

Ofsted
Piccadilly Gate
Store Street
Manchester
M1 2WD

T 0300 123 1231
Textphone 0161 618 8524
enquiries@ofsted.gov.uk
www.gov.uk/ofsted



22 June 2018

Paul Boyce
Corporate Director for Children
Children's Services Department
Cheshire Lines Building
Canning Street
Birkenhead
Wirral
Merseyside
CH41 1ND

Dear Paul Boyce

Monitoring visit of Wirral children's services

This letter summarises the findings of the monitoring visit to Wirral children's services on 30 and 31 May 2018. The visit was the sixth monitoring visit since the local authority was judged inadequate in September 2016. The inspectors were Sheena Doyle, Her Majesty's Inspector, Sue Myers, Her Majesty's Inspector, and Melanie Davies, Ofsted Inspector.

The local authority is making progress in improving services for its children and young people who need to be looked after.

Areas covered by the visit

The focus of this monitoring visit was on the experiences and progress of children who had recently become looked after, including those children at risk of child sexual exploitation and those on the edge of care, including pre-birth assessments. Inspectors reviewed the progress made in the areas of: thresholds for becoming looked after; the timeliness of statutory intervention; and the suitability of the plans and progress towards permanence for the children.

Inspectors considered a range of evidence, including electronic case records, strategic plans, and terms of reference for a range of decision-making meetings. Inspectors spoke to social workers, team managers, and the independent reviewing officer (IRO) for each of the six children's cases reviewed by inspectors and audited by the local authority. In addition, we observed a daily meeting on child sexual exploitation and spoke to senior managers about the new 'edge of care' services, arrangements to track all pre-birth referrals, and the role of legal gateway meetings.

Overview

At the time of the inspection in 2016, the judgement for the experiences and progress for children looked after and achieving permanence was that it required improvement. At this monitoring visit, inspectors found evidence of progress in relation to the local authority's strategic response to children looked after, through the implementation of new processes and procedures. However, more work is needed to improve social work practice to ensure that all children looked after receive a good service that improves their experiences. The local authority is aware of the shortfalls in practice and is taking steps to address them.

All the children's cases reviewed by inspectors met the threshold for care. Their progress towards legal permanence is monitored to ensure that it is timely. Children of all ages are appropriately considered for care and older children have a suitable range of options to help them progress towards independence. Many of the children have experienced lengthy poor parenting and inconsistent care and protection prior to becoming looked after. Some assessments of their needs are insufficiently detailed and lack analysis, resulting in plans that do not address all their needs, including those arising from historical abuse and/or neglect. Recently introduced arrangements to oversee children at risk of child sexual exploitation are robust. However, practice is too variable and some children at risk of child sexual exploitation need better support and protection.

Findings and evaluation of progress

All of the children reviewed are benefiting from being looked after and having social work input. All the social workers and team managers spoken to know their allocated children well. They articulated key information about each child/young person and were able to describe how they had built relationships with them. Inspectors also saw good examples of purposeful direct work. This had taken place despite children's young ages and/or communication difficulties. This was particularly encouraging with regard to older children who were reluctant to engage with social work support because of their previous experiences, with workers thinking sensitively about how best to build respectful and fruitful relationships with these children to good effect.

All of the children had experienced neglect and/or abuse over varying lengths of time, and workers, were alert to the impact that previous events have had on them. Despite this, assessments of older children who have had lengthy involvements with children's services take insufficient account of their earlier experiences. This means that important information is missing from their assessments and therefore does not inform their plan. For some children, for example those who have lived with domestic abuse for many years, it is difficult to see what their lived experience has been as this is not collated and analysed well enough. This reflects previous poor practice. For other children, important information is recorded in their file, or a sibling's file, but it has not been used to inform current interventions.

The audits of social work practice are generally appropriate. Some audits contain too much description of case events rather than an evaluation of practice and suggestions for improvements. Staff value the audits and are aware of the requirement to undertake remedial actions. Managers attempt to follow up and ensure compliance with all the actions that they, or others, have identified as outstanding tasks on children's cases. However, this is not fully effective, and inspectors saw important actions, such as progressing sibling contact, remaining unaddressed.

