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8 May 2019

Mr James Winterbottom  
Director of Children's Services  
Wigan Metropolitan Borough Council  
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Library Street  
Wigan  
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Dear Mr Winterbottom

### **Focused visit to Wigan Metropolitan Borough Council children's services**

This letter summarises the findings of a focused visit to Wigan Metropolitan Borough Council children's services on 6 and 7 March 2019. The inspectors were Nigel Parkes and Steve Lowe, Her Majesty's Inspectors.

Inspectors looked at the local authority's arrangements for children in need of help and protection, with a specific focus on the quality, impact and effectiveness of planning for these children. In doing so, inspectors considered the application of thresholds, the effectiveness of operational partnerships and the strength of management oversight.

Inspectors considered a range of evidence, including case discussions with social workers and managers. Inspectors evaluated the local authority's performance management and quality assurance information, and children's case records. They also met with child protection conference chairs.

### **Overview**

Issues and concerns about the quality, impact and effectiveness of assessments and plans, identified at the time of the last inspection in February 2017, have not been fully resolved. Needs and risks are identified appropriately, and inspectors did not find any evidence of children being left at immediate and unassessed risk of significant harm. But the quality of assessments is still too variable. Plans are still not easy to understand or use and, as a result, core groups and child in need (CIN) review meetings are not as effective as they should be in monitoring and evaluating

progress. Social workers are still not always getting the right level of critical challenge and case direction from supervision that they need and deserve.

The new senior leadership team in children's social care has a good understanding of these issues. The director of practice and her heads of service share a clear sense of purpose and direction and are taking decisive action to improve the quality of social work practice and, by extension, children's experiences of help and protection. This has undoubtedly contributed to a renewed sense of energy and pace. However, service plans are not specific or measurable. Performance management reports tend to be descriptive rather than analytical, and the quality assurance framework is not fully developed or embedded. This has the potential to undermine senior leaders' effectiveness and their ability to be held, and to hold each other, to account.

### **What needs to improve in this area of social work practice**

- Plans that are effective and lead to positive outcomes for children.
- Consistently robust management oversight and social work supervision.
- Service plans that are specific and measurable.
- Quality assurance that consistently promotes shared learning and drives improvements.

### **Findings**

- Most cases are being held at the right level, in line with assessed needs and risks. Children's cases are stepped up appropriately from CIN to child protection, and from child protection to care proceedings, via legal planning meetings. Letters issued using the Public Law Outline are clear and easy to understand. When needs and risks decrease, most cases are usually stepped down appropriately.
- Social workers talk knowledgeably about the children and families they are working with. Case summaries are clear, succinct and up to date and routinely describe children's personalities, interests, wishes and feelings. However, while consideration is given to past events, senior leaders recognise that the quality of chronologies is still an area for development.
- Although assessments, including reports for initial child protection conferences, are reasonably detailed, the quality of analysis they provide is not always sufficiently clear or succinct. Needs and risks are identified, but most assessments are better at describing issues and concerns than they are at identifying possible solutions. This is having an impact on the quality and effectiveness of plans.
- Most plans for children are not sufficiently specific or measurable. This is partly a product of the current child protection and child in need planning template, which is not fit for purpose. Not only is the template not outcome-focused, but in an

attempt to provide a one-size-fits-all solution for CIN plans, child protection plans and care plans, it encourages long lists of needs, risks and actions. This has the potential to distract attention away from what really matters and makes it difficult for parents and others to understand what they need to do and why. Senior leaders had already identified this as a critical issue and are in the early stages of introducing a new practice model with new planning templates.

- The way in which children's plans are written limits the ability of core groups and CIN review meetings to focus on those things that matter most. Strategy meetings, child protection conferences and core groups are, in most cases, well attended by an appropriate range of professionals and are well recorded. However, the minutes of these meetings reflect a tendency on the part of the participants to provide general updates rather than rigorously monitoring progress and evaluating their impact and effectiveness. This inevitably contributes to drift and/or delay in some cases.
- Despite the limitations of the local authority's planning template, inspectors saw several examples of constructive and purposeful social work intervention, including good and telling direct work with children and young people, leading to improved outcomes for children and families. Social workers are using the graded care profile well to assess parenting strengths and weaknesses and explore how well children's needs are being met. Inspectors also observed social workers mobilising support effectively for children and families, via, for example, children and adolescent mental health, and adult substance misuse, services.
- Staffing pressures in the targeted disability service (TDS) are starting to have a negative impact on the quality of the service that the team is able to provide. Senior leaders are aware of this and are taking appropriate action.
- The pace of progress, following the Ofsted inspection in February 2017, in addressing issues and concerns about the quality, impact and effectiveness of assessments and plans, was too slow. Senior leaders recognised this and in 2018 made some fundamental changes to the senior leadership and management structure within children's social care. This resulted in increased capacity, a key recommendation from the last inspection, and improved management oversight of children's cases.
- Following a comprehensive scoping exercise that was undertaken during the latter part of 2018, senior leaders understand the challenges, know what needs to be done and are acting accordingly. Vacancies have been filled and social workers and managers talk about having a renewed sense of optimism for the service.
- A number of new panels that have been introduced, which means that senior leaders now have a clearer oversight of practice and are able to exert more influence over key decisions that affect children's and families' lives. Social workers recognise that, far from being a restrictive approach to gatekeeping,

these panels are helping to make sure that children and families get the right support and resources quickly and easily.

- Although senior leaders have a clear plan about how best to drive the much-needed improvements, written service plans are not specific or measurable. They do not provide any detail about who is responsible for doing what by when. This has the potential to undermine accountability and contribute to drift or delay.
- Performance management reports lack robust commentary and the reports that accompany them tend to be descriptive rather than analytical. Currently, frontline managers receive as many as 25 separate management reports each week, which they are expected to open, sort and filter in order to ascertain what information applies to their teams. This is not an effective use of their time.
- The quality assurance framework, which was introduced at the time of the last inspection in February 2017, is not fully developed or embedded. The quality of case management audits varies. Some audits offer astute observation and critical challenge, rightly identifying where practice needs to improve. Others do not. Most audit action plans lack conviction or are conspicuous by their absence. This hinders the ability of senior leaders to drive improvements.
- Most social workers receive regular supervision, but the quality of that supervision varies. In some cases, supervision case notes are clear, well-written and provide an appropriate level of case direction. In others, case supervision notes simply summarise the status quo rather than offering effective critical challenge and/or thoughts about what might be done differently.
- The local authority is in the process of creating an environment in which social work can flourish. With the exception of the TDS, where caseloads are higher, workloads are relatively low, and staff talk positively about the range and quality of training on offer. One new recruit was particularly impressed by the quality of her induction and IT equipment and the fact that she has been able to build up her caseload gradually.

Ofsted will take the findings from this focused visit into account when planning your next inspection or visit. Ofsted will send a copy of this letter to the Department for Education and will publish the letter on our website on 8 May 2019.

Yours sincerely

Nigel Parkes  
**Her Majesty's Inspector**