quality of some referral information provided to the SPA. In a minority of cases, the information from health and other providers contains insufficient information relating to children's circumstances or the level of concern about them. This creates delay, as the need to gather more information prohibits a timely response to the needs of children and families.

Not all services obtain consent, when required, before submitting a referral, meaning families are unaware that such a referral has been made. The outcome of safeguarding decisions in relation to contacts and referrals is not consistently shared with partners who make such a referral. This means partners are not aware of what actions have or have not been taken to help protect children. Consequently, practitioners are unable to plan support based on the picture of the multi-agency intervention. The partnership is aware of this shortfall and has actions planned to address it.

Strong and effective partnerships in the MASH help to protect children from harm. A clear system to screen and track referrals, aligned to consistent management oversight, ensures that risks are prioritised appropriately. Children's experiences are central to timely decisions about the steps needed to help and protect them from harm.

Professional communication in the MASH is mostly effective. This leads to risks identified by all agencies being appropriately prioritised. Proportionate checks are undertaken, and consent is appropriately considered or overridden, to protect children. In a small number of cases where consent had been sought, it was not recorded which specific requests for information from agencies parents had consented to.

Responses to requests for information from the MASH are mostly sent out and received in a timely manner. The MASH health coordinator is proficient in drawing together relevant information to support safeguarding decisions within extended family households. Responses from health providers are succinct, with good consideration of wider risk factors, and the information gathered is analysed to inform proportionate decision-making for children. For a small minority of children, there are delays in requests for information being sent out and received.

Children and families benefit from a clear early help offer which ensures that families have access to a wide range of targeted support services. However, not all intervention is sufficiently timely. When there are delays in some health input, early help intervention helps to minimise the negative impact for children who are waiting for these services. However, there is a point at which the plan cannot progress

without this intervention. This leads to delays in some children getting the help they need quickly enough.

Some children receive swift support from the early help service when they need it, resulting in successful progress and positive outcomes. The involvement of early help practitioners in MASH meetings enables information relating to early help services to be shared. Their involvement at this stage enables referrals to early help to be progressed in a timely manner. Early allocation by the early help hub, with a range of coordinated provision, results in positive outcomes for most children.

Early help plans appropriately include parents and carers. Their views are clearly articulated, and children's needs are helpfully identified using the preferred model of practice. In many cases, children's experiences improve through actions set out in the early help plan. However, in some cases, families wait too long for an allocated worker, resulting in a delay in their needs being fully addressed.

Early help advisers, funded by schools, provide strong support to schools in their work with vulnerable children. They advise school personnel on the information required to make a referral to children's social care and this has improved the quality of referral information. This means that children's needs can be assessed more quickly and helps to determine the most appropriate level of intervention to meet need. Early help advisers help schools access a range of support for pupils and parents, even when a referral is not merited. The strong positive relationships between early help advisers and school staff help to improve communication between schools and families and resolve disagreements which are impairing children's progress.

Responses to children at risk of harm are timely and effective. Strategy meetings are mostly used constructively to share relevant information about children and to make decisions about the next steps. However, health representation at strategy meetings is not always effective. Public health nurses routinely attend on a rota basis but are not necessarily the most appropriate health professionals to inform effective decision-making. The full range of health partners supporting a child are not represented and those attending do not have all the relevant health information needed. This means that decisions are often made without a full picture of children's risks and needs. Strategy meetings mostly identify relevant actions to safeguard children; however, action plans do not consistently articulate timescales for their completion. This limits the capacity to hold professionals in the partnership to account for their actions. In a small number of cases, appropriate decisions to conduct joint police and social care child protection enquiries were overridden outside the strategy meeting, limiting joint risk assessment and intervention for these children.

The outcomes of most child protection investigations result in a fitting response, reflective of the level of risk to children. Decisions to convene initial child protection conferences are appropriate and there is good attendance by multi-agency partners.

Children affected by domestic abuse receive a timely service response. Contacts and referrals made by police in response to contact with families affected by domestic abuse incidents are triaged effectively and a proportionate response identified. Specific safety plans are identified to help protect non-abusing parents and children when circumstances warrant such steps being taken.

Virtual meetings have enabled wider participation by partners in strategy meetings and initial child protection conferences, which means they are quorate, with multi-agency representation. However, as the range of partners use different information technology communication systems, this has led to an inconsistency in virtual participation by professionals who do not have access to the communication system used by professionals in the MASH.

