

Wirral Metropolitan Borough Council

Inspection of services for children in need of help and protection, children looked after and care leavers

and

Review of the effectiveness of the Local Safeguarding Children Board¹

Inspection date: 4 July 2016–28 July 2016

Report published: 20 September 2016

Children’s services in Wirral are inadequate		
1. Children who need help and protection		Inadequate
2. Children looked after and achieving permanence		Requires improvement
	2.1 Adoption performance	Requires improvement
	2.2 Experiences and progress of care leavers	Inadequate
1.	Leadership, management and governance	Inadequate

¹ Ofsted produces this report under its power to combine reports in accordance with section 152 of the Education and Inspections Act 2006. This report includes the report of the inspection of local authority functions carried out under section 136 of the Education and Inspections Act 2006 and the report of the review of the Local Safeguarding Children Board carried out under the Local Safeguarding Children Boards (Review) Regulations 2013.

Executive summary

There are widespread and serious failures in the services provided to children who need help and protection in Wirral. Services for care leavers are inadequate, because the local authority does not know where many of its care leavers are living or what they are doing, and some of the most vulnerable have not received a service that adequately recognises risk. Services for children looked after and children in need of adoption require improvement. This demonstrates a significant deterioration in the quality of all services that children and young people receive since Wirral was last inspected in 2011 and 2012.

Inconsistent and sometimes poor application of thresholds by both the local authority and partner agencies is evident at every point that children and young people come into contact with children's social care. This leads to drift and delay for children who need help and protection, with insufficient recognition that action taken has failed to reduce risk in too many cases. At the other end of the spectrum, some children who are looked after remain subject to statutory orders for too long.

Almost all of the deficits identified in this inspection were known by senior leaders. However, a corporate failure to recruit and retain a permanent head of service has severely impaired the capacity of the director of children's services and the senior leadership team to address them. Plans to restructure services to respond better to children's needs were delayed for a year due to competing council priorities. While a new structure was completed following the appointment of a permanent chief executive 15 months ago, this has not yet resulted in the anticipated improvements.

Despite significant investment in training for frontline and middle managers and independent reviewing officers (IROs), managers do not clearly communicate good practice standards to social workers through managerial oversight of case records and workers' supervision files. IRO challenge, while increasingly present, is ineffective and does not lead to positive change for children. As a result, a culture of over-optimism often goes unchallenged.

Case recording is sometimes so poor that it is not possible to tell how decisions have been reached or even what has happened as a result of intervention in children's lives. Assessments and plans are often insufficiently focused on what will make the most difference for children and young people within a timescale that is right for them.

While most social workers' caseloads are not excessive, they are often complex. The local authority has high levels of staff changes for a variety of reasons, including sickness absence and staff turnover. As a result, children and young people experience too many changes of worker, making it difficult for them to form enduring, positive relationships with staff.

Performance management data is widely scrutinised by managers and elected

members, but is not yet leading to improvement and is not always focused on the right things. Accuracy of data collected is sometimes compromised by absent or faulty recording on the local authority's electronic system. This was most prevalent in relation to care leavers, where the local authority gave conflicting basic information to inspectors throughout the inspection. The local authority undertakes a wide range of quality assurance activities, including a well-established programme of internal audit that identified many of the issues seen in this inspection. However, learning from this activity is not used well to inform action planning, nor shared with staff through learning and development programmes. As a result, practice has not improved.

Children's services undertake no quality assurance of the work of the out-of-hours service, despite the responses to children's needs constituting a significant proportion of their work. This means that the local authority cannot be sure that children are responded to appropriately at times when they are at their most vulnerable.

Strategy discussions are often delayed for a number of reasons, including in some cases non-availability of the police. While the local authority has challenged the police, these challenges have been ineffective. When children are subject to allegations of abuse by professionals or in their homes, investigations are not always compliant with statutory guidance. The local authority designated officer is sometimes informed retrospectively, after a strategy discussion about an allegation against a professional has taken place.

Children who live in private fostering arrangements do not receive an adequate service that ensures that they are identified early, that the suitability of their living arrangements is fully assessed and that help is offered, if needed.

The majority of children who are looked after benefit from stable, good-quality placements with carers who know them well. Recent significant improvement in the numbers of young people who leave care through special guardianship orders, combined with improving timeliness of adoption, means that more children are achieving permanence. However, the recruitment of adopters is not sufficiently targeted to the needs of the children waiting, and some children and adopters still wait too long to find a family.

Advocacy services for children, while of good quality when used, are not routinely offered to children in need of help and protection, and the take-up by children looked after is low. The independent visitor service does not have sufficient capacity to provide a visitor for each young person who is waiting.

The Children in Care Council is active and influential, and is well supported by an effective inclusion team. The contribution that children and young people make to strategic planning is a strength.

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The local authority

Information about this local authority area²

Previous Ofsted inspections

- The local authority operates one children's home. It was judged to be outstanding at its most recent Ofsted inspection.
- The last inspection of the local authority's safeguarding arrangements was in March 2011. The local authority was judged to be good.
- The last inspection of the local authority's services for children looked after was in March 2011. The local authority was judged to be good.

Local leadership

- The director of children's services was acting in the post from June 2012 and was permanently recruited in April 2013.
- The chair of the LSCB has been in post since June 2013 and also chairs the adult's safeguarding board in Wirral. He announced his intention to step down following the end of his tenure shortly before the inspection was announced and recruitment to the post is underway.

² The local authority was given the opportunity to review this section of the report and has updated it with local unvalidated data, where this was available.

Children living in this area

- Approximately 67,600 children and young people under the age of 18 years live in Wirral. This is 21.1% of the total population in the area.
- Approximately 23.8% of the local authority's children are living in poverty.
- The proportion of children entitled to free school meals:
 - in primary schools is 17.7% (the national proportion is 15.6%)
 - in secondary schools is 14.7% (the national proportion is 13.9%).
- Children and young people from minority ethnic groups account for 5.0% of all children living in the area, compared with 21.5% in the country as a whole.
- No single minority ethnic group is larger than any other.
- The proportion of children and young people with English as an additional language:
 - in primary schools is 3.4% (the national proportion is 19.4%)
 - in secondary schools is 2.7% (the national proportion is 15.0%).

Child protection in this area

- At 4 July 2016, 2712 children had been identified through assessment as being formally in need of a specialist children's service. This is a reduction from 2,882 at 31 March 2015.
- At 4 July 2016, 393 children and young people were the subject of a child protection plan. This is an increase from 233 at 31 March 2015.
- At 4 July 2016, two children lived in a privately arranged fostering placement. This is a reduction from seven at 31 March 2015.
- Since the last inspection, six serious incident notifications have been submitted to Ofsted and two (one completed, one ongoing) serious case reviews have been completed or are ongoing at the time of the inspection.

