Inspection of Wigan local authority children's services

Inspection dates: 9 May to 20 May 2022

Lead inspector: Lorna Schlechte, Her Majesty's Inspector

Judgement	**Grade**
The impact of leaders on social work practice with children and families	Requires improvement to be good
The experiences and progress of children who need help and protection	Requires improvement to be good
The experiences and progress of children in care and care leavers	Requires improvement to be good
Overall effectiveness	Requires improvement to be good

The standard of social work practice in Wigan Metropolitan Borough deteriorated after the last inspection in 2017. Three focused visits during 2019 and 2020 raised serious concerns about increased caseloads and the response to risk. At the last visit, a focused assurance visit in October 2020, there were emerging signs of progress following the appointment of a new director of children's services (DCS) and increased investment in children's services.

Since then, the local authority has established a new senior leadership team and continues to make the necessary improvements for children. There is now effective external scrutiny of children's social care from a range of improvement partners. Significant investment has led to increased workforce capacity through the creation of 40 additional social work posts, but the challenge remains to fill these posts. There have been improvements in the quality of child-protection investigations and services for disabled children, and in identifying and achieving permanence for children.

Despite this, there is too much variability of practice across the service. There continues to be a reliance on four agency social work teams while additional social workers are recruited to permanent posts. This has led to delays, drift in delivering against plans and frequent changes of social worker for children. In addition, the local authority has responded to the impact of the COVID-19 pandemic, where rates

across the borough have been consistently high, and families have been under additional pressure. This has led to increased demand at the 'front door'.

Senior leaders now have a more accurate self-assessment of the improvement work required, and have been proactive in responding to those issues that were only identified during the inspection, such as improving the recording of management oversight at the front door. There is now a much clearer focus on delivering long-term sustainable change alongside their improvement partners.

What needs to improve?

- The level of management oversight regarding screening decisions at the front door.
- Strategy discussions, to ensure that multi-agency decision-making is timely and not subject to delay.
- The quality of assessments, plans and pre-proceedings work, to reduce over-optimism and increase the level of professional curiosity.
- The recording systems for allegations against professionals to ensure that a clearer rationale for outcome decisions is evident.
- The variability of life-story work for children in care.
- Support for care leavers at the point of transition.
- The impact of quality-assurance activity on practice, including the response to audit actions and the learning from recent case reviews.

The experiences and progress of children who need help and protection: requires improvement to be good

1. The quality of social work practice in the Children First Partnership Hub (front door) is variable. This is due to a high number of agency social workers and managers and a lack of robust management oversight until recently. There is sometimes limited professional curiosity by social workers when considering basic information in contacts. When determining how quickly contacts need to be screened and responded to, managers' decision-making is not always clear.

2. There are sometimes inconsistencies in the application of thresholds between social care and early help, which result in delays in some children and families having their needs fully met. A local authority thematic audit, carried out in April 2022, identified similar issues, although it was too early to see the impact of the local authority's response to recommendations from this piece of work.

3. In the Start Well (early help) service, there is some good-quality early help assessment and direct work being completed with children and their families to address identified concerns. A review of early help has highlighted the need for further development with partners, in accordance with the revised threshold document and demand management strategy. Senior leaders are working with partners to ensure that families receive appropriate support earlier, prior to Start Well involvement.

4. The out-of-hours service is appropriately staffed, responds well to urgent issues, and visits families when requested to check on children's welfare.

5. Child and family assessments are of mixed quality. Some stronger examples provide an appropriate focus on the current circumstances and past histories of the children. However, other assessments are too adult-focused and lack

analysis and professional curiosity, with too much emphasis on parental self-reporting of progress and a limited focus on positive changes for children. Senior leaders identified the variability in the quality of pre-birth assessments prior to the inspection, and a more robust pre-birth protocol, including a multi-agency panel chaired by the practice director, is now leading to more appropriate managerial oversight when there are concerns pre-birth.