There is sometimes an over-reliance on a single event, such as a bruise on a child, to justify legal proceedings, and insufficient weight and analysis is given to chronic long-standing neglect and/or abuse, which ultimately reinforces the need for statutory intervention. Incomplete understanding of a child's history leads to weaker assessments, and plans and interventions that do not address all their needs. While this is a shortfall, it hampers rather than negates the positive progress that the children are making.

All the children reviewed met the threshold for care, with senior managers authorising all admissions into care, including emergency admissions. The legal status and progress of children are monitored at regular legal gateway meetings. Once children become looked after, their progress is tracked to ensure that permanency plans and legal security are achieved as swiftly as possible. Legal gateway meetings are attended by the local authority's legal advisers and provide a record of the social workers' key concerns. However, the minutes do not detail any legal advice on the available options open to the local authority alongside the viability and benefits of each option. This means that it is not always clear what alternative courses of action were considered and discounted, and for what reasons.

The need for older children and young people to become looked after is properly considered, although there is high demand for suitable places and this limits choice. In one case, it was unclear whether the local authority had complied with statutory guidance with respect to informing a young person over the age of 16 about the benefits of becoming looked after instead of receiving services as a 'child in need'. This had been rectified prior to this monitoring visit and the young person is receiving appropriate services, with the IRO's guidance having a positive impact.

Senior managers were aware of weaknesses in some policies and procedures and have recently taken remedial steps to address these. The local authority's review of practice in relation to youth homelessness earlier this year found shortfalls. The joint protocol has been revised in line with statutory guidance, and arrangements are now in place between housing and children's social care services. The aim of these arrangements is for all potentially eligible young people to receive appropriate services. The plan to improve arrangements includes the new 'edge of care' panel, which will consider all young people who present as homeless. Ongoing meetings between senior staff in both departments are underway in order to address other deficit areas, such as sufficiency of accommodation. While it is too soon to judge the impact of the edge of care panel, the model is strengthened by being multi-agency, with the panel having the capacity to spot-purchase bespoke services for individual

children and their families. This is one of several examples where the local authority's pace of progress and targeting of priority areas can clearly be seen and is positive.

Children do not always benefit from effective work between partner agencies. Inspectors saw extreme variations with respect to joint work. For some children, there was frequent, effective communication and effort between partner agencies. This supported children well. At other times, joint work and communication was poor. It is positive that the local authority had already recognised the need for improvement. Reviews are underway in children's social care and the health trust, which plan to share findings and jointly progress recommendations for improvements. Joint working is also a recent area of scrutiny by the local safeguarding children board.

The local authority has recently implemented daily child sexual exploitation multi-disciplinary meetings. Senior managers advised that they had become aware that children at risk of sexual exploitation were receiving a variable service, so introduced this arrangement to improve oversight. These meetings are robustly chaired and accurate minutes are taken. It is a strength that each meeting considers all those who have gone missing in the previous 24 hours. Actions are clear, ascribed and reported on at the next meeting, ensuring that progress is swift. While these new arrangements are positive, the local authority must also ensure that social work practice improves to support and protect individual children who are deemed to be at risk of child sexual exploitation. From the small sample of cases looked at by inspectors, plans did not take account of the child's known characteristics, such as significant cognitive delay, and the narrative on files was too negative, for example describing a young person as making a lifestyle choice that placed themselves at risk.

A further example of how the local authority is improving processes to support practice improvement is in relation to pre-birth assessments. Where there are concerns for the unborn children, monthly multi-disciplinary meetings are held, and the pregnant woman is provided with support appropriate to their level of need and risks. The progress of all women is monitored via a single spreadsheet, reducing the likelihood of any being missed. Professionals are positive about arrangements but are unable to quantify their impact; there are no success criteria, or other evaluation of available data. Feedback from the women is not sought and this is a missed opportunity for the local authority to learn and improve practice.

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