Children looked after in this area

- At 4 July 2016, 705 children were being looked after by the local authority (a rate of 104 per 10,000 children). This is an increase from 675 (100 per 10,000 children) at 31 March 2015.
 - Of this number, 113 (or 16%) live outside the local authority area
 - 40 live in residential children's homes. Of this 40, 28 live outside the authority area

- 18 live in residential special schools,³ all of whom live outside the authority area
 - 540 live with foster families. Of This 540, 9.8% live outside the authority area
 - 80 live with parents. Of this 80, 8 live outside the authority area
 - one child is an unaccompanied asylum seeker.
- In the last 12 months:
- there have been 30 adoptions
 - 75 children became subject to special guardianship orders
 - 215 children ceased to be looked after, of whom 2.3% subsequently returned to be looked after
 - 14 children and young people ceased to be looked after and moved on to independent living
 - no children or young people ceased to be looked after and are now living in houses in multiple occupation.

³ These are residential special schools that look after children for 295 days or less per year.

Recommendations

1. Urgently progress plans to recruit a permanent head of service for children's social care to provide consistent and effective operational leadership of services for vulnerable children.
2. Ensure that thresholds are consistently understood and applied by the local authority and partner agencies, so that all children receive appropriate responses to risk and intervention at the right level when they need it.
3. Ensure that all performance management information is based on accurate data, and that managers, leaders and elected members use it effectively to measure and inform service improvements.
4. Ensure that recommendations from local authority audits of social work with children, themes from complaints and other quality assurance activities are fully reflected in subsequent learning and development programmes, and that the impact is demonstrated in regular management supervision of social workers.
5. Ensure that the underlying causes for changes of social workers are quickly and purposefully addressed to reduce the use of temporary social workers and the disruption that this causes for children
6. Provide regular supervision to social workers that demonstrates reflective analysis of challenging and complex issues arising in their work with children and families.
7. Ensure that strategy meetings are timely and include information from key professionals to inform identification of risks to children, when assessing the need for child protection intervention.
8. Improve the quality of assessments and plans to ensure that all risks to children, young people and care leavers are identified, including their family history and diverse needs. Ensure that plans are specific and realistic to achieve change, and are informed by children and young people's views, balanced against an holistic assessment of risk.
9. Ensure that all case records fully and accurately reflect children's and young people's experience so that there is sufficient information available to inform decision making, including out of hours, and so that young people have a clear account of actions taken, should they choose to access their records.
10. Ensure that the emergency duty team's involvement in children's casework is regularly quality assured and analysed, and that its performance is included in wider performance management reporting to senior leaders and elected members.

11. Ensure that, when contact has been lost with care leavers, strenuous and regular efforts are made in all cases to re-establish this contact and engage young people in services.
12. Ensure that those children in private fostering arrangements are identified, assessed and visited within statutory timescales.
13. Ensure that procedures for referral to the designated officer are understood and followed by staff to provide a consistent, timely and effective response to allegations against professionals.
14. Ensure that homeless 16- and 17-year-olds receive a coordinated response from children's social care and housing, so that assessments identify their vulnerabilities early and ensure that they are offered and receive appropriate services and accommodation.
15. Ensure that independent reviewing officers (IROs) have sufficient capacity to fulfil all of their responsibilities towards children in need of help and protection and children looked after, and that, when IRO challenges to poor practice are unsuccessful, escalation processes are used to achieve positive change for children.
16. Ensure that the progress of children in pre-proceedings agreements is regularly reviewed to make sure that there is no delay in planning for them.
17. Ensure that children's emotional health needs are better understood through the completion of strengths and difficulties questionnaires, in accordance with statutory guidance, and that their emotional health needs are met through provision of timely, effective support.
18. Ensure that young people's personal education plans are specific, measurable, match the identified needs of children and young people, and include progress against targets.
19. Ensure that all children who would benefit from an advocacy service or an independent visitor have the opportunity to do so.

Summary for children and young people

- Since Ofsted last inspected Wirral, services have got worse for children and young people. Children who need help and protection do not always get the right levels of support to keep them safe. The local authority does not know where too many of their care leavers are, where they are living or what they are doing. This means that it cannot offer them the help and support that they may need.
- Families who need early help with their problems usually get it quickly, but sometimes there are waiting lists for important services, for example to help with parenting and domestic abuse.
- Managers do not always make sure that social workers receive the right support and guidance to do their best work. Sometimes, they do not recognise soon enough that the help that children are receiving is not working and that something different needs to be done to improve children's lives.
- Children have too many changes of social worker, and too many families and children do not have the chance to get to know their social worker very well. Social workers do not always know as much as they should about the lives of children because of these changes. Sometimes, they do not listen closely enough to what children and young people are telling them, not just by what they say but by what they do. They do not always plan and work well with others to make children's lives better.
- Most children who are looked after by the local authority either live in Wirral or nearby with carers who look after them well. This means that they are close to the people who are important to them. They usually do well at primary school, but not as well at secondary school.
- Children who are looked after do not get help to understand their life history quickly enough. When children are adopted, they get good help with any problems, which means that they settle in well.
- Young people aged 16 and 17 who are homeless do not receive a good enough assessment of their needs to make sure that they receive the best services and accommodation to help them.
- Many young people leaving care live in good places and many stay with their foster families. However, some care leavers who need extra help with housing or to stay in good health do not get as much support as they need.
- The Children in Care Council is helping to improve services for children, and leaders and managers listen carefully to what it has to say.

<p>The experiences and progress of children who need help and protection</p>	<p>Inadequate</p>
<p>Summary</p> <p>Services to children in need of help and protection in Wirral are inadequate. Many children experience unacceptable drift and delay at every stage of their journey, with increasing and progressive risks to them going unrecognised. Thresholds are not understood or consistently applied, so children often do not receive help early enough or at the time when they need it. When children do receive help, cases are stepped down too soon from children in need and child protection plans without evidence of sustainable change and reduced risk, leaving children at potential risk of harm.</p> <p>Frequent changes in social workers do not support effective engagement with children and families, who can lose confidence in the service and support available. Children’s views are not always clearly evident in assessments and plans. In a small number of cases, the expressed views of older children, that they are not at risk, are given too much weight despite clear evidence to the contrary. This includes homeless 16- and 17-year-olds with additional vulnerabilities who are not encouraged to become looked after early enough. Nor are child protection processes considered for some of those who refuse.</p> <p>The quality of assessments and plans is too variable. Although some are good, too many repeatedly fail to consider children’s histories to ensure that all risks to children are identified. Plans are often based on an unrealistic optimism about parents’ capacity to change or their ability to protect their children, particularly for those children who experience domestic abuse and chronic neglect.</p> <p>Strategy meetings are frequently delayed and do not always include information from key professionals to help to inform risks to children so that appropriate action can be taken. This does not give social workers sufficient information on risks to children when initiating child protection enquiries.</p> <p>The identification of, and response to, those children in private fostering arrangements and the management of allegations against professionals are inconsistent, so the local authority cannot be fully confident that children are safeguarded quickly and effectively.</p> <p>Early help for families is improving. Partner agencies support the early help strategy and action plan with a shared understanding to ensure that families receive appropriate early help and intervention. The local authority has identified the improvements required to develop effective multi-agency working within the multi-agency safeguarding hub, although changes to practice are not yet evident. Children who are identified as being in need of urgent action receive an appropriate immediate response to risk.</p>	

