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Dear Colette

Focused visit to Wigan Metropolitan Borough Council children's services

This letter summarises the findings of a focused visit to Wigan children's services on 6 October 2020. The visit was carried out by Her Majesty's Inspectors Caroline Walsh, Michele Costello, Paula Thomson-Jones, Mandy Nightingale and Jan Edwards.

Her Majesty's Chief Inspector of Education, Children's Services and Skills is leading Ofsted's work into how England's social care system has delivered child-centred practice and care within the context of the restrictions placed on society during the COVID-19 (Coronavirus) pandemic.

The methodology for this visit was in line with the inspection of local authority children's services (ILACS) framework. However, the delivery model was adapted to reflect the COVID-19 context. This visit was carried out remotely, with the addition of a meeting with a group of children in care. All inspectors used video calls for discussions with social workers, managers and leaders. The lead inspector and the director of children's services (DCS) agreed arrangements to deliver this visit effectively while working within national and local guidelines for responding to COVID-19 and meeting the needs of the local authority's workforce.

Overview

Leaders made significant changes to the senior leadership team in children's services following the focused visit by Ofsted in January 2020. This visit highlighted the very high social work caseloads that were having an adverse impact on children's experiences and significant shortfalls in management processes. The current experienced DCS joined the local authority in July 2020 in the permanent role, after five months of alternative interim management arrangements.

The improvement programme following the focused visit had only begun to take shape when the crisis of COVID-19 surfaced and emergency management arrangements were implemented across the council. These have continued to operate. The shift in focus slowed the pace of improvement in children's services.

However, this has been significantly reinvigorated in the last few months. New arrangements have now been established to provide external scrutiny and governance to progress the extensive improvements required.

Additional capacity in social work teams has reduced caseloads for many staff, and the impact of this is beginning to be seen in the quality of work with children. However, inconsistency remains in the quality of practice and not all children receive the right level of support, particularly those experiencing chronic neglect. Risks to children are not always fully explored and responses to disabled children do not consistently address their needs.

Social workers and personal advisers have creatively maintained positive relationships with children and young people throughout the COVID-19 period. During the first wave of the COVID-19 pandemic, leaders and staff maintained oversight of over 10,000 children identified by agencies as being vulnerable. Regular contact with families and liaison with partner agencies and schools ensured that these children's needs were known and supported during the lockdown. However, the oversight of children who have not returned to education in September is less robust.

The rate of children coming into care continued to increase over the last six months. Managers struggled to find suitable homes for all the children they care for and some children have experienced too many moves before they settle. Transition arrangements for young people leaving care are not considered early enough. Many young people leave care too early and not enough are in education, employment or training.

Leaders know that there are insufficient processes, systems and policies to guide and support the workforce to maintain a focus on children's experiences. Supervision and management oversight are not providing the support and critical challenge required to ensure that children's plans are progressed, and drift is avoided. Quality assurance and performance reporting have not been effective in identifying the drift and delay experienced by some children.

Staff are positive about the support that they have received since the start of the pandemic.

What needs to improve in this area of social work practice

- The understanding of thresholds and the effectiveness of planning to ensure that children receive appropriate support at the right time.
- The timeliness and quality of responses to children experiencing neglect, including those children subject to pre-proceedings under the Public Law Outline.
- The responses to vulnerable adolescents and children who go missing.

- The oversight and support for the educational needs of children in care and disabled children.
- The preparation for leaving care and the effectiveness of support to care leavers who are not in education, employment or training (NEET).
- The effectiveness of management oversight, professional challenge and supervision.
- The accuracy and effectiveness of performance reporting and quality assurance.

Findings

- Not all children receive the right support when they are first referred for help. Arrangements in the multi-agency safeguarding team are not fully developed. Although decision-making has improved recently, with better information gathering and analysis, the work of the duty teams does not ensure that children's needs are consistently understood and appropriately supported. Leaders have a good understanding of the shortfalls of their front door and the gaps in processes and management that are affecting the quality of practice.
- The early help offer known as Start Well has continued throughout the COVID-19 pandemic, with many families benefiting from this support. However, not all families engage well with this service, especially those families whose needs are higher and, therefore, require a social work service. Consequently, some children experience delay before their needs are assessed by social workers and this leaves them in vulnerable circumstances. Too many families move between Start Well and social work support repeatedly, as the decision-making is too optimistic about parents' capacity to change and thresholds to services are not well understood. The recording of interventions in Start Well is not sufficiently detailed, making it hard to see if there are delays in children being seen.
- The timeliness of strategy discussions, child protection enquiries and child protection conferences has improved significantly in recent months. The use of virtual meetings has increased partner engagement. The work that leaders completed during the period of COVID-19 has helped improve relationships with school leads and health partners so that their input is more visible in these discussions. This has led to better shared analysis of risk and decision-making for children.
- The quality of children's assessments and plans is not good. Many assessments of need are too focused on recent events and do not consider the cumulative impact of harm, which leads to weak plans and interventions. Professionals at review meetings do not challenge drift effectively. Some children's circumstances do not sufficiently improve before the work is ended, resulting in children being referred back to the service within a short time.
- Many disabled children do not receive an effective assessment or response. For some children, appropriate packages of support meet their needs and their situation improves. However, when there are safeguarding concerns, thresholds

are not well applied, and decision-making is less effective. Social work assessments are not sufficiently holistic and lack essential information about parents' needs and how this affects their ability to care for their children.

