

13 June 2017

Ms Julia Hassall
Director of Children's Services
Metropolitan Borough of Wirral Children's Services
Conway Street
Birkenhead
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Dear Ms Hassall

Monitoring visit of Wirral Metropolitan Borough Council children's services

This letter summarises the findings of the monitoring visit to Wirral Metropolitan Borough Council children's services on 5 and 6 April 2017. The visit was the second monitoring visit since the local authority was judged inadequate in September 2016. The inspectors were Ian Young HMI, Susan Myers HMI and Shabana Abasi, seconded inspector.

The local authority is making some progress in improving services for its children and young people.

Areas covered by the visit

During the course of this visit, inspectors reviewed the progress made in the area of help and protection, with a particular focus on children's cases that step up and down across the thresholds for intervention.

During the visit, inspectors considered a range of evidence, including electronic case records, observation of social workers and senior practitioners and other information provided by staff and managers. In addition, inspectors spoke to a range of staff including managers, social workers, other practitioners and administrative staff.

Overview

The quality of social work practice in Wirral remains hugely variable. While there has been some improvement in children's services, progress overall has been slow since the local authority was judged as inadequate in September 2016.

A legacy of weak assessment and planning that has led to poor outcomes for children is still in evidence, particularly in children who are stepped up to child protection or become looked after for a second or subsequent time. The rationale for stepping cases up or down across thresholds is, in most cases, well recorded. The

step down from social work to early help is not routinely overseen by managers and therefore the rationale for the decision is not always clearly recorded. An absence of routine re-assessment is leading to poor planning in all but some of the most recent cases. Social workers are not identifying problems in children's lives consistently and addressing them in a timely manner. This means that children are not yet receiving a social work service of a suitable quality.

Findings and evaluation of progress

Based on the evidence gathered during the visit, inspectors identified areas of strength, areas that are improving and some areas where they considered that the progress has not yet met expectations.

The local authority is now rolling out its preferred model of social work practice to improve consistency. Social workers told inspectors that their caseloads are reducing and that good support arrangements are in place for newly qualified workers. Social workers report that they now have a good understanding of the needs of children they support. Some very recent social work demonstrates an improvement in quality, with assessments driving focused planning and intervention to improve children's lives.

Auditing of services has improved since the last monitoring visit and it is now more of a learning process undertaken by frontline managers alongside social workers to support their practice. Moderation by middle managers is effective in picking up gaps and balancing the audits' findings. Inspectors were in agreement with all of the moderators' findings. However, opportunities to learn from audits are being missed because frontline managers and moderators are not working together to share or to clarify expectations and standardise their approach to audit. This also means that senior managers are not ensuring that staff recognise what good practice is.

Early help from teams around the family (TAF) identify support needs effectively so that risk to families can be reduced, and outcomes improved for their children. Discussions among early intervention professionals at locality meetings on the most suitable package to help families are clearly recorded. TAF meetings are also well recorded with children's views evident within them. However, TAF planning is variable; grading and timescales are not always evident, making it difficult for TAF to track progress of the child against agreed outcomes.

Case summaries on social workers' records are generally up to date and give a good sense of the child. However, closing summaries written by social workers stepping cases down are not always clear about what the focus of early help work is to be, how any risk is to be managed and whether there is agreement to step down to early help from the social worker's team manager. For partners and parents, this lack of clarity prevents continuity in services. In several cases seen, the step back up to social work intervention was within a period of three months or less. This leads to further disruption in the service to families and raises questions about the depth of

understanding of professionals in making decisions about how and who is best to support the family.

In contrast to decisions taken in relation to early help, evidence seen by inspectors indicates that decisions taken in relation to thresholds for social work intervention are made appropriately. All cases seen had been through the multi-agency safeguarding hub and First Response team as referrals. The rationale for stepping cases up to social workers is therefore clearly recorded. Where young people are at risk of sexual exploitation, plans to keep them safe could be more clearly integrated with child protection or care plans.

