

Wakefield District Metropolitan Council

Inspection of children's social care services

Inspection dates: 4 June to 15 June 2018

Lead inspector: Neil Penswick HMI

Judgement	Grade
The experiences and progress of children who need help and protection	Inadequate
The experiences and progress of children in care and care leavers	Inadequate
The impact of leaders on social work practice with children and families	Inadequate
Overall effectiveness	Inadequate

There are serious and widespread failures across children's services in Wakefield. Inspectors found cases of children throughout the services for whom risk had not been identified and where appropriate action had not been taken to help and protect them. There are serious delays in achieving permanence for children in care and in ensuring that their needs are met.

Recently, a director of children's services (DCS) was appointed and she has started to recruit a new management team. The council has committed to additional resourcing. An improvement plan, developed with partner agencies and other regional local authorities, is being implemented. This is being developed and has initially focused on urgent prioritisation of key tasks identified by previous inspections and a focused visit. However, the plan is not based on a systematic evaluation of the current service weaknesses, or on a full understanding of the experiences of children.

Since the last Ofsted inspection in 2016, senior leaders across the council and partnership have not effected the improvements necessary to remove serious weaknesses or counter a decline in service quality. In 2016, services were judged to require improvement to be good. Many of the identified improvements have not been delivered and previously good services have deteriorated. An Ofsted focused visit of front door services in February 2018 identified that children were not being protected and that there were serious gaps in the management of the service.

Managers did not know the full extent of the problems at the front door until the focused visit, and the problems across the rest of the service until this inspection. Capacity issues are considerable, with too few social workers to carry out the work needed. This results in delays in seeing children, undertaking assessments, making plans and taking necessary action. Social worker turnover and sickness absence are high, prompting increasing numbers of short-term staff. Too many cases are being referred to children's social care of children who are not in need of statutory intervention. Social workers are not supported sufficiently or challenged by managers, and their oversight of cases is not making a difference to children.

A situation has developed where the absence of case recording has become a pattern in many teams, and some managers do not consistently challenge this. There is little accurate performance data, and quality assurance has not identified and responded to the weaknesses throughout the service.

What needs to improve:

- managers' oversight of the quality and impact of practice in all children's cases, including effective supervision of all staff
- the quality of social work practice, including seeing children, the quality of assessments, recording and plans for children in need of help and protection, children in care and care leavers
- the recognition of risk and the identification and response to neglect
- recruitment and retention of a sufficient number of experienced social workers, managers and senior managers
- the strength of relationships and timeliness of meetings between the local authority and partners in order to better support understanding of thresholds and their application as well as attendance by some partner agencies at locality social work team strategy meetings
- the response to and monitoring of allegations made about professionals (designated officer arrangements)
- escalation to pre-proceedings where children's circumstances do not improve quickly enough
- the engagement of children in return home interviews and analysis of what children say so that there is a greater understanding of the reasons why children go missing
- placement stability and the timeliness in achieving permanence for all children, including those placed with connected persons, parents and foster carers

- the availability of sufficient, suitable local placements to meet the needs of children in care and care leavers
- life-story work for all children in care
- emotional and mental health support for children in care and care leavers.

The experiences and progress of children who need help and protection is inadequate

1. Services for children in need of help and protection in Wakefield are inadequate because there are widespread and serious failures that leave children at risk of harm or living in harmful situations for too long.
2. Thresholds for access to children's social care are not well understood across the partner agencies in Wakefield. Far too many children are being referred to children's services who do not need this level of support. This means that children and their families do not always get the right help they need in a timely way. The reduction in the number of children's early help hubs has impacted adversely on the capacity of children's services and partner agencies to provide support promptly when problems first arise.
3. The work of the integrated front door varies too widely in terms of quality and impact. Social workers and managers do not always recognise risk of significant harm. Inspectors saw cases prematurely closed that required social work intervention to ensure that children were protected. Other children are sent inappropriately to the multi-agency safeguarding hub (MASH) for assessment for statutory services when their needs could be met at a lower level. This means that valuable time is lost in dealing with a large volume of inappropriate contacts, reducing the efficiency and responsiveness of this service. An improvement in actioning referrals within one day, identified at the focused visit in February, is not being sustained, and timeliness has declined.
4. A significant weakness across Wakefield's social work practice is the failure to recognise and respond to risk. When risks increase for children receiving a social work service, locality social work team strategy meetings do not always take place, and when they do, not all of the appropriate agencies, including the police, are represented. This includes when potential crimes are being reported. Vulnerable children from known high-risk groups, such as those who are privately fostered and homeless 16- and 17-year-olds, are not supported effectively. This fails to ensure that children across the service are appropriately protected.
5. Designated officer arrangements (known locally as the LADO) are ineffective in managing and tracking serious allegations against professionals who work with children. Due to capacity issues, there are serious delays in completing

