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Dear Ms Ioannides

Focused visit to Wakefield Council children's services

This letter summarises the findings of a focused visit to Wakefield Council on 27 and 28 February 2018. The inspectors were Neil Penswick, HMI, and Matthew Brazier, HMI.

Inspectors looked at the local authority's arrangements for the 'front door', the service that receives both single and multi-agency contacts and referrals.

Inspectors looked at a range of evidence, including case discussions with social workers and an evaluation of children's case records. They also looked at local authority performance management, quality assurance information, commissioned evaluations of current practice and relevant action plans.

Overview

There are significant weaknesses in the quality of children's services in Wakefield, resulting in some children not being appropriately safeguarded or having their needs met. There are delays in allocating cases, visiting children and their families, carrying out assessments and in taking the appropriate action to protect children. Management oversight, including supervision, is variable and in some cases not evident. Social work recording is too often missing and quality assurance and performance management systems are not sufficiently robust to ensure that managers are fully aware of the quality of services and the experiences of individual children and their families. The chair of the Local Safeguarding Children Board

(LSCB) has significant concerns about the quality of the local authority children's services.

Politicians, the chief executive and senior managers are well aware of the issues, have taken some positive steps and have plans in place to address the concerns. However, at the time of the focused visit there was insufficient capacity at all levels of the service, and the issues of poor practice were so widespread that it will be a significant challenge for these plans to result in children being sufficiently safeguarded in the immediate future.

Areas for priority action

The local authority needs to take swift and decisive action to address the following areas of weakness in child protection:

- delays in case allocation, assessment and seeing children at risk of harm
- management oversight and decision-making in relation to safeguarding practice, including supervision of staff
- social work recording, performance management and quality assurance arrangements.

What needs to improve in this area of social work practice

- Audits need to recognise good practice and consistently challenge weak practice, and identified concerns need to be immediately addressed.
- There needs to be a sufficient number of experienced social workers, managers and senior managers, who in turn need to be suitably deployed to ensure a robust social work response to children and families.
- The relationships between the local authority and partners through the LSCB need to be strengthened in order to better support understanding of thresholds and their application, including the attendance by partner agencies at strategy meetings.

Findings

- At the time of the focused visit, there were significant capacity issues throughout Wakefield children's services. At the most senior level, the previous and longstanding director of children's services (DCS) left in November 2017. A permanent DCS has been recruited and is due to start in March 2018. An experienced DCS has been in post during the interim period. The service director for safeguarding and family support left the local authority in April 2017 and this post has not been filled, although another senior manager is covering the duties of the post. The local authority was

open with inspectors about the concerns around the quality of their services. They described the changes they are bringing in, including a 'transformation plan' to incorporate the recommendations from recently commissioned reports from external consultants. They are also starting to work with regional partners to help them with the key areas that need to be improved.

- There are significant gaps in frontline management and social work staffing throughout the service. Social work teams have insufficient capacity to meet the needs of children and families. At the time of this focused visit, senior managers had recruited 29 agency staff and were looking to recruit to two additional social work teams to address the staffing issues. The social workers who met inspectors reported being under a lot of pressure. Many of them have high caseloads. While some reported being well supported by their managers, others were unhappy with the support they receive. A significant number of the social workers who spoke to inspectors said that their morale is low and that they regularly work evenings and weekends. There are high sickness rates, and some workers state that there are increasing numbers of social workers leaving to work elsewhere.

- Prior to the focused visit, the local authority and the LSCB had identified concerns about the application of thresholds at the front door. A commissioned report in November 2017 identified that around 90% of contacts being received by Wakefield children's services did not meet the agreed thresholds for social work intervention. Conversely, a January 2018 multi-agency audit identified that about 10% of cases at the front door had been closed inappropriately without further work being undertaken, including ensuring that children were safe. Partner agencies do not agree on the thresholds for intervention and closure, which reinforces the LSCB's concerns.

- Senior managers have responded to the concerns and introduced some changes very recently to management and social work capacity in the Wakefield 1 call centre and in the Multi-agency Safeguarding Hub (MASH). These are staffed by experienced social workers and partner agency representatives, including staff from the West Yorkshire Police, and from health and education services. Since December 2017, the response time in actioning referrals within one working day has improved from 43% to 82%. However, this has resulted in the number of referrals being passed to the struggling social work locality teams doubling: from 66 per week at the beginning of January to 130 in the week prior to the focused visit.

- Recently, the MASH has instigated strategy meetings on new child protection referrals promptly, with good attendance from partner agencies. However, in the cases seen by the inspectors, there were delays in progress from this point, and in a few cases there was no evidence that the children had been seen. There are difficulties in ensuring full attendance at strategy discussions for open cases in the locality teams, and inspectors saw correspondence from

the West Yorkshire Police stating that they would not be able to attend strategy meetings for 48 hours.

- Inspectors reviewed the circumstances of the last six children who had come into care. All of these children should have been in care, but overall the decision-making was not timely and was generally reactive to crises. There were serious delays, and decisive action had not been taken, despite the awareness of long-standing risks. This resulted in lack of progress and poor outcomes for the children. Decision-making was not consistently robust, and there was limited evidence of management oversight and direction. Assessments for these six children were of variable quality and timeliness; generally assessments were descriptive rather than analytical, and did not describe children's experiences well.
- The most recent local authority performance data continues to identify significant challenges in relation to managing the volume of work. The impact is evident in high numbers of unallocated cases and delayed assessments. Most child protection visits were not being completed within the timescales agreed to safeguard children or meet their needs.
- Inspectors sampled unallocated cases across the teams. In most of the cases, there was no evidence of risk being identified, managed or reviewed. This lack of oversight and poor management through the duty systems is leaving children at risk of harm, and there is unassessed risk.
- At the last Ofsted inspection in 2016, inspectors identified that the electronic database was not fit for purpose. The new database has been commissioned and will go live in March 2018. However, the database is not presently supporting the social work task. Recording of some work is poor. Key planning documents and records of visits are absent, including those for child protection enquiries. This makes it difficult for the local authority to understand the nature of the risks to the child and what actions have been taken. This does not support management oversight and challenge. Inspectors raised issues in about 10% of the cases they looked at and found that the quality of recordings was so poor in some instances that it was not possible to identify what work had been undertaken.
- Social workers reported to inspectors that they had irregular supervision, with some experiencing months between supervision meetings. Supervision records seen did not focus on decision-making around cases and were not reflective. Inspectors did see some examples of good supervision records, but mostly they were poorly written or not written up at all. Support for newly qualified social workers is inconsistent.
- The local authority is rolling out a programme of training and supervision for all workers on an established and well-regarded model of social work practice. Social workers report that due to work pressures, they have been unable to attend training sessions. The local authority has recently delayed the training programme because of these issues.

- Inspectors also sampled audits conducted by the authority. There is no agreement amongst auditors of what good looks like. Consequently, some audits are too accepting of weak practice, including judging cases to be 'good' when there were delays in allocation and actions, poor planning and no supervision. The local authority, aware of these issues, commissioned a consultant who has developed a new approach to carrying out audits. This is due to be rolled out across Wakefield.

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

Yours sincerely

Neil Penswick
Her Majesty's Inspector