Inspection findings

20. In Wirral, risk management systems and the application of thresholds to identify and respond to children in need of help and protection are inadequate. The lack of understanding of thresholds by partners and staff, linked with insufficient scrutiny of performance within the multi-agency safeguarding hub (MASH), leads to inconsistent responses to protect children. Children experience drift and delay in receiving the right help at every stage of their journey across services, and risk is not recognised soon enough.
(Recommendation)
21. Although no children were seen to be at immediate risk of significant harm during this inspection, in too many cases children experience unacceptable levels of risk that is gradual and increases over time, particularly those living in neglectful and domestic abuse situations.
22. Consent by families is not consistently sought, pursued with rigour or clearly recorded when contacts and referrals come into the MASH, so families are not appropriately involved in decision making. In some cases, management decisions and the rationale to overrule consent are not recorded. The local authority completed a MASH diagnostic assessment in April 2016 and, while it recognised the changes required to deliver an effective and timely multi-agency response to protect and help children, the plan for improvement is too recent to have had any immediate impact.
23. Local authority data shows that the numbers of repeat contacts and repeat referrals to the MASH is high. In three months prior to inspection, 539 children had two or more contacts made to the MASH who did not receive a service and 25 children had five or more. Just over a quarter of children, 26.1%, were re-referred and some incorrect inputting of data seen indicates that this figure could be even higher. The local authority had not analysed patterns or themes that contribute towards children being repeatedly referred or experiencing multiple step up and down processes. It did not know, for example, that the vast majority of children with five or more contacts were children placed with Wirral by other local authorities until informed by inspectors. High levels of repeat contacts and referrals lead to delay in children's needs being identified early, and ultimately delays in children being seen, and this was also evident on many sampled cases of children who had finally begun to receive a service.
24. There is inappropriate delay of police notifications to the MASH for some children who witness and experience domestic abuse incidents. Delays seen ranged from three days to four weeks. Although the local authority commenced assessment of risk swiftly on receipt of notification of these cases, the delay between the incident and commencement of the assessment meant that children had been left in situations of unassessed risk. This delay also has significant negative impact on the understanding of the seriousness of the incident for families and encourages minimisation. The use of various risk assessment tools and ratings, particularly in the domestic abuse triage process

between police and children's social care, does not efficiently identify levels of risk to children. However, when children need an immediate and urgent response, prompt decision making is effective, and communication with police and health partners is stronger.

25. Strategy meetings are not consistently held quickly enough. In a few cases, records show significant delays of up to four weeks following concerns being identified for children. While immediate action is taken by the local authority to commence assessments or enquiries to safeguard children in these cases, it is done without the benefit of full information.
26. When strategy meetings are held, the majority include relevant information sharing from police and the health professionals based in the MASH. Some meetings do not have information available from other key professionals, including education, so decisions on risk and initiating section 47 enquiries are made without a full picture of the child's life experience and, in particular, their family history. In the six months leading up to the inspection, 48% of the 615 section 47 enquiries concluded that children were not at risk of significant harm. Inspectors found a small number of enquiries that should have led to a child protection conference had not, with insufficient or no action taken to reduce risk for those children.
27. The local authority does not quality assure decision making within the emergency duty service, so it cannot be confident that the response to children who need help outside of normal working hours is always timely, effective or safe. Capacity within the emergency duty service is limited and, while in cases seen decisions were mostly appropriate, a small number of young people did not receive a service that was timely or in line with statutory guidelines. (Recommendation)
28. Assessments of need for children vary in quality and often do not provide a full analysis of risk. The local authority has a comprehensive single assessment policy and provides social workers with tools to analyse risk effectively. These are not consistently used or evident in operational practice. Most assessments lack reference to, or detailed analysis of, previous interventions and repeatedly lack the inclusion of family history. This important deficit means that assessments of parents' capacity to change are often over-optimistic and based on a limited understanding of the child's lived experience. Some assessments seen do not explicitly explore the emotional impact on children of repeated domestic abuse incidents. (Recommendation)
29. Children with disabilities receive an inconsistent response when help is needed, with some families receiving direct payments supported in children in need and child protection teams, which is not appropriate to their needs and does not provide the level of expertise and knowledge required to support them. Although assessments, provision of support services and the voice of children are stronger in the specialist children with disabilities service, planning for education, health and care does not always follow statutory guidance. This

means that some children who have an education, health and care plan may also have a child in need plan when it is not required. This is ineffective and unhelpful for both families and professionals.

30. Consideration of children's diversity needs within assessments and plans is inconsistent. Stronger assessments recognise the impact and importance of identity to children and young people, and are central to planning for them. Weaker assessments lack detailed exploration and understanding of the impact of religion and culture in families, and this does not help in identifying the right services for children. (Recommendation)
31. Social workers make insufficient attempts to complete direct work with those children and families who are reluctant to engage with them. When children see social workers, they do not always have the opportunity to see them alone. Children are often unable to build trusting and positive relationships with social workers, particularly in teams with frequent changes of staff. Unrecognised disguised compliance means that too much emphasis is placed upon families' ability to improve outcomes for children, without evidence of sustainable change.
32. Since March 2015, published figures report a 41% increase in children with child protection plans, from 233 to 392 at the time of the inspection. Children do not have sufficient advocacy support to attend child protection meetings and families do not always receive information in a timely way so that they can prepare and contribute meaningfully to decisions. (Recommendation)
33. Most children in need and child protection plans are of poor quality, rarely including timescales for expected change, so families have no sense of urgency in working towards what needs to be done to improve their child's experience. Many plans seen during inspection do not receive updates following core group meetings and have unrealistic expectations of parents' ability to protect children, particularly those who are victims of domestic abuse. Significantly, professionals involved in planning do not receive a copy of the child protection plan, reducing their ability to monitor children's welfare effectively or to be clear about what actions they need to take. (Recommendation)
34. The local authority has identified that some children who experience and witness domestic abuse and become subject to a child protection plan are wrongly categorised as being at risk of physical abuse rather than of emotional harm. As a result, the overall plan is ineffective because it does not address known risks to children. Some progress is being made, with an increase in the percentage of children who are recognised as being at risk of emotional abuse from 9% to 25%. However, this is not happening quickly enough for some children, and in one conference observed by an inspector, although the category had changed, the outline child protection plan did not refer to the risk of emotional harm.