- Neglect is poorly identified. While many children and families benefit from wide-ranging support, some children are left in unsatisfactory home conditions for too long. There is insufficient consideration of parental capacity to change within children's timescales. Children experience too many changes in social worker and there is weak analysis of the impact on children of living in long-term neglect.
- Leaders have recently acted to address drift in planning for children in pre-proceedings under the Public Law Outline. Letters to parents before proceedings do not provide enough clarity to help families and professionals know what is expected of them.
- The response and support provided to vulnerable adolescents is too inconsistent. Many of the most vulnerable children have benefited from the coordinated support by partner agencies, which has reduced risk for them. However, not all children who are at risk of child criminal exploitation are appropriately identified or supported and remain at risk. The response to children who go missing is too limited for many children and there is not sufficient focus on identifying actions to reduce repeat episodes. This leaves children vulnerable to continued harm.
- During the pandemic, the council had a good oversight of many children who were potentially at risk of hidden harm. Senior leaders tracked school attendance for over 10,000 vulnerable children during the first national lockdown. Council employees redeployed to assist children's services regularly liaised with schools, partner agencies and families to support children's well-being. When there were concerns that children's needs were not being met, referrals were made for assessments of need.
- Leaders did not have enough visibility of disabled children or those in care who did not return to school in September. While they had a high proportion of children return to education overall, managers did not closely track school attendance for these children until it was raised at this visit. Managers were not aware that the proportion of these children returning to school was lower and had not sought to understand the barriers for them to return to school. The number of children electively home educated has increased by a small number during the COVID-19 pandemic. Managers have recently implemented a new process to visit these children to ensure that support is provided. Leaders did not know which children were missing education after schools returned in September and now plan to track children who are missing education more closely. Senior leaders have not maintained good oversight to ensure that children receive a safe and good-quality education from alternative provision.
- Staff were creative in engaging with children throughout the lockdown, visiting them at home and school as well as making good use of technology to talk with them. Balanced and clearly written COVID-19 risk assessments were completed for all children known to social care to prioritise children's needs and inform visiting patterns.

- A significant number of children came into care over the last six months. Many decisions to look after children were overdue as the children had experienced long histories of neglect which had not been properly addressed, leaving them vulnerable to further harm. A small group of disabled children came into care during COVID-19, in part, due to reduced support packages. These children were placed out of the borough to ensure that their needs were fully met. This highlights a gap in local residential provision for disabled children.
- Regulation flexibilities were used during the early period of COVID-19 in relation to the fostering panel and short-breaks arrangements. These were child-focused decisions that supported children with continuity of care.
- Known weaknesses in the sufficiency of placements before the COVID-19 pandemic proved challenging for senior leaders. The service struggled to identify suitable homes for children with complex needs and some children experienced several moves. When homes did not meet all of children's needs, the necessary additional wraparound support was provided for the children. These children were closely monitored by senior leaders, who continued to explore more suitable options to meet children's needs and avoid further moves.
- Children were supported during the pandemic to maintain relationships with people important to them. Staff responded imaginatively to the needs of children in care, and foster carers, who needed additional support. An interactive activity programme was popular with children and young people and a multi-agency panel coordinated support from specialist services. The emotional well-being needs of children in care were prioritised by child and adolescent mental health services, who provided regular advice and support directly to foster carers to prevent disruptions in placements. Foster carers and school leaders told us that the well-being personal education plans (PEPs) completed during this time were useful, and leaders plan to incorporate these into the more traditional PEPs in the future.
- Transitions to the leaving care team are not well planned or early enough for most children in care. The recent practice changes to introduce personal advisers to young people at 17 years old is a small improvement, but too many young people leave care before they are 18. The number of care leavers in staying-put arrangements is also low. Pathway plans are not consistently updated when young people's circumstances change. This limits their effectiveness to be used as a tool to help young people identify the changes needed to progress.
- Too few care leavers are engaged in purposeful activity and there is limited bespoke support to help young people into training or work. The rate of young adults who are not in employment, education or training (NEET) is high and has deteriorated over the last year. There is a lack of strategic overview of this, with insufficient dedicated support available to care leavers to prepare them well for economic independence. However, some young people have successfully achieved high educational outcomes and benefit from the support provided. Care leavers described feeling well supported during the pandemic. Inspectors saw positive practice supporting some young people to make improvements and to live successfully independently.

- Quality assurance and performance reporting do not provide leaders with the right information. Performance data is not readily available for leaders and managers to monitor performance effectively or provide a direct line of sight of practice. Audits of practice have a limited impact on staff development as they are not accurate or child-focused. Findings from audits are rarely discussed in supervision, which does not support individual learning opportunities for social workers and managers.
- The last 12 months have presented significant challenges to children's services. Political and senior leaders had not ensured that sufficient governance of children's services was in place. A lack of effective scrutiny and financial investment resulted in children's services struggling to respond to the larger numbers of children being referred for services. Leaders have recently made some improvements to performance and there is progress in reducing caseloads for many staff. The DCS acted quickly to replace the poorly performing agency workers in the duty service when she arrived, and the newly commissioned social work teams are having a positive impact in providing capacity and improving practice.
- The DCS has prioritised getting to know her services and now has a more accurate and realistic view. Political and corporate scrutiny has, therefore, increased and an investment of approximately £5 million is being discussed to meet the challenges of ensuring that suitable homes are available for children in care, and to deliver a sufficient staffing establishment. This investment is critical given the shortfalls identified during the visit. Relationships at a strategic level have strengthened during the pandemic. There is now an appropriate plan, with an independently chaired improvement board, to strengthen the governance of children's services and provide the necessary external accountability and challenge.
- Staff have continued to compensate for many of the weaknesses in the management of children's services. They have worked in an environment with few policies and procedures and have not received the professional challenge needed to consistently make good decisions. Supervision and senior manager oversight have not been sufficient to raise the standards of practice.
- Staff told us that they feel well supported by managers and leaders during these challenging times and that they receive regular communication from the senior management team. They have been provided with laptops and continue to work from home while local infection rates are high.

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

Yours sincerely

Caroline Walsh
Her Majesty's Inspector