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Dear Paul Boyce

Monitoring visit of Wirral local authority children's services

This letter summarises the findings of the monitoring visit to Wirral local authority children's services on 4 and 5 September 2018. The visit was the seventh monitoring visit since the local authority was judged inadequate in September 2016. The inspectors were Sheena Doyle and Shabana Abasi, Her Majesty's Inspectors.

The local authority is making progress in improving social work support in some areas of services for children in need of help and protection. However, there are some areas of joint working with health and police services that are poor, and this is a risk to children. The local authority is aware and is working with its statutory partners to resolve these deficiencies.

Areas covered by the visit

The focus of this monitoring visit was on the experiences and progress of children who had recently been the subject of safeguarding referrals and initial child protection conferences (ICPCs). Inspectors reviewed the progress made in the areas of: thresholds for safeguarding referrals; the timeliness of statutory intervention; thresholds for convening child protection conferences and the effectiveness of child protection plans since April 2018.

Inspectors considered a range of evidence, including children's electronic case records, service plans and performance data. Inspectors spoke to social workers, team managers, and the independent reviewing officer (IRO) for each of the children's cases audited by the local authority. In addition, inspectors sampled the records for seven other children from this cohort who had not been subject to audit by the local authority.

Overview

At the time of the inspection in 2016, the judgement for the experiences of children who need help and protection was that it was inadequate. At this monitoring visit, inspectors found evidence of progress in relation to the local authority's response to children who need protection through a child protection plan. The children tracked and sampled on this visit had all their safeguarding needs identified and met. All had received timely assessments of need and were in receipt of appropriate services. Thresholds were appropriate. It is encouraging that earlier poor assessments and weak practice in a few cases had been recognised, resulting in remedial action and fresh assessments and support being provided for children. The quality of social work practice in each case was effective and making a difference.

Some strategy meetings are not compliant with statutory guidance because health services are not always in attendance. Police and children's social care staff do not share information well enough or plan together to ensure that children's needs can be met in a timely way because criminal investigations sometimes take priority over the safeguarding plan for the child. This has resulted in delays in children's needs being assessed fully and met.

Findings and evaluation of progress

Thresholds for child protection enquiries are appropriately applied. Strategy discussions occur, and children are seen by social workers to assess their safety. In a minority of cases, the strategy meeting was delayed. Strategy meetings are recorded well and the rationale for actions is clear. The meetings are routinely attended by children's social care staff, the police, and other specialists as requested. However, most strategy meetings lack information or attendance by any health professional. This is not compliant with statutory guidance, and means that decisions are potentially made on incomplete information.

Some child protection investigations proceed as single agency (children's social care) when a joint visit by police and social care would be more beneficial. Strategy discussions do not fully consider the complexities of the parallel processes of criminal enquires and child safeguarding processes proceeding simultaneously or ensure the effectiveness of both. Records show that the criminal investigations can take priority. This has resulted in, for example, social workers being constrained from discussing serious incidents with parents and/or children, being unable to establish the impact of traumatic events on children or establish the parental capacity to protect and being unable to provide suitable support. Social care staff do not always understand the reasons for some police actions, such as refusing 'achieving best evidence' interviews.

Two examples were seen where children have been stepped down from social care support to early help services but have then been quickly re-referred to social care. It is a concern that the children were stepped down prematurely, but the clear route for early help services meant that these children were promptly escalated and received appropriate support.

The format and guidance for ICPCs has improved, and minutes show that the areas of concern are explicit. Timeliness of conferences is poor, with only 65.5% occurring within statutory timescales, although the local authority advises that approximately a third of late conferences occur by day 18, which is three days beyond the expected target. Inspectors were advised by senior managers that every child has an agreed safety plan in place in the interim. The local authority monitors and understands the reasons for the delays. These include increasing demand on the conferencing service as the number of ICPCs has increased, resulting in more children being on plans. At 31 March 2018, there were 253 children on a plan, but at 5 September 2018 this was 422, an increase of 169 over five months. Senior managers advise that this is a positive outcome of deliberate scrutiny of safeguarding activity and believe that children are now receiving appropriate levels of safeguarding support. Current figures place the authority in line with its statistical neighbours, which is an improvement.