35. At the time of the inspection, the local authority performance data reports that 35% of children remain on a child protection plan for three months or less. In cases seen, the majority of these children were removed prematurely, before risk was reduced, with no positive change sustained. In some cases, actions remain outstanding and unmonitored. The number of children subject to repeat child protection plans at the time of the inspection was 22%, which equates to more than one in five children, and has not changed since the most recently reported figures for 2014–15, when Wirral was above comparators and the England average by five percentage points. This demonstrates a longstanding failure to address delays in securing sustained safety and stability for children.
36. Child protection chairs do not demonstrate effective challenge to drift in plans and, when challenges are made, they do not result in a swift management response. Many children in need of help and protection experience delays in achieving change. They are stepped down to children in need or 'Team around the Family' (TAF) plans inappropriately, or remain on plans with no progress in improving their outcomes. The process for lead professionals to escalate concerns back to social care is unclear, leading to further delays and increased risks to children.
37. In early help, the understanding of thresholds is improving, supported by partnership working between children's centre staff and locality social workers. The number of common assessment frameworks (CAFs) completed has improved significantly and referrals to early help are appropriate, but the quality of many CAFs is not good enough. Too many are incomplete, lack clear and detailed action plans, or do not always include children's views. Central recording of CAFs from all agencies is in the early stages, so the total number of CAFs is not clear to the local authority or partner agencies.
38. Children's centres, organised in three localities with social care, now contribute well to meeting the needs of many families and young children in Wirral. They provide a good range of relevant services to those families in need of support that engage with the centres. Staff in children's centres offer parents advice and guidance about accessing education, training or employment and, when required, direct them to other services offered by partner organisations.
39. When children go missing from home, the police undertake safe and well checks with effective information sharing in the MASH between police and children's social care. A commissioned service makes good efforts to locate young people to undertake effective return home interviews, the majority of which are evidenced in children's records. The information gathered from children is not collated or used well to evaluate the reasons why they go missing or to inform their care planning. As a result, children do not always receive the help that they need, and the risk does not reduce.
40. Professionals identify children at potential risk of child sexual exploitation and make appropriate referrals to the multi-agency child sexual exploitation (MACSE) meeting, which has a consistently high rate of partner attendance and

engagement. The experiences of children that are discussed at the panel provide a clear source of intelligence. As with children missing from home, there remain missed opportunities for maximising the benefit that this meeting offers. Minutes do not provide specific or timely actions to improve planning for individual children.

41. The local authority is not adequately addressing the underlying causes of children who are at risk of child sexual exploitation. There is over-optimism about the home circumstances and parental ability to protect children from future risk. For example, in cases seen, five of six children included in the MACSE cohort had a significant history of neglect that was not adequately considered as part of plans to reduce their sexual exploitation.
42. The local authority maintains an up-to-date register of children and young people who are missing from education, and has appropriate, well-established processes to find them, including effective coordination with the police and health services. Of the 91 young people, 78 have been found and work is continuing to locate the remainder.
43. Parents who elect to educate their children at home can access support, and the local authority has appropriate procedures to check on the welfare and education of children. When concerns for children's welfare are identified, they are quickly escalated to the right agencies for appropriate further action. In the most recent academic year, as a result of these efforts, seven children were identified as children in need and one child was placed on a child protection plan.
44. Multi-agency risk assessment conference (MARAC) partners demonstrate expertise and professional knowledge of the implications for children of adult mental health, substance and alcohol misuse, and domestic abuse. This understanding is often not evident in frontline social work practice or records. MARAC arrangements are strong, in part due to the commitment and oversight of the family safety unit (FSU) and its effective contribution to meetings. The local authority has recognised a need for more appropriate children's social care representation at MARAC meetings, but this has not yet been achieved.
45. Wirral has a good range of services to support the victims, including children, and the perpetrators of domestic abuse. However, professionals report a reduction in support services for those families that do not meet the high threshold for MARAC intervention and a 17% increase in referrals this year to the FSU, placing increasing demands on resources. All services have waiting lists even for those families that do meet the threshold, and some cases are inappropriately closed or stepped down before support has been provided, based on the assumption that a lack of reporting of further incidents must mean that none have occurred.
46. Sixteen- and 17-year-old homeless young people do not receive an adequate joint response from social care and housing services before being placed in

temporary accommodation as children in need. As a result, the potential for them to become looked after is not explored early enough. Social work assessments undertaken for those children referred by housing services do not often lead to young people becoming looked after, even when they have identified additional needs or vulnerabilities. In half of the cases seen during the inspection, young people's needs would have been better met via section 20 accommodation and the provision of stronger support planning. (Recommendation)

47. Children privately fostered are not well identified by the local authority and partners. When children are living with private foster carers, the local authority does not discharge its statutory responsibilities effectively. Despite systems for an independent reviewing officer (IRO) to review and oversee private fostering arrangements, quality assurance of practice with these children lacks effective scrutiny. Children are not visited in line with requirements, and assessments seen are unsatisfactory. They do not include an analysis of suitability of living arrangements for children, so the local authority cannot be sure that privately fostered children are adequately cared for. (Recommendation)
48. The management of allegations against professionals is not consistently effective and investigations are sometimes delayed. This is largely due to a lack of compliance with procedures. The designated officer does not receive reports of concerns about professionals quickly enough and the quality of information, when it is provided, is poor. Many referrals are made after the strategy meeting has taken place, without the designated officer present. Communication and feedback to the designated officer from other agencies are poor, with large numbers of investigations remaining open for long periods while police investigations are ongoing. (Recommendation)
49. No cases of children identified as being at risk of female genital mutilation were seen during this inspection. Staff report positively on awareness-raising training events and the local authority has appropriate procedures for staff to follow.
50. The local authority and partner agencies have clear procedures in relation to risk of radicalisation that have been effectively communicated to staff through awareness-raising activities. As a result, agencies are appropriately alert. During the inspection, the local authority, with partners, took swift authoritative action to assess the risk of radicalisation within a family, and this ensured that the children were appropriately safeguarded.

The experiences and progress of children looked after and achieving permanence

Requires improvement

Summary

The poor service that many children experienced before they became looked after is mitigated by the care that they receive. Almost all children looked after live within Wirral itself or nearby. Most benefit from good, stable placements with carers who know them well. The vast majority of primary schoolchildren attend good or better schools, as do most secondary age young people. Children make good progress between early years and key stage 2. However, this declines when they move to secondary school. Plans to support young people at key stage 4 to achieve their full potential are not sufficiently ambitious.

Recent decisions for children to become looked after are, in the main, timely. Edge of care arrangements, while fragmented, help some children to remain with their families and some to return home successfully. The vast majority of children become looked after through court proceedings. Decision making within court is timely, reducing delays for children. However, a few older children remain in the pre-proceedings phase of the Public Law Outline for too long.

Although the timeliness of looked after children’s reviews is good, independent reviewing officers are not effective enough in challenging poor practice and do not escalate their concerns soon enough to senior managers when improvements have not been made.

