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1 November 2019

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Dear Beate

Monitoring visit of Wakefield children's and young people's services

This letter summarises the findings of the monitoring visit to Wakefield children's services on 9 and 10 October 2019. The visit was the third monitoring visit since the local authority was judged inadequate in all areas at the inspection of local authority children's services in July 2018. This visit was carried out by Her Majesty's Inspector, Lisa Summers and Her Majesty's Inspector, Caroline Walsh.

The local authority is making steady progress in improving services for its children and young people in need of help and protection. Extensive work in building core service foundations means that circumstances are improving for some children.

Areas covered by the visit

During this visit, inspectors reviewed the progress being made for children in need and those subject to a child protection plan.

A range of evidence was considered during this 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, advanced practitioners and managers.

Overview

Since the last inspection, senior managers have continued to work tirelessly on building and strengthening the foundations to improve services for children in need of help and protection. Senior managers have focused on developing the right service structures, and increasing staffing, in order to enable social workers to focus on core practice. As a result, significantly improved recording is supporting stronger performance monitoring and quality assurance. Improved management oversight at all levels is helping to sustain better performance in critical areas. Themes identified through audits and monitoring visits are starting to shape and inform training and

learning opportunities. Positively, inspectors identified some areas of improving core social work practice, including some assessments, and routine multi-agency planning, which is ensuring that some children have their needs well met. The co-located children vulnerable to exploitation team is having a positive impact on completing return home interviews and identifying risk.

Although management oversight is improving, not all frontline managers and child protection chairs challenge weak social work practices or ensure that timely authoritative action is taken when change is not achieved. In some cases, managers and child protection chairs do not fully reflect on or help social workers to recognise all areas of risk. Most plans are not good enough, and, as a result, planning is not strong enough to bring about the necessary changes for some children. There is insufficient social work oversight of some disabled children with highly complex needs, and expected standards of practice are not always adhered to. Senior managers have a realistic understanding of the work they need to do to ensure that the quality of social work practice is more consistent in improving children's lives, and that it has more impact. This forms the basis of the local authority's next steps in their improvement journey.

Findings and evaluation of progress

Since the last inspection, considerable financial investment has supported a large and rapid expansion in social work locality teams and increased social work capacity at all levels. Reduced caseloads are better supporting social workers to focus on core social work practice. All social workers spoke positively about the support and accessibility of managers and senior managers, reporting a significant change in service culture to one now where their views are sought, and they feel valued. This is reflected in reducing sickness levels. The recent expansion of advanced practitioner posts builds in a career pathway for social workers.

Case recording has significantly improved. Senior managers have successfully tackled widespread recording deficiencies through extensive data cleansing, enhancing the current recording system capabilities, while simultaneously addressing poor and previously accepted recording practices. The local authority has redesigned and relaunched new systems for recording children's experiences, and continues to design a suite of new templates to support improving practice. Work with children is now routinely recorded. This supports the monitoring of progress for individual children, as well as facilitating performance oversight overall.

The quality of some assessments is starting to improve. Inspectors identified some examples of good assessments that included better use of case histories to inform a clear analysis and understanding of risk and need. Senior managers understand that this is not consistent across the service, and there are still too many assessments that lack depth and do not identify children's lived experiences. The cumulative effect of neglect is not always sufficiently explored and understood.

For children subject to child protection plans, thresholds are appropriately applied. However, most plans are not good enough. Some do not address all the areas of risk or identify interventions that would reduce risk to children. They also focus heavily on the needs of parents and concentrate on tasks rather than identifying what needs to improve for children. They also lack meaningful contingency plans, making it difficult for parents to clearly understand what will happen if change is not achieved. Although plans are regularly reviewed, there is not enough consideration given to, or challenge of, the difference that the interventions are making in children's lives. This delays escalation into pre-proceedings when there is no improvement. Inspectors identified a small number of children for whom known risks were not effectively managed, and for whom planning has been ineffective and unchallenged by conference chairs and frontline managers. As a result, planning is not always improving children's circumstances, and this was seen particularly in the cases of older adolescents experiencing ongoing long-term neglect. Senior managers have rightly identified that the next phase of development is to focus on the improvement of the quality of plans and planning.