Inspectors saw very few social work re-assessments to inform planning across any threshold, up or down. One exception is where a child is to be the subject of an initial child protection conference. In these cases, assessment of their current circumstances is routine. All assessments seen on more recent cases stepping up to child protection conference were at least satisfactory. Some were good and a few very good. This is an improvement since the last inspection. However, routine updating of assessments is mostly absent across other thresholds, even where children's circumstances have changed considerably, such as becoming looked after. Plans to improve children's lives are not therefore routinely based on a thorough and up-to-date understanding of their current needs.

Inspectors found that social workers spoken to were confused about the status of children in need cases where a multi-agency risk management meeting had taken place. Some incorrectly believed that such cases met the threshold for child protection but could be managed without the need for a child protection plan. Local authority senior managers have not ensured that every social worker is clear about exactly what risk management meetings are and why they are used. If children meet the threshold for child protection then a child protection plan should be considered.

Plans written by social workers are highly variable in quality. Some children in need plans are very clear. In these, step up was appropriate and social workers' reasoning was sound. In another case tracked by inspectors, when a child stepped down from being looked after, children in need planning was of very poor quality, yet the case was again being stepped down to TAF after only three months. Child protection plans seen were not sufficiently specific and measurable, with no timescales set nor outcomes agreed. The local authority has recognised the limitations of the planning format on their electronic recording system and has changed it, but it has still not introduced new plans.

In all cases sampled where children had recently become looked after, step up is appropriate. Legal planning meetings held under the Public Law Outline clearly record decisions. Letters before proceedings appropriately inform parents about social workers' concerns, what needs to change and what potential next steps could be taken by social workers if change is not achieved by parents. Up to date case

summaries are evident on all children looked after's case records, although it is not always clear where the child is currently living.

Care planning for children who are becoming looked after for a second time is highly variable. All young people whose cases were sampled were affected by their early life experiences. In the best cases seen, re-assessments set out clearly the child's need for a further care plan and a timetable for outcomes to be achieved from the care episode. In other cases, assessments had been completed for court hearings and care planning for these children was also of a better quality. However, not all re-assessments were this strong. Updates to care plans are slow to take effect and are in some cases very slow, with no sense of urgency when the child has suffered the significant trauma of placement breakdown. The current absence of swift access to a child and adolescent mental health service (CAMHS) hampers social workers' response. The waiting list is eight months, and this is too long. The local authority has recently recommissioned CAMHS to improve access for children looked after. Poor care planning by social workers does not always address the situation that caused the step up to being looked after for a second time. Very poor placement planning gives no indication of what will be different this time from the circumstances that led to placement breakdown last time.

Placements for some children with connected carers have ended too quickly because the carers have not always received appropriate levels of support. For example, inspectors sampled one case that had been assessed by a social worker as having no ongoing support needs, but placement breakdown occurred within one month of a special guardianship order being made. Little evidence was available to inspectors that independent reviewing officers are driving care planning as they should. For instance, there is no evidence of reviews being brought forward after significant changes in children's circumstances. There is no sense from case records that anyone understands the negative direction the lives of some of these very vulnerable children looked after is taking. Current solutions are fragile and in distinct danger of failing again, because little or no effort has been made to learn from the breakdown of the previous placement.

Some level of management decision-making is evident on all case files, although the way this is recorded is highly variable, ranging from a clearly thought-through rationale for approving step up, to a single sentence stating agreement. Recording on social worker's supervision notes is also variable. Timescales are not always set when tasks are identified. This makes it difficult for managers to monitor progress. However, some supervision notes rightly refer back to previous supervision sessions to check social worker's progress on management directions. Some team managers sign off minutes of core groups of professionals delivering the child protection plan, as they should, and they offer challenge where there is drift. Far more management oversight and discussion takes place than is recorded. Social workers and managers are more reflective and analytical than is evidenced in files, and they are therefore not always capturing their own good practice.

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

Yours sincerely

Ian G Young
Her Majesty's Inspector