The responses to children missing and who are at risk of sexual exploitation are mostly timely and effective. Good attention is paid to children’s physical health, with clear health plans being devised from health assessments. However, there is inconsistency in the level and quality of emotional health support that children receive.

Adoption performance is improving, and children and families receive appropriate support post-adoption. Delays in completing life-story work and books mean that adopters and children do not always have the full information that they need to help the children to understand their history. A concerted focus on permanence has led to high numbers of children leaving care under special guardianship orders. While many of these children had been waiting a long time, this represents a significant improvement in achieving permanence for children and young people.

The local authority fails to keep accurate data on care leavers. It has lost touch with too many care leavers and has made little or no effort to contact most of them. This is a serious failure and means that these young people are disadvantaged, as they are not able to benefit from the advice and support of their corporate parents. While most care leavers receive good support, some of the most vulnerable have not received a service that adequately recognises risk.

Inspection findings

51. At the time of the inspection, the local authority was looking after 705 children. Numbers of children looked after have remained relatively stable over the last two years. Many children who are currently looked after have experienced historic drift and delay before coming into care, due to deficits within the child protection system. However, very recent decision making is timelier and, in these cases, thresholds and management decisions to look after children had been applied appropriately in almost all cases. However, a very small minority of children and young people had remained in situations where risks had escalated and had waited too long before the local authority took action to look after them.
52. The local authority provides a range of responsive services to children on the edge of care to prevent family breakdown. Current arrangements are fragmented, and the reduction in service provision, combined with staffing vacancies, means that the local authority's capacity to support children to remain at home or, if looked after, to be safely rehabilitated home, is reduced. Nevertheless, in the six months prior to the inspection, 11 children returned home from care. In cases seen, despite the challenges within the edge of care service, these children and young people were offered appropriate support, which was helping them to remain with their families successfully. Numbers of children who return home who then become looked after again are small. The local authority has applied for Department for Education innovation funding to develop an evidence-based edge of care service which, it anticipates, will increase capacity to reduce the comparatively large number of children looked after, although the funding had not been agreed at the time of the inspection.
53. Children who are subject to letters before action, the pre-proceedings phase of the Public Law Outline (PLO), are not reviewed regularly enough. Although letters before action are clear, this lack of review means that progress is not formally considered and actions updated. As a result, some children spend long periods at this stage. The local authority has recognised the need to track these children's experiences more closely. However, it has not yet introduced a more effective system. At the time of the inspection, 67 children (39 families) were subject to pre-proceedings. A very small minority of these children had not had a review of their circumstances for over 24 weeks. Delays at the pre-proceedings stage mean that children and their families are unclear for too long about what the local authority's plan is for their future care. (Recommendation)
54. For children who enter care proceedings, the length of care proceedings has reduced from 30 weeks, in Q3 2015–16, to 27 weeks, which is very close to the national target of 26 weeks. The Children and Family Court Advisory and Support Service (Cafcass) and the judiciary both report that this is due, in part, to an improvement in the quality and timeliness of assessments placed before the court reducing the need for further assessment or use of expert witnesses. The majority of children looked after in Wirral are under legal orders, with their

permanence plans determined through court processes. Very few children are looked after by voluntary agreement (8%).

55. The local authority is appropriately committed to ensuring that children are placed within their extended families, when it is safe to do so. At the time of the inspection, 186 children had been matched long term with connected carers. The numbers of children who cease to be looked after due to being placed within their extended families is very high. In the six-month period prior to the inspection, out of the 93 children who ceased to be looked after, 41 (44%) went under a special guardianship order. In cases seen, this had been the plan for those children for lengthy periods, sometimes years. Nevertheless, this represents significant progress in achieving permanence for children. However, for a very small minority of older children, there has been delay in approval of their permanence plans.
56. Of the 705 children currently looked after, 61 were placed with parents under a full care order. In cases sampled by inspectors, no children were at home inappropriately. The local authority has identified those children who no longer require this level of intervention and is taking steps to ensure that applications for discharge are prioritised. However, at the time of the inspection, some children remain subject to unnecessary statutory intervention into their lives.
57. The number of school changes for children looked after in Wirral is low, with over 80% of children looked after having attended just one or two schools. This helps to contribute to consistency of education provision for children. The majority of children attend good or outstanding schools, at primary level 92% and at secondary level 72%. The quality of personal education plans (PEPs), although mixed, requires improvement overall. Too many PEPs include actions that are not specific, measurable or match the identified needs of children and young people. Progress against targets is rarely measured. The links between pupil premium spending and pupil progress are not clear. (Recommendation)
58. The attainment and progress of children looked after from early years to key stage 2 is good, and 89.4% of children in early years and 81.7% of children in key stages 1 and 2 make the expected level of progress. However, at key stages 3 and 4, too few make the expected progress (59.2%), which is in line with low national rates. Attendance of children looked after at primary school is good, at 98%, though this drops to 92% at secondary level. In the most recent reported data, the virtual school head reports that this has increased to 93% due to action taken, which, while still not good, represents an upward trajectory. Positively, there have been no permanent exclusions in 2015–16.
59. The local authority keeps appropriate records of children looked after who attend alternative provision. In 2015–16, of 11 such children, six attended for 25 hours a week or more. Although the register contains brief details of the reasons for such provision, PEPs do not sufficiently monitor the progress of these children. The local authority has recently employed a seconded headteacher with a view to improving arrangements for alternative provision.

Overall, the virtual school has not been effective enough in ensuring a concerted focus on the needs of children looked after within schools. For example, no training has been offered to teachers in the last 12 months to improve the quality of PEPs, and there are no networking events for designated teachers where issues can be raised and good practice shared.

60. Assessments of children's needs are variable and do not always include information on changes in children's circumstances. The quality of the care plans is inconsistent. Many do not demonstrate a rigorous analysis and they lack sufficient focus, detail and clarity about desired outcomes. This means that neither involved professionals nor children and their families are always clear that actions are being taken and that progress is being made.
(Recommendation)
61. Wirral independent reviewing officers (IROs) also chair child protection conferences. They have high caseloads, split between children looked after (60%) and child protection work (40%). On average, combined caseloads are between 90 and 110, limiting their capacity to track and monitor cases between reviews and to provide effective quality assurance. IROs have appropriately raised 260 escalations on behalf of children since 1 July 2015. However, these rarely progress beyond team manager level if improvements are not made, and IROs reported delays in some of their concerns being addressed. The local authority has recognised the need to strengthen the escalation policy.
(Recommendation)
62. The vast majority of looked after reviews are completed on time and, as of June 2016, this was almost at 100%. Children are encouraged to attend and participate in their reviews. Advocacy services for children are available through a commissioned service. The quality of advocacy support is good, which means that children are helped to have their concerns addressed and to take part effectively in their looked after reviews. However, the number of children receiving support from advocacy services is low, with only 20 children looked after receiving this support. The independent visiting service currently supports 14 children, with a further six waiting to be matched. The local authority needs to do more to ensure that young people who do not have contact with families and friends receive this valuable service quickly. (Recommendation)
63. The Children in Care Council has contributed effectively to ensuring that all children in care are aware of the complaints process. Children's complaints are managed well on an individual basis. All of the 35 complaints in 2015–16 were resolved for children with the help of an advocate and in a timely manner. An outcome meeting is offered to all children with the team manager of the relevant social work team, supported by an advocate. Themes from these meetings have not been analysed or disseminated to staff, and this is a missed opportunity to learn from children's experiences.
64. Reviews of health assessments of children looked after for 12 months or more are not consistently timely, at 83.9%. Current performance in relation to initial

