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Ms Beate Wagner
Corporate Director, Children and Young People's Services
Wakefield Council County Hall
Bond Street
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Dear Beate,

**Monitoring visit of Wakefield local authority children's services**

This letter summarises the findings of the monitoring visit to Wakefield local authority children's services on 21 and 22 May 2019. The visit was the second monitoring visit since the local authority was judged inadequate in all areas in the SIF in July 2018. This visit was carried out by Her Majesty's Inspectors, Lisa Summers and Rachel Holden.

The local authority has made some progress in strengthening its initial response to help and protect children and young people, but the identification of, and response to, risk is not sufficiently robust.

## Areas covered by the visit

During this visit, inspectors reviewed the progress being made in relation to the local authority's arrangements for the 'front door', the initial response to children in need of help and protection, and the management of allegations of abuse, mistreatment and poor practice by professionals and carers.

A range of evidence was considered during the visit, including electronic case records, performance management information, case file audits and other information provided by senior managers. In addition, inspectors spoke to a range of staff, including social workers, managers and the designated officer.

## Overview

The local authority has undertaken significant activity to strengthen the front door and build a sustainable framework to support social work practice. However, the impact of planned actions is too slow in some critical areas of core social work practice. This includes, weaknesses in identifying risk, screening of contacts and decision making at the front door. Although some assessments are improving, too

many are still of poor quality, and child protection enquiries are not consistently thorough. Not all frontline managers consistently challenge poor practice. Senior managers have a clear understanding of the significant weaknesses still to be addressed in services for children and young people. They continue to progress actions from their comprehensive and appropriately focused improvement plans. Senior managers rightly recognise this will take time to implement fully given the scale of improvement to social work practice needed.

Progress has been made in some specific areas. The multi-agency safeguarding hub (MASH) has been restructured and there has been significant council investment to secure a stable and permanent workforce. This is supporting improved challenge at service manager level, partners' increased understanding of thresholds and more manageable caseloads. Compliance in a number of areas of performance is improving, for example, timely decision-making and assessments, and allocation of cases. The response to allegations against professionals who work with children has significantly improved. A specific team has been created to support the local authority's response to children at risk of immediate harm, and those children vulnerable to exploitation and children who go missing from home and care. These changes are still very new and are not embedded in practice.

**Findings and evaluation of progress**

Since the last inspection, senior managers have restructured the MASH to provide an accessible single point of contact for professionals and families requesting help and support. Senior managers have spent time supporting partners to better understand thresholds. More children are now being appropriately referred who need this level of support. This is a significant improvement since the last inspection.

The responsibility for strategy meetings has moved from the MASH to the newly developed investigation team. Very recent changes to contact pathways and workflows are supporting timelier and more effective screening of contacts through the streamlining processes. Management oversight is clear and offers appropriate initial direction to social workers about contacts. Social workers consistently contact referrers in order to ensure a comprehensive understanding of the concern and to gather further information. Consent is routinely and appropriately sought.

The screening of contacts is not always effective. History is not always well used to understand children's experiences, and some decisions are too reliant on self-reporting without information being corroborated. As a result, some contacts are closed prematurely. The MASH service manager provides rigorous challenge through sampling decisions that result in no further action where this is not appropriate and serves as an appropriate 'check and balance' to ensure that the right decisions are being made. Where deficits are identified, assertive action is taken to ensure that children receive an appropriate social care response.

When children are identified as being at immediate risk of harm, the initial response is generally swift. Strategy meetings held within the newly established investigation team are timely, facilitate information-sharing and identify how the investigation will

be undertaken. However, there is a lack of multi-agency planning and action to reduce immediate risks to children. The local authority relies too heavily on parents to implement safety plans and keep children safe while child protection investigations are undertaken. The safety plans are often overly optimistic, for example inappropriately depending on the compliance of non-abusing partners to keep children safe, including from domestic abuse.

The response to requests for help and protection out-of-hours is not always robust. Not all children who had been identified at risk of significant harm have had a timely strategy discussion to understand and address risk. In some cases, this has been left to daytime services to undertake, leaving some children in situations of unassessed risk for too long. The local authority recognises that weaknesses in identifying risk remain, that too many assessments are poor and that child protection investigations are not consistently thorough. While some children are receiving better assessments of risk, for too many children this is not the case. Inspectors identified missed opportunities to address risk and need. Some investigations fail to fully explore risk because some social workers focus on presenting issues and too often lack professional curiosity in understanding children's broader needs and risks. History is not used well enough to give a deeper understanding of children's lives or identify patterns of concerns and needs. As a result, the response has not been robust enough to assure inspectors that risk and children's needs are always identified and met at the earliest opportunity, and children have experienced repeat child protection investigations or multiple assessments.

The newly restructured children missing service is showing early signs of improvement in engaging and understanding why children go missing from home and care. Workers are finding creative ways to engage with children, helping them to explain the reasons why they go missing. Staff work collaboratively with partners to help keep them safe. Return home interviews are beginning to be more timely. This is an improving picture since the last inspection. The newly developed vulnerable children's team is in its infancy, and it is too soon to see impact for children.

Senior managers continue to stabilise the workforce and secure more manageable workloads. Following the inadequate inspection judgement, the local authority experienced a significant loss in social workers and managers. Consequently, high numbers of agency staff cover these posts and provide additional capacity over and above core staffing levels. This has reduced caseloads from over 40 to approximately 20. Despite the significant challenges in recruitment across the region, senior managers have very recently successfully recruited a number of permanent social workers and team managers within the locality teams. Social workers say that they have improved and trusting relationships with the management team because of their increased engagement, high visibility and support. This is improving staff morale. They spoke highly of the support they receive and feel safe and secure. There are high rates of job satisfaction.

Frontline managers are not routinely identifying some of the continuing shortfalls in the quality of social work practice, such as the quality of child protection investigations and

poor identification of risk. Progress has been made in improving the frequency and regularity of supervision. However, supervision is not always regular and is not supporting practitioners and frontline managers to reflect critically on the impact of their decisions or provide clear case direction to improve children's lives. Auditing is now routine. However, frontline managers focus heavily on process rather than reflecting on children's experiences. Service managers provide moderation to these audits. They bring a sharp focus on the quality of social work practice, identify assertive corrective actions and ensure that these are completed.

Improving performance information and routine auditing is enabling managers and leaders to better monitor and understand workloads, compliance, and quality of social work practice. Given the legacy of significantly poor and inconsistent recording practices, managers have appropriately invested significant effort to address this through improved workflows and recording processes. This is now enabling managers to extrapolate better performance information about compliance indicators, such as data about key activities within the MASH. This helps them to identify and challenge weaker performance. As a result, some areas of performance are improving since the last inspection. This includes timelier assessments of children's needs, swifter decision-making on contacts and ensuring that all children have an allocated social worker.

Increased scrutiny through better performance monitoring is starting to enable managers to appropriately target areas of practice requiring a deeper interrogation. Senior managers understand the deficits in practice. Themes are identified and disseminated through team learning sessions to reinforce expected standards. However, this is not impacting sufficiently on frontline practice. The limitations of the current case recording system are well recognised and action is underway to procure a system that better supports social work in Wakefield.

Designated officer (DO) arrangements are now effective. Capacity has increased through the recruitment of an additional DO and dedicated administrative support. This is enabling more timely investigation meetings. Allegations against professionals are robustly managed. The response is thorough, and there is effective information-sharing and decision-making. Thresholds for providing advice and guidance are appropriate, and referrals are tracked and monitored. This was a significant weakness at the last inspection.

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

Yours sincerely

Lisa Summers
**Her Majesty's Inspector**