6. The risk of immediate harm is mostly recognised well and responded to promptly. However, there are sometimes delays in holding strategy discussions in a timely way due to police availability. This means that some children are not protected as quickly as they could be, and, in a small number of cases, social workers complete visits and develop safety plans prior to a multi-agency discussion to agree next steps. Senior leaders have been working closely with the police and these issues are starting to be addressed. Guidance on strategy discussions was reissued to staff during the inspection and specific cases of delay were escalated to senior officers in the police in accordance with a new protocol. When strategy discussions do take place, they are well attended by all relevant professionals, reach appropriate decisions and provide a clear rationale for next steps, using the local authority's model of practice.

7. Section 47 child-protection enquiries are thorough, and consider current and historical risks and protective factors for children. Actions are clearly identified and carried out in a timely way. Children are at the centre of the decision-making, which is an improvement on the quality of this work since the last focused assurance visit.

8. The majority of child in need and child-protection plans are not specific enough about who should do what, and by when. They are too adult-focused, with limited actions specific to children. In a minority of cases, involvement can end before sustainable changes are evidenced in families, and some plans drift without the impact on children being fully understood. This was recognised by senior leaders, who support the plan for further training for practitioners. In addition, new templates have been developed to improve the quality of plans, and these are due to be launched imminently.

9. The quality of intervention with families in the locality teams is mixed, but with some areas of stronger practice. Direct work is completed with children subject to children in need and child-protection plans to help understand their experiences. Family support workers carry out a lot of direct and practical support with families, which complements the social worker task. There is now appropriate management oversight of plans to step down from a child-protection plan prior to a child-protection review conference.

10. Social work with disabled children is child-focused and individually tailored to meet their needs. This is an area of improvement since the last focused assurance visit.

11. The response to domestic abuse concerns is not sufficiently robust. Although an experienced social worker is based in the victim hub with the police triage team to offer a more appropriate response to domestic abuse referrals at the front door, inspectors saw a high number of repeat interventions. Families experience multiple contacts, repeat referrals and reassessments for similar concerns, causing drift and delay in children's needs being met. A recent local authority audit identified similar issues, and senior leaders acknowledge that there is more work to do to embed the necessary changes to include more professional curiosity and less reliance on parental self-reporting in relation to domestic abuse.

12. There have been some recent improvements in the coordination of pre-proceedings work, with helpful input from a sector-led improvement partner. This includes some positive and timely work which has resulted in a significant cohort of children stepping down appropriately from pre-proceedings due to a reduction in risk. Despite this, there remain a small number of children who have been subject to pre-proceedings processes for too long due to a legacy of weaker practice and management oversight. The key features of this weaker practice are over-optimism, lack of consideration of history and delay. There are also a minority of children whose cases have entered pre-proceedings recently and have experienced drift and delay due to basic social work tasks not being completed, sometimes because of changes of social worker. Letters to parents at the commencement of pre-proceedings do not clearly outline what the parents need to do.

13. Children who are at risk of coming into care benefit from effective and timely intervention from the multi-disciplinary ATOM (edge of care) service. This means that more children are supported to live at home with their families as a result of this thoughtful and sensitive work.

14. The complex safeguarding team is a well-resourced multi-agency service which provides good-quality support to social workers working with children at risk of sexual and criminal exploitation and those who go missing. There is a thorough multi-agency process for consideration of missing-from-home notifications. Most return home interviews are undertaken by workers in the complex safeguarding team. This offers consistency for children, and an appropriate focus on their push and pull factors and how those relate to children's level of risk.

15. Allegations management meetings are well attended by relevant professionals. The minutes from these meetings are sufficiently detailed and clearly outline the nature of concern, historical information and the agreed actions. There are some weaknesses in recording and monitoring systems to track allegations when there are concerns about professionals who have contact with children. As such, it is difficult to understand the nature of referral concerns and the rationale for decision-making, in particular when it is identified that there is no further role for the local authority designated officer.