health assessments, at 78%, also requires improvement to ensure that all children's initial health needs are responded to and met at the point at which they become looked after. More positively, all out-of-area health assessments are quality assured by the specialist nurses for children looked after to ensure that the health needs of children placed out of Wirral are addressed. Take-up of dental assessments is 91%, as of June 2016, which is good.

65. The majority of children benefit from contact with family and friends at a frequency that meets their needs. However, children's diversity needs are less well considered, with no clear plans to identify how they will be met. This is particularly the case when broader issues of identity, such as the emotional impact of past life events, have lacked sufficient attention or consideration.
66. All children looked after live with foster carers unless their needs cannot be met in a family environment. The Wirral access to resource panel (WARP) ensures consistent decision making for children regarding placements. The vast majority of children looked after do not experience placement moves. Short-term stability of placements is strong; just 6.6% of children experienced three or more moves during 2015–16. This is lower than most recent published data for 2014–15 for statistical neighbours, at 9.7%, and the England average of 11%. Long-term placement stability is also good, at 75.2%. Children are carefully matched with suitable carers, together with their brothers and sisters where this is appropriate and in their best interests, which means that they are able to settle and develop attachments with their carers. Good support arrangements contribute to the stability of placements.
67. Fostering services meet the needs of children well. Foster carers benefit from good initial training and ongoing training on specific themes, including an intensive therapeutic parenting course. Well-established groups for carers and their families support them in their caring role. Children looked after have good access to a range of leisure activities. Foster carers exercise delegated authority on an individual basis, making day-to-day decisions for children in their care, which helps to normalise children's experiences
68. Sufficiency planning of placements for children who are looked after is highly effective. Targets for recruiting local foster carers are consistently achieved. More children looked after, compared with the large majority of other English local authorities, live within the local authority boundary, with only a small minority (7%) living more than 20 miles from their home. Plans are underway to increase the number of foster carers who could offer placements to children with additional needs to increase the number of children placed in Wirral still further. When children cannot be looked after within Wirral's own resources, initial placements are only considered from services that are judged good or better. If judgements decline, the service is reviewed and decisions to continue the placement are risk assessed and considered in the best interests of the young person.

69. The reporting of children missing from care is undertaken promptly. In most cases, risks relating to young people going missing were managed appropriately. In the six months prior to the inspection, 227 missing episodes were recorded that involved 44 children looked after. All children are offered a return home interview conducted by an independent provider. Inspectors saw examples of sustained input from these workers to encourage young people to engage in return home interviews. When completed, the vast majority of interviews contained significant information relating to children's circumstances when they had been missing, with some analysis of the level of risk that they faced. However, in a minority of cases, the information gathered from these interviews had not been referenced in children's care plans. As a result, important information is not always available to all professionals involved.
70. Children looked after who are at risk of sexual exploitation are appropriately referred to the MACSE panel. Links between young people who are absent from care and potential child sexual exploitation are appropriately considered. At the time of the inspection, a commissioned child sexual exploitation service which is well regarded by young people was undertaking risk-reduction work with 23 young people. This service works as far out as a 30 mile radius of Wirral, so the small number of young people who are placed outside the borough can benefit from the service. A multi-agency audit of all children in out-of-authority foster or residential placements who were assessed to be at risk of child sexual exploitation has been carried out. The audit found that the majority (80%) of children also had a history of missing episodes and that a small number of children had not been referred to MACSE who should have been. In cases seen, the risk of sexual exploitation to children had reduced as a result of them becoming looked after.
71. Social workers regularly visit children looked after and see them alone, when appropriate, at least within minimum timescales. However, the quality of records of these visits is variable. In some, there is clear detail relating to the purpose of the visit, with children's views well recorded and information about what work is being done. In others, there is a lack of clarity about the purpose of the visit, with children's voices less well evidenced. A high turnover among social workers and managers has, for a small minority of children, resulted in inconsistency in quality of practice, management oversight and the progression of their care plans.
72. A focus on individual youth crime prevention work through the youth offending team ensures that children at risk of offending are identified early and receive a timely, focused intervention. The needs of children at risk of or engaging in substance misuse are met well through a commissioned service.
73. The provision of emotional health support to children looked after is not good enough. Children have identified this themselves through a recent consultation exercise. Strengths and difficulties questionnaires are not always timely, and are completed by a health professional and not by a carer who knows the child well. Each child whose score indicates a concern is referred to the child and

adolescent mental health service (CAMHS) for assessment. A lack of qualitative and substantive data relating to the service offered means that the local authority cannot be reassured as to the effectiveness of this provision.
(Recommendation)

74. Wirral Children in Care Council has undertaken some valuable work to improve the quality of service that children receive. Examples include: the recent completion of a DVD which will be used in foster carer training and recruitment; involvement in social work interview panels; and refreshing Wirral's promise to young people and care leavers. It has recently formed an additional group for older young people, in recognition that the issues that affect them can be different. Currently, there is no group for children under 13, although their views are captured in other ways. The Children in Care Council is well supported by experienced, sensitive workers.

The graded judgement for adoption performance is that it requires improvement

75. Wirral's adoption service requires improvement because, despite progress in meeting government timescales, too many children and too many adopters still wait too long to find a family.
76. The most recently published figures for 2012–15 show that the average time between entering care and moving in with an adoptive family was 640 days, which is 153 days over the government threshold of 487. The time between receiving court authority to place a child and deciding on a match with an adoptive family, at 225 days, is significantly longer than the government target of 126 days. More positively, during 2012–15, 43% of children waited less than 16 months between entering care and moving in with their adoptive families. This is better than the national average of 47%.
77. According to data provided by the local authority during the inspection, Wirral's performance in relation to the overall threshold set by the Department for Education for the average length of time between children becoming looked after and moving in with adopters is now broadly in line with national targets. Wirral's performance on the national scorecard for 2013–16 was 431 days, which is just over the target of 426 days. Data provided by the local authority for 2015–16 shows that, of the 31 children, a small number had additional needs which meant that securing a match took much longer for appropriate reasons. This demonstrates tenacious commitment to achieving permanence for those children, resulting in good outcomes for them.
78. Current performance monitoring systems to analyse the adoption service's performance and focus on any problems or issues affecting the timeliness and quality of the work are overly dependent on paper-based systems and the individual expertise of the managers concerned. While adoption managers demonstrate an impressive understanding of the progress of individual children,

there is no easily accessible overview, either for senior managers to quality assure the work or to assist managers to identify themes.