Children are now regularly seen by their social workers, and more recent social work practice is leading to improved outcomes for some through better focused interventions. This is leading to positive changes for these children, including some highly vulnerable disabled children. Inspectors saw examples of good engagement and of agencies working together on longstanding neglect issues. Despite agencies' commitment to planning, their roles in protecting and meeting children's needs are not always sufficiently considered or maximised. For example, although the local authority has worked with health partners to improve the timeliness in accessing services to support emotional and mental health needs, children still wait too long to receive help.

There is insufficient social work oversight of disabled children. The local authority has identified 66 'closed for review' cases that they believe require support at an early help stage. These children are not reviewed by social workers, which means that their needs may not be fully understood or met at the earliest opportunity. These assessments are too narrowly focused on children's health, to the detriment of understanding all of their and their families' needs. Expected standards of practice for disabled children receiving support as a child in need are not routinely met. Child in need reviews and visiting patterns are not consistent with service standards. As a result of this visit, senior managers are reviewing all of these children and will ensure that social workers undertake reviews so that wider needs are identified.

The recently established children vulnerable to exploitation team is having a positive impact on completing return home interviews and identifying risk. Return home interviews identify risk effectively, and are completed by persistent and appropriately curious workers. Risks are identified, and appropriate support is mobilised. Risk assessments are generally of a good quality, but they don't always translate into effective multi-agency planning to address the risks quickly enough. Co-location supports information-sharing between social care and the police, but there is insufficient action to disrupt and prosecute individuals who present a risk to children.

When risks to children escalate, strategy meetings are not always taking place to manage the concerns.

The oversight and management grip for children escalated into the public law outline (PLO) in respect of pre-proceedings is significantly stronger than at the last inspection, and is now well established. Work is now regularly monitored and tracked, which is reducing delays. Where children are subject to pre-proceedings for longer than the local authority's own 12-week standard, the reasons are well understood. Some of these cases are outside the control of the local authority. The legal gateway panel fully explores family support and alternative options to bringing children into care. For a small number of children, panel recommendations for social workers to continue to try and work with the family are unrealistic, particularly when parents refuse to engage. As a result, a small number of children still wait too long before more authoritative action is taken.

Senior managers continue to have a good understanding of the areas of practice that require improvement. Performance data is showing sustained improvement in key areas, for example timeliness of initial child protection conferences and reviews, frequency of social work visits to children and reducing delays in escalating children into court proceedings. Performance reporting has continued to improve, and routine quality assurance activity is enabling managers to accurately understand the quality of frontline social work practice. Since the last monitoring visit, the quality of auditing has been strengthened. The recent development of a collaborative auditing system with both manager and moderator facilitates timely corrective actions, but is also starting to help develop frontline managers' understanding of good practice. Consequently, the vast majority of audits seen by inspectors were accurate and effective.

Good progress is being made in building a sustainable and suitably skilled workforce. A stable and talented senior leadership team is in place. Managers have recently and successfully recruited a high number of permanent assisted and supported year in employment social workers (ASYEs), advanced practitioners and team managers, and there is a keen focus on ensuring high-quality appointments. Senior managers know what good practice looks like and are using this knowledge to further develop frontline managers. Where senior managers have oversight of cases through different mechanisms, including panels and auditing, the quality of the practice is generally improving. Themes from audits and monitoring visits are starting to inform and shape training and learning opportunities. For example, targeted training and support for frontline managers are showing some early signs of progress, with clearer management oversight and decision-making, and more regular and better focused supervision. This is providing better reflection and direction for social workers. Senior managers are aware that this is not yet consistent across the service and that there is more work to do to ensure that actions identified in supervision are timebound.

More recently, senior managers have revised their approach to learning through the creation of a new learning academy, the purpose of which is to provide a consistent

approach to learning and development across the whole of the children's workforce. It is too soon to measure the impact of this.

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