investigation meetings. The poor recording of actions to be taken means that there is no assurance that these important matters are well coordinated. Other agencies report positively about the consultancy available from the LADO.

6. Deficits in the quality of basic social work practice across the service, including for disabled children, are significant. Assessment timeliness is poor and does not reflect the level of risk and need in a family. For example, fewer than half of assessments are being completed within local authority guidelines, and many are taking twice as long as the maximum timeframe set out in statutory guidance, and not in a timeframe bespoke to individual children's needs. Some assessments are of acceptable quality, but a considerable proportion are poor. The use of a widely recognised practice model is inconsistently applied. Risks and strengths are often described rather than coherently analysed and are not translating into effective planning. Most assessments do not show good consideration of the unique characteristics of the child, their voice and their wishes and feelings.
7. Recording is poor across children's services. The majority of child protection and child in need plans are not fit for purpose. Some have nothing recorded on them. Others are overly long, repetitive and confusing for families. In some plans, the many actions recorded mean that it is difficult to see what is most important. In some cases, core groups and children in need meetings, while sharing information well, do not effectively challenge delay and the lack of progress. Contingency plans are frequently too generic and not individualised to families' situations. As a result, inspectors saw children who had been left in neglectful situations for too long. Delays in improving children's lives are further compounded by numerous changes of worker.
8. Only three quarters of initial child protection conferences (ICPC) are convened in a timely manner. Other agency attendance is also limited. Social work visits to children in need and children on a child protection plan are not undertaken in line with presenting risks and needs and are not timely. Many children are not able to build positive and meaningful relationships with their social worker due to the number of changes or lack of contact with them. Where visits are taking place, some positive and sensitive direct work facilitates wishes and feelings.
9. The response when individual children are identified as at risk of exploitation is generally effective, and there is good use of a specialist risk assessment tool to identify levels of risk. However, young people do not consistently receive return home interviews and more is needed to be done to engage them following a missing episode. When return home interviews are conducted, social workers often fail to understand the triggers or offer advice and support to prevent future episodes. Well-established systems are in place to monitor and track school attendance and work with children receiving elective home education and children missing education.

The experiences and progress of children in care and care leavers is inadequate

10. Services for children in care in Wakefield have deteriorated since the last Ofsted inspection in July 2016. Decisions to take children into care are too slow, resulting in some children living in risky situations for too long. Too many of those children who do come into care do so in an unplanned or crisis situation. Once in care, too many children do not achieve positive outcomes.
11. The Public Law Outline (PLO) is not always used effectively. For some children, the process starts too late and for others, a lack of robust and focused planning during the pre-proceedings stage causes drift and delay. The Children and Families Court Advisory Service (CAFCASS) and the local designated family judge reported that, for some children, particularly those affected by long-term neglect, protective action should have been taken sooner. Once initiated, court proceedings conclude in a timely manner.
12. Significant delays in achieving permanence for children in care result in some of the most vulnerable children in Wakefield not having their needs met in a timely way. For instance, there are delays in family finding in order to identify a permanent placement, in connected carers becoming special guardians, and in foster placements being ratified as a long-term match. Inspectors saw cases where vulnerable children has waited too long for placements to be made permanent. Many children subject to care orders are placed with their parents for some years without timely and purposeful review of whether the care order is still required. This means that children remain in care longer than they should and continue to be subject to social work involvement unnecessarily.
13. In the main, social workers' assessments of children in care and care leavers are poor. Some assessments are not completed and many are not updated when the children's situations change. As a result, plans for children and pathway plans for care leavers are generally out of date. Local authority records show only a quarter of children in care have an up-to-date care plan as of April 2018. Care plans are not specific enough about actions to be taken, by whom and within what timescale. Some children's cases do not include any risk assessments, despite known concerns in their lives, for example care leavers temporarily living in bed and breakfast accommodation or houses of multiple occupancy. The failure to consider risk, such as the risks posed by other resident adults, places these care leavers at risk of harm.
14. Social workers do not always provide reports for reviews for children in care. This hinders effective multi-agency planning. The independent reviewing officers' (IROs) role to check the progression of plans for children is ineffective. Managers and IROs do not consistently review children's care plans or ensure effective parallel planning, which means that children do not