79. The adoption panel is made up of representatives with relevant professional experience of adoption. The level of debate, questioning and decision making from the panel is appropriate, with well-considered matching. The panel has appropriately identified areas for improvement in relation to the quality of reports, but this has not yet achieved consistently high standards. Issues highlighted by the panel in its quality assurance report of October 2015 to March 2016 were also seen at this inspection.
80. The quality of child permanence reports (CPRs) is of a variable standard, and most require improvement. The reports are not consistently updated, reflecting changes in the child's development and/or circumstances to ensure that all of the child's experiences are captured. In a small number of cases, the quality of the CPR reports resulted in panel decisions being deferred and contributed to delays for children. The adoption team is undertaking training with the district childcare teams to improve the quality of reports.
81. Assessments to determine if it is in children's best interests to be placed with their brothers and sisters are of good quality. They reflect the needs of each child, with sound analysis of their attachments to each other. Where recommendations are made to separate children, there is a very clear rationale. Permanency decisions seen by inspectors were made in the best interests of each child.
82. The quality of prospective adopter reports, while variable, is mainly good. Most reports contain good analysis of how prospective adopters' experiences will enable them to parent a child placed with them, assisting the panel to make timely recommendations to the agency decision maker (ADM). However, a small minority of reports are repetitive and analysis is weak.
83. The quality of life-story work and life-story books that children receive is generally good, but there have been delays in this work being completed for some children. The local authority had recognised this as an area for improvement prior to this inspection. As a result, it has recently appointed additional staff to support social workers to improve the quality and timeliness of life-story work and the completion of life-story books. The impact of this initiative is too early to evaluate. However, letters for children in their later life are timelier and provide clear, age-appropriate information about the child's family, circumstances and experience in a child-centred way. The letters sensitively outline why and how decisions were made for children and they mitigate, to a degree, the delays in completion of life-story work.
84. Recommendations made to the ADM by panel are well recorded. However, there have been four ADMs in the last 12 months. As a result, meetings between the adoption panel chair and the ADM have not been regular, and this

lack of consistency has hampered the local authority's effectiveness in ensuring that the service delivered meets the needs of children who require permanency.

85. Adopters are recruited from a wide range of backgrounds that reflect the diversity of the population. However, targets are not aspirational, and are based on what has previously been achieved rather than projected future need. While all routes of permanence are discussed, the numbers of carers willing to consider fostering to adopt and concurrent planning are low. In the past 12 months, two 'fostering to adopt' assessments have been completed. This limits the opportunity to reduce the number of changes in placement that children experience. The service is currently undertaking training and awareness raising with staff and foster carers to increase the potential pool of carers for fostering to adopt placements. However, it is too early to evaluate the impact of this initiative.
86. Once adopters are approved, they are not routinely referred to the adoption register when there is no suitable match available in Wirral. On average, it takes 188 days for referral. This is twice as long as the government-set timescale. This means that adopters are not considered at the earliest opportunity for children for whom they could provide a home. At the time of the inspection, there were 21 approved adopters waiting to be matched. Eight couples have been waiting for over 12 months. In a number of these cases, adopters have very narrow criteria, and this is contributing to the difficulties in matching.
87. From April 2015 to March 2016, 31 children were placed for adoption in Wirral. At the time of the inspection, there are 30 children with a decision for adoption, 12 are placed with prospective adopters with a placement order and 18 are in the family-finding stage. Of this cohort, there are six sets of brother and sister groups. There was one recent disruption, and the child returned to their previous foster carer. Although a disruption meeting had been held at the time of the inspection, minutes had not yet been distributed and the dissemination of learning had not yet taken place.
88. In the 12 months to inspection, seven children had their plan for adoption reversed. No analysis of the cases has been undertaken. This is a lost opportunity for the local authority to identify themes and any implications for practice improvement.
89. All adopters spoken to during this inspection were positive about their social workers, who are available and supportive. Post-permanence support is a significant strength. Support plans are timely and appropriately identify support for families, including birth families. Effective use is made of the adoption support fund to access a range of support for carers and children, including therapeutic services and training courses. Examples seen include support in accessing parenting courses, which has enabled carers to meet the changing needs of the children, preventing family breakdown, and emotional resilience therapy provided to children to support their understanding of being adopted.

The graded judgement about the experience and progress of care leavers is that it is inadequate

90. The local authority does not collate and manage data about care leavers effectively. As a result, managers and senior managers do not have a realistic understanding of the progress of these young people, the risks that they face and the services that they need. Managers are unable, for example, to provide accurate information about the accommodation of care leavers or the educational or employment activity in which they are engaged.

91. The local authority has lost contact with 27 (13%) of its 205 19- to 21-year-old care leavers. In 16 of these cases, staff have made insufficient efforts to re-establish contact or have not taken any action at all. As a result, the authority does not have any information about the welfare of these young people and is unable to support them effectively. This includes some care leavers known to be vulnerable prior to losing contact, such as single parents who had had contact with the local authority regarding the welfare of their own children.

92. There are five care leavers who have recently been homeless for periods of time, one of whom senior managers were unaware of until informed by inspectors. In this case, it was not clear how the local authority had supported them initially. In some cases, workers had failed to maintain adequate contact with the young person and, as a result, did not understand or address the risks that they faced. For example, some care leavers living in temporary arrangements did not feel safe. Management oversight and monitoring of these cases was insufficient. It failed to identify potential indicators of exploitation or take appropriate action to ensure care leavers' safety and welfare. Initial responses by middle managers to inspectors' concerns were dismissive and ill considered.

93. Pathway planning is inconsistent and, in too many cases, pathway plans are of poor quality. There is no external scrutiny or review of these plans, and management oversight has not led to improvements. Too often, they are updated by personal advisers and then given to care leavers without any formal meeting or discussion. This is a missed opportunity to offer independent challenge both to young people and the multi-agency team that surrounds them.

94. A small minority of plans are either not completed within the required timescales or not updated at appropriate intervals. In a few cases, they have not been completed at all. Where staff have completed plans, they contain a thorough assessment of the young person's requirements, and workers demonstrate a detailed understanding of the young person's needs and aspirations. However, in most cases, the action plans derived from these assessments lack relevance, are insufficiently specific and do not have clear timescales for completion. Care leavers themselves have mixed views about the

efficacy of these plans, with approximately half of those spoken to by inspectors finding the process helpful in keeping them focused on their goals and the remainder finding it of limited or no use.

