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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 children's services on 21 January 2020. The inspectors were Peter McEntee, Her Majesty's Inspector, and Lisa Summers, Her Majesty's Inspector.

Inspectors looked at the local authority's arrangements for receiving referrals to children's services (the front door), making decisions about further action and the undertaking of assessments of need for children and families. Inspectors looked at a range of evidence, including case discussions with social workers and team managers. They also looked at local authority performance management and quality assurance information and children's case records.

Overview

Over the last six months, the local authority has undertaken a planned review of the operation of thresholds. This has been in relation to decision-making for referrals and to ensure that children in need work is allocated appropriately to social work services rather than to early help. Development work has been undertaken, and this has ensured that there is now a single effective front door response for early help and social care.

However, as a result of the strategic review of thresholds, workloads in social work teams have significantly increased, and the local authority did not plan ahead effectively to meet these demands. This resulted in high levels of unallocated cases over the course of three months. Extra resources have now been put in place in response to this increased demand. A wider recruitment strategy is in place with agreed funding. While this response has enabled the local authority to allocate all

current work, significant issues remain in terms of the consistent application of thresholds and timely allocation of children's cases.

Weaknesses are also evident in the responses to children, in terms of the quality of work in assessments of need, partnership-working with the police and timely decision-making in relation to child protection enquiries. This means that children and families are not receiving a timely or consistently good quality of service. For many children, outcomes are delayed, and some children remain at risk or in situations of harm for longer than they should. Poor supervision and ineffective management oversight in many instances mean that progress, or delay in progress, is not always being recognised, and senior managers are less aware of practice quality as a result.

What needs to improve in this area of social work practice

- Partnership working with the police to ensure that strategy meetings and child protection enquiries are prioritised as soon as possible.

- Work with the police to ensure that the local authority is informed of domestic violence incidents where children are present as soon as possible.

- A reduction in social worker caseloads to manageable levels to help ensure a more focused and timely delivery of services.

- Assessments and plans that have children's needs as a central focus and are written in a way that enables parents and carers to better understand the impact of their actions on their children.

- Casework audits to have a focus on the quality of work as well as on compliance with policy, and moderation of audits to be extended to better provide an accurate picture of practice to the local authority.

Findings

- Senior managers have undertaken a review of the operation of thresholds and decisions made at the front door in the last six months. Significant changes have taken place, including a rise in the number of contacts deemed to meet the threshold for referral for statutory services, from 30% to a peak of 70% in this period. A review of children in need thresholds, including work in the early help 'Start Well' service, has also taken place, which has meant that there are now greater numbers of children and their families who are receiving more appropriate assessments of need from social work teams. An improvement plan has been put in place, but these changes have meant significantly increased work demands, which the local authority has struggled to respond to. While extra resources have been put in place to deal with the, at times large, numbers of unallocated cases, the local authority is now reliant on two out of four assessment duty teams being wholly staffed by agency staff. This includes managers of those teams. The local

authority currently has no unallocated work, but its ability to deal with demand remains fragile.

- The local authority has strengthened its initial response to concerns about children by creating an effective single front door service for both early help and social care needs. Decisions are made on almost all contacts within 24 hours. Partners demonstrate an understanding of thresholds in most cases. There is consideration of previous knowledge of families, and this is used to help make decisions on appropriate further work. Up-to-date information from the police, schools and health is also available and is used to inform decision-making. Consent is sought and is well recorded, and parents and carers are appropriately contacted to discuss issues and concerns. In the very few cases when consent is dispensed with, this is appropriate.

- There are delays, sometimes of several weeks, in the police referring concerns to children's social care when children have been exposed to domestic abuse. The police acknowledge that there is a backlog in the triage and referral of those cases assessed at medium risk, and they are reviewing their response. However, these delays have resulted in children being left in situations of unassessed risk and delays in children and their families accessing services at the earliest opportunity

- Arrangements for children to be stepped down to the early help 'Startwell' service are effective. Processes are clearly established for children requiring early help and targeted support through the front door. Screening is effective, using history and information from partners well to analyse concerns and to inform appropriate decision-making. In the majority of cases, application of thresholds is appropriate, with clear management oversight and rationale. However, when decisions are made for families to access early help via partnership arrangements, for example through schools, there is no system in place to easily check that these services have been delivered. On this basis, the senior leaders cannot assure themselves that these children receive the services they need at the right time.

- Staff in the assessment duty teams have high caseloads, up to 40 cases, and some state that this is impacting on the quality of their work and their ability to maintain up-to-date records. One social worker reported that her caseload was 'horrendous', making her feel as if she is not doing her job.

- Some team managers are trying to supervise every case open to a social worker at every supervision session, meaning that they cover up to 350 cases a month. Such a volume makes it difficult to maintain an overview of their individual team's work and provide clear guidance on every case. Supervision lacks reflection, critical challenge and clear case direction to improve children's circumstances. Induction processes for new staff are very limited, and there are expectations that social workers can quickly pick up and 'run' with cases. This means that some new social workers, including agency staff, are without the appropriate guidance needed on casework to ensure that good outcomes for children are achieved.

- Previous poor social work practice has impacted on many cases, including when allocation had previously been delayed or when children's cases have had to be re-opened and re-evaluated. For some children, this had meant that assessments of need and associated risk had been delayed. During the visit, inspectors asked the local authority to review their response to a number of cases. In almost all of these cases, senior managers agreed to initiate either new assessments of need, strategy meetings or an initial child protection conference in response to the concerns raised.

- Despite the implementation of a recognised systemic approach to the consideration of children's needs and risk, in the majority of cases assessments are too focused on parents and carers, and do not identify children's needs clearly enough. This extends to children in need plans which fail to clearly explain the purpose of proposed actions, the impact for children and the outcomes expected. This means that, in some cases, parents will not fully understand how changing their behaviour will help to influence better outcomes for their children.

- The purpose and function of strategy meetings and subsequent child protection enquiries are seriously compromised by poor partnership working between the local authority and Greater Manchester Police (GMP). Despite a number of challenges at the highest level from the local authority to GMP, the partners have not been able to ensure that properly constituted strategy meetings that the police attend take place as and when they should. In a significant number of cases, strategy meetings have not taken place for several weeks after they have been recommended. In some instances, this delayed the start of child protection enquiries. While the local authority has continued to visit children during the time between decision-making and the strategy meeting being held, the lack of timely partnership discussion and agreement on child protection issues and planning means that there is an increased risk to children. In a small number of relevant cases, strategy meetings and child protection enquiries have not been considered at all. This absence of coordinated planning and decision-making potentially compromises the availability of evidence and may lead to a failure to take into account significant issues that may compromise children further.

- A number of child protection enquiries do not sufficiently analyse historical information and so there is not a full understanding of the child's situation or a thorough assessment of risk. This means that managers cannot be assured that risks are sufficiently understood or that subsequent actions address all the concerns. Risk is not, therefore, effectively minimised for these children.

- Performance management and quality assurance frameworks are in place. Both have been enhanced since the last focus visit, including better availability of performance reporting for managers and the introduction of thematic audits, which provide a greater insight into overall service quality. However, case audits in many cases remain over-optimistic, and some audit gradings are not justified by the auditor's evidence. There is inconsistency in how audits are completed, with

some questions being poorly answered. Key areas are rarely addressed at all, for example whether the 'right' plan is in place and whether it is being progressed on a timely basis. The audit template attempts to address both compliance and quality issues, but too often auditors are focusing on compliance and not exploring quality issues sufficiently. There is some moderation, which has served to reframe judgements, but this moderation is limited.

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

Yours sincerely

Peter McEntee
Her Majesty's Inspector