16. The support to 16- to 17-year-olds presenting as homeless is mostly appropriate and based on a joint assessment of their housing and care needs. A draft protocol is in place, and more work is planned to devise relevant information leaflets to ensure that young people have a clear understanding of their rights and entitlements. Private fostering arrangements are usually actioned in a timely way.

17. Recent improvements in the management of those children and young people electively home-educated and children missing education are having a positive impact on the way that they are identified and monitored. However, the procedures are not fully embedded in the practice of all relevant staff.

The experiences and progress of children in care and care leavers: requires improvement to be good

18. Children only come into care when it is in their best interests to do so. This is usually done in a timely way and with an increased level of oversight by relevant senior officers and managers through the challenge to care panel and legal gateway panel. Social workers know children well and visits are mostly regular and purposeful, although the turnover of social workers has resulted in less meaningful visits by duty social workers pending allocation of a new social worker. This affects some children and can delay progress with their care plans.

19. Children's physical and emotional health needs are appropriately identified and responded to. Specialist workers such as the drug and alcohol service are utilised effectively, and children with complex health needs or chronic conditions are well supported.

20. Workers in the virtual school team have good relationships with schools and are ambitious for children in relation to their achievement and well-being in education. The team is appropriately focused on improving the variable quality of personal education plans (PEPs) and ensuring that the needs of children are met. The child's voice is evident in some PEPs, and there is appropriate consideration of education outcomes, including the promotion of reading at key stage 3 and key stage 4 with foster carers.

21. Although care planning for most children in care is responsive to their changing needs, care plans are not child-friendly or accessible documents. Reviews are mostly timely and consider children's basic needs and current plans. Independent reviewing officers (IROs) usually meet with children prior to their review and appropriately complete mid-point reviews to check for progress, although some reviews do not offer sufficient challenge in relation to drift. Meetings are not always planned to accommodate the attendance of children, which means that some children do not have a chance to talk about their plans with the people who are responsible for reviewing them.

22. Despite the notable increase in the children in care population in Wigan, the majority of children are settled in foster care, including children living out of

borough. Most children in care live in Wigan. There is a lack of appropriate placements for older children and those with more complex needs, which means that some children experience multiple placement moves before they achieve permanence. Some children have experienced instability and anxiety as a result of this.

23. Some children in care benefit from thoughtful life-story work, but this is not always completed, which means that some children may struggle to understand their histories and experiences. Most children in care are supported to see their family when it is safe and in their best interests to do so.

24. Decisions to return children home to the care of their parents are appropriate, although statutory checks are not always clearly evidenced on the child's records. Some children who return home benefit from the family group conference service or ATOM edge of care service, resulting in improved family relationships and stability. For other children, the ongoing support that they receive when they return home is less clearly defined.

25. Permanence is mostly well considered and timely for children. When possible, children are placed with family and friends. A recently created special guardianship social worker post is starting to have a positive impact in supporting children and their carers who have already achieved permanence in this way.

26. When children live in long-term foster placements, the match is formally agreed at permanence panel, where the skills and qualities of the foster carer are carefully considered by panel members before the permanence decision is ratified. The placement stability panel members offer additional oversight of the support needs of children and carers who are not ready to be matched. This ensures that permanence is regularly considered when it is in the best interests of children to do so.

27. When children in care experience risks from exploitation or they go missing, they receive direct individualised support from their social workers and the complex safeguarding team to reduce risks. Children are usually offered return home interviews, which inform future work to reduce their level of risk. However, strategy discussions are not always held prior to taking action, which means that decisions about immediate risks to children are made without access to full multi-agency information and planning.

28. The Children in Care Council, A Million Voices, provides an opportunity for some children to have their views heard and to be regularly consulted about service plans. Children told inspectors that they feel involved and listened to, and that their ideas are helping to shape training and service provision. The local authority acknowledges that there is more work to do to hear the voices of other children in care.