Inspectors reviewed cases where a child protection enquiry had been undertaken but had not led to an ICPC because of the low level of risk identified. These decisions were appropriate to the level of risks identified, with the children benefiting from ongoing assessment and provision of services. All other cases reviewed met the criteria for ICPC.

Conferences are generally well attended and are used to share background information. IROs reported that the health service attendee often does not know the child, which reduces the value of their contribution. IROs also told inspectors that the police do not always attend ICPCs.

Family members are encouraged to attend conferences and are well supported when they do so. The local authority monitors the performance of conferences, including attendance and preparation, such as providing parents with advance copies of reports, to help continuous improvement. Inspectors were provided with feedback gathered from parents and professionals about conferences that they had attended, and these were overwhelmingly positive. Parents said that they understood the reasons for the concerns and felt listened to. However, the electronic child protection plan template that the local authority use is not family friendly and is not easy to understand.

Core groups are well attended and include parents. Efforts are made to maximise parental attendance by considering times and locations. Outline child protection plans drafted at conferences are actively updated at core groups and most show whether progress is being made. In a few instances, it is unclear whether children are making progress. This is because their plans lack timescales and are insufficiently focused on the key areas where change is required. Some plans use professional jargon, which does not help parents to understand what they need to do.

Children's electronic files are up to date and well recorded. Case notes, case summaries, descriptions of activity and analyses are generally clear and give a good

picture of case progress. Other aspects of children's files, such as chronologies and genograms, are weaker. Chronologies are generated by the electronic recording system, and do not provide a good account of key events in a child's life, and genograms are often absent or inaccurate.

Files show increasingly robust management oversight. Managers regularly review cases and provide clear advice and direction for social workers. The voice of the child was evident in all of the files reviewed. Social workers visit children in accordance with agreed timescales and the visits are well recorded. Records show that the visits are purposeful and include direct engagement with children.

Social workers understand and recognise risk factors in children's lives, for example the impact of domestic abuse on non-abusive parents and their children. Inspectors also saw social workers maintaining appropriate levels of professional curiosity and understanding the limitations of uncorroborated parental self-reporting. Disguised compliance is understood and worked with diligently. Most assessments took good account of all risk and protective factors. One was weak and overlooked risks. However, this was rectified by a subsequent thorough assessment. Assessments take account of family history and previous concerns and this is a significant improvement since the last inspection. One case, where intra-familial and multi-generational sexual abuse was a feature, benefited from a thorough review of the historical files, resulting in effective current assessments and protection plans.

Children receive appropriate support services promptly, apart from those referred for child and adolescent mental health services, where a 12-week waiting list was noted. Funding for specialist placements, such as a mother and baby placement, was promptly agreed, enabling placement finding to proceed swiftly.

The involvement of members of the wider family is variable. In some cases, members of the extended family are involved in safety plans for children, where appropriate, and this is positive. Other cases show that workers have not been proactive in engaging with extended families. This includes children's fathers, for example, where the father has perpetrated domestic abuse or does not live in the same household. However, inspectors also saw social workers persevering well to engage reluctant families and cases being able to progress because of the quality of trust and the relationship between the worker and the family.

All social workers, team managers and IROs spoken to know the children and their circumstances well. Staff were keen to engage in discussions about what best practice is and where cases could be strengthened further. They were positive about working in Wirral. They also reported feeling that progress was being made, and early fears about change are falling away. Team managers are positive about the renewed emphasis on performance information and the higher standards they are being held to.

The local authority reports improved stability in the IRO workforce, with a gradual shift from agency to permanent staffing. Recent recruits are positive about the induction and management support available to them, and the general direction of

travel in children's social care services. However, because of the increase in numbers of their caseloads, IROs are concerned about their ability to be effective if caseloads remain at these levels.

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