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Dear Mr Boyce

Monitoring visit to Wirral children's services

This letter summarises the findings of the monitoring visit to Wirral children's services on 14 and 15 March 2018. The visit was the fifth monitoring visit since the local authority was judged inadequate in September 2016. The inspectors were Sheena Doyle, HMI, Paula Thomson-Jones, HMI, and Melanie Davies, Ofsted Inspector.

The local authority has made progress in improving the arrangements for access to services for those children who need support and protection.

Areas covered by the visit

The focus of this monitoring visit was on the arrangements for access to early help and statutory children's services via the multi-agency Integrated Front Door (IFD) service.

Inspectors considered a range of evidence, including electronic case records, minutes of meetings, and observations of referral-taking, recording, analysis, and case discussions. Inspectors also spoke with administrators, social workers, advance practitioners, managers and specialist staff from partner agencies.

Overview

The local authority has made effective efforts to address some of the shortfalls identified in the single inspection framework inspection of September 2016 regarding help and protection services. Threshold guidance was successfully relaunched in 2017. A survey undertaken by the local safeguarding board in October 2017 confirmed an increase in understanding and use of the thresholds guidance among practitioners and managers across the partnership. The quality of assessments at the

IFD is good. However, further work is needed to ensure that there is a full contribution from partners and to improve the quality of assessments undertaken by the locality social work teams.

A single point of entry for all contacts to children's services, the IFD, has been developed. Social work staff review all contacts, apply thresholds consistently and ensure that all children are swiftly diverted to the appropriate level of help. This includes those children who are suitable for early help services below the threshold of statutory intervention.

Information gathering and decision-making is recorded well on children's files, enabling clear understanding of the actions taken. Careful attention is paid to securing parental consent or recording the reason why consent is not required. Children referred to IFD who are at risk of significant harm are identified quickly. Prompt and effective multi-agency strategy meetings take place to plan effective intervention to keep children safe.

There continues to be delay in police notifications regarding domestic abuse incidents being reviewed and referred to social work staff. This leads to some children not receiving the support they need quickly enough.

The quality of assessments is variable, with those undertaken by district social work teams having significant weaknesses. This leads to some children being subject to multiple assessments as well as delay in their receiving the support that they need.

Findings and evaluation of progress

The IFD includes the multi-agency safeguarding hub (MASH), which means that there is only one point of contact for all requests for help. Contacts to the IFD come from a wide range of sources, indicating good awareness of how to make referrals and request services. The quality of information provided by partners is variable, and often provided over the telephone rather than in writing. While the majority of referrals seen were timely, referrals are not being made early enough to social care for some vulnerable unborn children, and assessments are taking place at a late stage of their mothers' pregnancies.

Experienced and knowledgeable social workers and managers respond to all contacts in a timely way. Thresholds are well understood and applied, ensuring that children are referred to the right place to receive help and support. Decision-making is clear and well recorded, and demonstrates that full account is taken of children's histories when deciding on suitable next steps. Managers in the IFD have access to a live desktop performance report, which enables them to ensure that work is progressing in a timely way. Recent changes to recording practice have streamlined the way that contacts are recorded. This enables managers to capture data about contacts more

accurately. Importantly, it also makes it easier to see a child's history and therefore inform decision-making. However, it is too early to judge the impact of this change.

The quality and appropriateness of threshold decision-making is tested on a weekly basis at multi-disciplinary meetings. This is done using a random sample of contacts that have not led to a social care referral, and by identifying strengths and shortfalls in the management of each contact, leading to remedial action where necessary. This practice promotes a continuous cycle of improvement in the quality of decision-making and thoroughness of response, such as routinely informing referrers of the outcome of referrals.

There is prompt consideration of requests for early help and referral to suitable services. Locality-based early help social workers ensure that these referrals lead to timely provision of appropriate services for children and their families. Weekly early help allocation meetings ensure effective consideration of cases where there is a need for additional advice, and provide a clear route by which cases can be stepped up to children's social care.

There continues to be delay in referring for a service those children who experience domestic abuse. Insufficient capacity within the police in the IFD results in delays in domestic abuse incident reports being screened and progressed for referral to children's services. Police officers attending an incident risk assess the immediate situation so that they are able to prioritise and deal with the most serious incidents quickly. When officers in the IFD review the incident reports, they consider the history or the potential impact on children and, as a result, some are then upgraded when additional risks are identified. A small number of children are left living in situations of unassessed risk when risks exist, but are not identified in the original incident report. This demonstrates little improvement since the inspection over 12 months ago, which found a delay in police notifications to the MASH ranging from three days to four weeks.

The co-location of multi-disciplinary staff within the IFD enables frequent discussions and appropriate information sharing about children. Relevant agencies are approached for background information where this is warranted, and relevant consents are sought. Decisions to override consent are appropriate and clearly recorded. Responses to safeguarding concerns are prompt.

Daily liaison between the daytime and out-of-hours services ensures a smooth transition of information. Staff at the out-of-hours service have strategy discussions and take appropriate emergency safeguarding actions as necessary. All out of hours activity is recorded on the children's electronic files promptly, ensuring that relevant workers have up-to-date information to progress children's assessments and plans.

When children who are at risk of significant harm are referred, the IFD responds quickly, and effective multi-agency strategy meetings take place. Information sharing is effective, but investigations often result in professionals working in parallel with each other rather than undertaking effective joint working.

The quality of assessments undertaken with children is not yet consistently good. Those completed by social workers in the IFD are generally stronger, with good consideration of historical information and good quality contributions from partner agencies. Assessments completed by locality teams are consistently weaker, with poor consideration of a child's history or their lived experience, even when this includes periods subject to protection plans or being in care. For these children, there were often repeated referrals and assessments, and ineffective or no interventions. Children who are allocated to social workers in the locality teams, and are thought to be at risk of significant harm, do not benefit from timely strategy discussions to plan investigations. For some children, there were delays of many weeks before strategy discussions took place, despite concerns being identified. This resulted in delays in effective plans being put in place to safeguard them.

Children who go missing from home or care receive a prompt, thorough and sensitive follow-up service from the contracted third sector provider, in partnership with statutory agencies.

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

Yours sincerely

Sheena Doyle
Her Majesty's Inspector