The process of children's social care staff requesting police presence at strategy meetings through the police control room causes delay. Thames Valley Police has recognised this and has plans to use an automated process to manage requests.

Operation Encompass has operated in the local area since 2017. The aim of this operation is to ensure that schools have timely information about all police-attended incidents of domestic abuse. This enables schools to have a better understanding of children's circumstances and risk. Police do not always record which school the child attends and this leads to delays in schools receiving this important information. This inhibits schools in being able to support children affected by such incidents.

Partners mostly demonstrate effective scrutiny and oversight of most frontline practice across agencies. For example, midwives, health visitors and other health professionals work diligently with the MASH to raise concerns about unborn children who need help and support. Children's needs, to be protected from abuse and escalating harm, are appropriately prioritised and inform analysis, which results in proportionate decisions being made.

The partnership has a clear escalation process which identifies the actions to be taken when there is a difference of professional opinion. There is little recorded evidence of the use of such procedures leading to more appropriate actions when there is disagreement, such as to the outcome of strategy meetings.

Within adult mental health services, monitoring and oversight of safeguarding practice are variable and insufficient. There is a lack of understanding about risks to children resulting from behaviours of adults being worked with, or the processes involved in making a referral to the SPA for children who need help and protection. Adult services practitioners are not curious enough about the safety or needs of

children living with the adults being worked with, and therefore miss opportunities to support service users as parents and to safeguard their children effectively.

The quality of the emergency duty service response to requests out of office hours for support and intervention for children is inconsistent and not always subject to due diligence. For a minority of children, the initial response to identification of their needs is insufficiently robust. Contacts to the service are of variable quality and some do not provide sufficient information about children to identify their level of need and their current circumstances. Relevant partners and agencies do not exhibit a clear understanding of the role and function of this service.

Reports of any children who have been reported missing are responded to effectively and quickly. If a child is over the age of eight, they automatically have a child exploitation tool completed. This helps workers to identify any additional risks. This information is well used to inform the assessment of the child's needs.

Children and their families requiring further assessment and protection are promptly passed from the MASH to the social work duty and assessment team, where they are allocated for assessment. Most children are visited promptly by social workers. Social workers mostly see children on a number of occasions during the assessment, which enables them to have a better understanding of children's experiences. Assessments using the local authority's preferred practice model provide an effective framework for multi-agency consideration of risk and need and are completed in a timely manner. There is some variability in the quality and depth of partner agency information but, in most cases, it is gathered effectively and used to help inform assessment outcomes. When partners contribute to an assessment, they are not routinely informed of its outcome.

While there is a clear commitment across the partnership to workforce training, the partnership has not evaluated effectively the impact of this on improving professional practice.

When audits are completed, appropriate learning is identified. This is captured in action plans designed to implement this learning. However, the difference this makes to the quality of professional practice is not consistently evident.

An effective working relationship between the local authority and schools enables schools to be fully briefed on pertinent and relevant safeguarding matters.

The single and multi-agency audits completed by the local area as part of this inspection identified some key learning points, which demonstrates a willingness to learn from previous practice and processes. In the multi-agency audits, audits did not always focus sufficiently on the impact of actions on children. For example, audits did not always reflect on the timeliness of services and interventions for children and the impact where a plan has been agreed for a child but not followed.

The partnership has a focus on understanding the impact of services on children's and families' experiences but is not sufficiently embedded. The gathering of information directly from service users is limited, however, which diminishes the partnership's capacity to evaluate service impact.

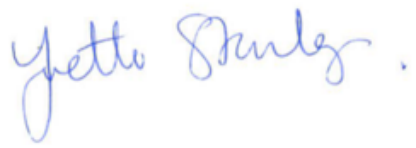
Staff across frontline teams and services report feeling well supported in their work. Professional development is encouraged, with a range of single and multi-agency training. Managers across agencies are identified as being visible and approachable.

**Next steps**

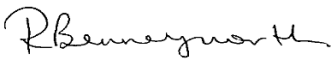
The Royal Borough of Windsor and Maidenhead should prepare a written statement of proposed action responding to the findings outlined in this letter. This should be a multi-agency response involving key partner agencies. The response should set out the actions for the partnership and, when appropriate, individual agencies.

Windsor and Maidenhead should send the written statement of action to ProtectionOfChildren@ofsted.gov.uk by 12 September 2022. This statement will inform the lines of enquiry at any future joint or single-agency activity by the inspectorates.

Yours sincerely



**Yvette Stanley**
**National Director Regulation and Social Care, Ofsted**



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