live in their permanent homes quickly enough. Other agencies, such as health services, are not held to account to ensure that they provide timely and effective services to support children to make progress.

15. Children are supported effectively to take part in their reviews and have advocates to represent them. There is good use of independent visitors, particularly to support children living out of area. Children told inspectors how much they valued this service as they feel listened to and, as a result, empowered.
16. Social workers do not always see children regularly. The local authority's own management information indicates that about half of visits to children in care are overdue. When social workers see children, many of them report having little time to engage in quality direct work with them. This includes important life-story work to support children to understand their experiences and move on to the next stage in their life.
17. The quality of recording by social workers on children's case files is poor and often not completed. As a consequence, should children wish to see their records in the future, they will not be able to understand their history and the reasons for decisions made about their lives. This reduces accountability and continuity of oversight, further exacerbating drift and delay for children.
18. Too many children experience placement instability. Less than half of those children in long-term care have been in the same placement for at least two years. Children do not always live in suitable and stable placements because there are not enough local, skilled foster carers in Wakefield. Too often, children have to move placements, which is both unsettling and disruptive to their lives, and not conducive to supporting their emotional health and well-being. The lack of capacity in the emotional well-being service for children in care and care leavers, and unacceptably long waiting times for specialist child and adolescent mental health (CAMHS) support, further contributes to placement instability and undermines positive progress. Contact with family members is not appropriately supported in all cases, isolating children further from their family and friends.
19. Managers of the virtual school know what is working well and what needs to improve, and they are taking steps to affect necessary changes. Outcomes for children in care from the early years to key stage 4 show an improving picture over time. By the time they leave school, the progress made by children in care compares favourably to the national picture. High overall attendance figures mask some low attendance and high persistent absence for some children in care of secondary school age. The virtual school team is not automatically alerted to any safeguarding referrals made in various school settings about children in care.

20. The local authority promotes and encourages the participation of children and young people to shape and develop services. An active children in care council provides children with an opportunity to socialise with peers and play a part in the council's running of children's services. Children's achievements are celebrated at an annual award ceremony and children are integral to organising this event.
21. The journey of too many children to adoption is subject to drift and delay for a combination of reasons. These reasons include: poor recording, assessment and planning; numerous changes of social worker; weak management oversight and IRO challenge; and lack of an accurate system to track children's cases. The high turnover of social workers and lack of experience within the workforce mean that social workers do not always know children or understand adoption work. Inexperienced social workers do not receive adequate support or training.
22. Wakefield Council is a partner of One Adoption West Yorkshire, a regional adoption agency (RAA), and when this agency is involved, the quality and timeliness of the work significantly improves. Family finding and matching are provided in partnership with the RAA, which assists in improving the quality of the work. Introductions are managed with significant support from the adoption support worker as well as the child's social worker. Life-story work mostly takes place for children with a plan for adoption in order to help them understand their experiences and is supported by the RAA when the child's social worker has not been able to undertake this work with the child.
23. The service for care leavers has deteriorated since the last inspection. For three months prior to the inspection, there was no team manager, workers reported receiving little or no supervision, and highly vulnerable children received insufficient support. Around one in five children in care do not regularly attend education and training placements post-16 and virtual school leaders have identified this as an area for improvement.
24. The placements of vulnerable young people in unsuitable accommodation, including bed and breakfast, together with an absence of risk assessments, have left children at risk of harm. There is a lack of basic performance management information for this service, rendering it difficult for Wakefield council managers to track or evaluate the progress of some of the most vulnerable care leavers.