29. The local authority has four children in unregistered children's homes. Applications from providers are underway or imminent plans are in place to move children to alternative lawful provision in accordance with their identified needs. Unaccompanied asylum-seeking children are mostly living in accommodation appropriate to meet their needs.

30. Assessments of prospective foster carers are thorough and timely, and the fostering panel members provide effective scrutiny and oversight. Foster carers benefit from regular training and the support of more experienced carers, including support from the Mockingbird programme. Foster carers do not have personal development plans to help address any development needs.

31. Adoption is considered when it is appropriate for children, and planning for permanence is timely. Children are adopted alongside their brothers and sisters when it is in their best interests, and ongoing direct and indirect contact with family is considered well by their social workers. Comprehensive assessments of prospective adopters' suitability are completed. Adoption panel members ensure that the scrutiny of the suitability of proposed matches is effective. Adopters are provided with relevant training and access support for children through post-adoption support plans.

32. Most care leavers have regular and purposeful contact with their personal assistants (PAs) and are enabled to build trusting relationships with them. Care leavers told inspectors that their PAs were responsive to their requests for practical and emotional support. They also spoke appreciatively of the support provided by the connected families group during the pandemic, such as an online cookery group. PAs successfully keep in touch with a very high proportion of their care leavers.

33. Care leavers are informed of their rights and entitlements through the local offer, including the availability of support up to the age of 25. Some care leavers take up this offer and benefit from the range of additional, flexible support which is available to meet their changing needs. Most care leavers receive effective physical and mental health support.

34. Care leavers are supported well to pursue education or employment ambitions. Creative opportunities for input are available for care leavers who require additional nurturing to prepare them for employment. Well-established working partnerships between the 'aspiring futures' team and the virtual school help young people to receive additional monitoring and support at a key time in their lives. Care leavers who are not in education or employment (52%) are closely monitored. There is a good range of work experience, apprenticeship and traineeship opportunities available to care leavers. These often lead to employment and higher education for those who take up these opportunities.

35. Pathway plans are mostly timely and up to date, capturing young people's voices well. They include sensitive consideration of identity needs and appropriate actions to help young people to achieve their goals. Plans clearly

reference the local offer, such as gym memberships and driving lessons. Pathway plans are regularly reviewed by an IRO.

36. Care leavers contribute to the development of the service. To date, this has included representation at the Corporate Parenting Board and their contribution to the proposed plans for the redevelopment of the care leavers' hub. The refurbished hub is to include an area where care leavers can meet with partner agencies in one place in order to independently access support.

37. Arrangements for preparing a small number of vulnerable young people to transition from the children in care teams to PAs are not always effective, due to a lack of communication and coordination between the workers. In addition, a shortage of suitable accommodation options means that a small number of care leavers have experienced delay while suitable housing is secured for them. Other care leavers have benefited from 'staying put' arrangements or emergency crisis accommodation, which provides stability and support as care leavers transition into the next phase of their lives.

The impact of leaders on social work practice with children and families: requires improvement to be good

38. Since the focused assurance visit in October 2020, the new DCS has built her senior leadership team and sought external scrutiny and challenge from a sector-led improvement partner and the local government association peer-review process. An independently chaired children's improvement board has been established to take forward the specific areas for improvement identified in three focused visits and in the local authority's own analysis of practice. Although the pace of improvement has been affected by the pandemic, in part due to increased demand and virtual working, there is a clear focus and determination to make the necessary improvements for children. This can be seen in the stronger foundations that are now in place, from which improvement activity can be implemented.

39. There is strong corporate and political support from the chief executive and elected members. This has led to an increase in the base budget to £24m over a projected four-year period, in recognition of the fact that standards of social work had deteriorated since the previous inspection in 2017. Forty additional social work posts have been created in recognition of the need to reduce caseloads and increase capacity across the service. This strengthened position is reflected clearly in a revised self-assessment, which demonstrates that leaders have more self-awareness of current challenges and the extent of the improvement work required than was previously the case. There is now a clear acknowledgement from senior leaders that Wigan continues to be on an improvement journey and that the quality of practice remains variable.