The impact of leaders on social work practice with children and families is inadequate

25. Senior leaders across the council and partnership have not tackled the serious and widespread failures across children's services, and this has left children at risk of significant harm.

26. Since the focused visit looking at the front door in February 2018, the recently appointed DCS has quickly won the confidence of staff and external agencies. She has wasted no time in making new appointments to the team around her. She faces a challenging task. Work to support improvement has commenced with other local authorities and partner agencies. The council has committed to an increase in funding. However, inspectors found that there has not been a full evaluation of the extent of the serious weaknesses across all services for children. Inspectors also found significant weaknesses about which the local authority were not fully aware, including the designated officer arrangements, timeliness of adoption and support for care leavers.
27. The inspection of Wakefield Children's Services in July 2016 identified a number of areas for improvement, the majority of which have not been delivered. In addition, areas judged to be good previously, for instance the arrangements for responding to concerns about professionals potentially abusing children, adoption work, and support for care leavers, have deteriorated considerably, leaving children at risk and their needs not being met.
28. Inspectors identified that children at risk had not been identified and that other children are living in situations of unassessed or known risk without adequate steps being taken to protect them. In these cases, had inspectors not identified the deficits in practice, children would have continued to be exposed to risky situations.
29. There are too few social workers to provide a safe service to meet the needs of children and families. There are significant capacity issues across children's services. The action taken by senior leaders to increase staff, for example in order to ensure that all cases open to children's social care are allocated, has not addressed the problem sufficiently. Many social workers have too high caseloads and are not able to complete assessments, provide support and/or do direct work to ensure that children have better lives. Social workers said to inspectors that they are 'firefighting' and responding to crisis on a daily basis.
30. Supervision for many workers is irregular, with examples seen of several months passing between meetings. Records of meetings are often missing, are incomplete or are a repetition of previous sessions. Inspectors saw many cases across children's services without any documented direction or prioritisation of tasks.
31. Newly qualified staff are carrying cases well beyond their capability levels without support. Inspectors came across newly qualified workers coordinating care proceedings and adoption work with little understanding and no guidance about what they were supposed to be doing. Social workers are too often unsupported when deciding how to progress cases, resulting in children not being safeguarded and/or not having their needs met in a timely manner.
32. Inspectors did see some impressive social work support. Some children and families are receiving a high-quality service which is safeguarding and improving their lives.

33. The local authority was chosen to be one of the national pilots for a well-regarded practice model of social work intervention. This has not been successfully implemented and inspectors saw few examples of its use. Organisation-wide training has been delivered, but not all staff have been able to engage due to capacity issues.
34. A situation has developed where the absence of case recording has become a pattern in many teams, and some managers do not consistently challenge this. In many children's files, there are no case notes, key documents are missing, including assessments and plans, and 'forms' have sections not completed. There are few records of visits and little evidence of children being seen. Without clear and accountable record keeping, joint plans with other agencies and with families cannot be effectively progressed. Children, who have a right to see their files in the future, will look back and see long periods of their childhood undocumented and decision-making unrecorded.
35. Children experience too many changes of social worker, resulting in the lack of progress of plans. Due to the casework pressures and lack of support, social worker turnover and sickness rates are high, prompting increased reliance on temporary staff. Without recorded supervision, clear management direction and documentation, it is not possible for new workers to know what they need to do support children, to address risk and to promote permanence.
36. Social workers have continued to find serious problems in using the electronic recording system, despite the local authority's investment in updating this. Due to the poor quality of recording, even basic performance management information is not available to the authority. Without accurate data, the local authority cannot know and address the serious and widespread weaknesses across its services.
37. Experiential learning is not embedded across children's services. Management audits do not consistently recognise deficits in the quality of practice. Critical issues, such as lack of supervision, delays in planning, quality of assessments or plans and irregular contact with children, are not recognised by auditors as having significant impact on children's lives. When issues are identified, recommendations to address the issues for the individual child or the thematic concerns are rarely made.
38. The statutory duty to evaluate complaints and annually report to the council was not met last year. The local authority has acknowledged this failure and plans to produce a report that will cover both this and last year. Information held by the local authority shows that many complaints are not investigated within national timescales, leaving issues unresolved and learning not disseminated.



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