40. Strategic governance has improved since the multi-agency safeguarding partnership separated from adults' social care to focus more specifically on services for children. There are regular corporate accountability meetings in

which leaders offer more effective scrutiny of practice, informed by stronger performance data. Partners and stakeholders have confidence in the DCS to lead on the changes needed in order to make long-term sustainable improvements to social work practice.

41. Despite this increased focus on improvement, the quality of practice remains inconsistent. This is, in part, due to levels of experience within the workforce, the turnover of staff and the reliance on agency social workers while recruitment to permanent posts is underway. Early help is underdeveloped in some areas. Systems and processes at the front door require further attention, to ensure that all screening decisions are timely and clearly evidence the rationale for management decisions. More work is underway to streamline workflow processes across the service, including the roll-out of new templates for children's plans, with the launch of a new portal.

42. During inspection, senior leaders have been receptive to feedback and taken appropriate steps to address issues raised by inspectors. This action has led to increased scrutiny of management oversight at the front door in relation to screening decisions while new workflows are created, and the reissuing of guidance to the workforce regarding the timeliness of strategy discussions.

43. The corporate parenting strategy appropriately identifies key priorities, although there is more to do to make the corporate parenting board meetings more accessible to children. The Million Voices group has presented ideas that have led to changes in practice, such as considering the voice of the child in impact assessments. Corporate parenting is a priority for senior leaders. A recently established care leavers mentoring programme has resulted in 21 volunteers from across the council, including the chief executive, supporting and mentoring care leavers.

44. There has been an increase in the children in care population over the last 18 months, which has subsequently increased pressures on services and sufficiency requirements. Despite these challenges, the majority of children are living in foster care in Wigan. The sufficiency strategy is up to date and ambitious. Senior leaders are working closely with regional partners and residential providers to further develop capacity to meet children's identified complex needs.

45. Quality-assurance activity has improved since the last focused assurance visit. Audits are now routinely moderated. This moderation is adding value, as it ensures that the accuracy of audit findings is subject to effective scrutiny and challenge by an external moderator. It is recognised by senior leaders that audit actions are not consistently followed through to ensure that they are having maximum impact on practice. There is an appropriate plan in place to address this, including oversight of agency social workers.

46. The learning culture in Wigan is evolving. There are regular learning circles, and these, together with the social work forum, provide a collaborative space

for the workforce to share their views with the principal social worker on what is working well and what needs to change. However, learning from case reviews is not fully embedded across the service and this is acknowledged in the local authority's self-assessment. Professional curiosity training is soon to take place, which is relevant to address over-optimism when working with children and their families, lack of consideration of history and delay across the service. These were key features in recent case reviews and were evident in some of the work seen by inspectors.

47. Workforce stability has improved more recently and retention rates have increased to 89%. Social work capacity has increased as a result of increased investment. However, there is still a reliance on a high number of agency social workers across four managed teams due to recruitment challenges. Although the quality of work in these teams is subject to regular scrutiny, there has been variability in the quality of practice. The frequent changes of social worker have slowed, but the legacy of these workforce changes has affected the quality of services experienced by children.

48. The assessed and supported year in employment (ASYE) offer is appropriate and includes a social work academy for a small ASYE cohort, who have protected caseloads and co-working opportunities to develop their social work skills at a pace that is right for them. Caseloads for social workers have reduced, although they are still too high for some practitioners, including some newly qualified staff in the locality teams. This affects the capacity to complete direct work in a timely way with some children.

49. Supervision is regular, but of variable quality, and does not always reflect the level of support and discussion reported by staff. Social workers are positive about working in Wigan, state that managers are visible and supportive, and told inspectors they like the culture and the model of practice.

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