95. Health arrangements for care leavers are not sufficient to meet the needs of those who do not meet the very high threshold for intervention by adult services. No health services for care leavers are provided over and above those for all young people. Care leavers do not have access to their full health history, and this means that there are many who do not have important information about their own health and that of their birth families. Care leavers confirm that they do receive the other documents that they are likely to need in their transition to adulthood, including their birth certificate, passport and national insurance number.
96. Care leavers are not provided with sufficient information about their legal entitlements, particularly in relation to financial support. Although personal advisers provide information when they identify the need for it, care leavers do not know independently what support is available to them. For example, one care leaver was unaware that they could access funding for driving lessons, and another experienced some confusion over whether they would be supported to continue their education. Although the local authority has a website that provides basic information in this regard, it is not specific to local care leavers. A leaflet has also been produced, but those care leavers spoken with were unaware of it.
97. Care leavers who maintain contact with the local authority are supported well to make the transition to adulthood. Their personal adviser works with them to identify the skills that they need to live independently and provides support for such things as managing a budget. When young people live with former foster carers or in supported accommodation, carers and support workers help them to develop their domestic skills, such as how to cook, through one-to-one support activities and, for those living in supported accommodation, through workshops and structured learning activities. In the last 12 months, structured, formal training has been offered for young people in a range of life skills. However, because this was located at a relatively inaccessible centre, the take-up was low.
98. For some care leavers with enduring, significant health needs, the transfer to adult services is tailored to meet their diverse needs with effective, staged handovers and joint working between children and adult services. For most, this planning does not start until a care leaver is at least 16 years old. Transition workers are now starting to work with some care leavers, particularly those with high levels of disability, as early as Year 9. Transition services for children looked after with mental health issues that do not meet this threshold or substance misuse issues are less good. While the local authority reports transfer on a case-by-case basis for those at risk of or already involved in sexual exploitation, this was not demonstrated in some cases seen.

99. Care leavers develop good relationships with social workers and personal advisers who visit them frequently. They feel that these professionals are genuinely interested in them and how well they are progressing, and almost all report a high level of satisfaction with the support that they receive. Among those care leavers who do engage with the local authority, there are a number of examples of good work by social workers and personal advisers that has gradually strengthened relationships with young people and helped vulnerable care leavers to re-engage with services such as health education and training. However, this is too dependent on the individual knowledge and expertise of the workers involved.
100. Throughout the inspection, managers gave conflicting data about the numbers of care leavers who participate in education, employment and training. If the most recent data supplied can be relied upon, it shows that the proportion of 19- to 21-year-old care leavers who continue to participate in employment, education and training has risen to 56%, and this is higher than the last-published national rate. The local authority has implemented a set of well-considered actions to support participation. It provides individual coaching from Year 10 for young people at risk of not progressing from school to further education, training or employment and a similar service for older care leavers who have dropped out. It also offers an employability programme, 'Get real' that helps to re-engage young people in learning and work.
101. The local authority provides an additional financial incentive for local small- and medium-sized enterprises to take on care leavers as apprentices, and four care leavers have benefited from this service in the past 12 months. The local authority itself employs few apprentices, and only a small number of care leavers have secured such roles. A recently introduced supported employment scheme has allowed eight care leavers to gain full-time, paid employment for 12 months, with an expectation of permanent employment at the end.
102. Care leavers spoken to feel positive about themselves and many feel that their future is bright. The local authority celebrate their achievements. The local authority has recently established a separate Children in Care Council specifically for care leavers, with a view to strengthening this aspect of its work.
103. The local authority has access to a good range of accommodation suitable for care leavers, including emergency accommodation, semi-independent flats and houses, and supported lodgings. It has access to specialist accommodation for vulnerable young women and young parents. As a result, 84% of young people with whom the local authority is in touch are in suitable accommodation. No young people are accommodated in bed and breakfast, houses in multiple occupancy or foyers. The local authority works well with providers of accommodation to ensure that, when there are risks of tenancy breakdown, these are mitigated or alternative plans put in place. Currently, 16 of 57 (28.1%) 18-year-olds have taken advantage of staying put arrangements to remain with their former foster carers.

104. Care leavers spoken to by inspectors reported that they feel safe. Most live in accommodation that is suitable for their needs and are provided with appropriate support to help them with any particular difficulties that they face. Social workers and staff from supported accommodation schemes assess the needs of young people and ensure that they are provided with appropriate support for issues such as drug and alcohol misuse through referrals to external agencies. However, there is a small number of cases where the safety or well-being of a young person has been compromised. Examples include threats of violence and theft of possessions not being followed up on behalf of care leavers.

Leadership, management and governance	Inadequate
<p>Summary</p> <p>Senior managers and political leaders have not provided effective, stable leadership of services for children and young people over the past three years. The absence of a stable, experienced head of service for children’s social care has not provided the director of children’s services (DCS) with the capacity to improve services for vulnerable children through a measured and continuous focus.</p> <p>Service provision has deteriorated since earlier Ofsted inspections in 2011 and 2012, particularly for children and young people requiring help and protection, and for young people leaving care. Senior managers understand most, but not all, of the weaknesses in the service and have formed detailed operational and strategic plans to improve the quality of safeguarding and outcomes for children and young people, but these had not commenced at the time of the inspection.</p> <p>Performance management, quality assurance, scrutiny and oversight by managers and politicians do not lead to timely practice improvements. This is primarily due to a lack of engagement, analysis and ownership of performance by middle and frontline managers. The quality of management supervision of social workers is inconsistent and is not developing more effective social work responses to help and protect children and young people.</p> <p>The local authority has attempted, with the Local Safeguarding Children Board, to increase partner agency understanding of thresholds for social care intervention, but this has not reduced the number of repeat contacts and referrals, in part because the local authority has not fully recognised or addressed the widespread application of inappropriate thresholds within children’s services. While the DCS has challenged the police about delays in strategy meetings due to resource issues in the police, these challenges have been ineffective. Challenge was taken up by the chief executive during the inspection, but this should have been escalated to him earlier and has not yet resulted in improvements in attendance.</p> <p>Strategic plans to develop joint commissioned services are at an advanced stage, but joint commissioning across the spectrum of children’s services is not yet apparent, indicating slow progress by the local authority and clinical commissioning group.</p> <p>Cross-party political commitment to strengthening services is demonstrated through recent substantial additional funding to recruit more social workers and to attract a high-calibre permanent head of service.</p>	

Inspection findings

105. Services for children and young people requiring help and protection, and for care leavers, have declined significantly since earlier Ofsted inspections. A series of short-term interim and permanent appointments to the critical head of service position in children's social care over the last three years continued at the point of the inspection. A further interim had recently commenced, replacing a predecessor who had been in the role for six months. Two out of three senior operational management posts, positioned below the head of service, are also occupied by interim staff. (Recommendation)
106. The absence of an enduring, effective head of children's social care has impeded the director of children's services' (DCS's) understanding of the quality and capability of some operational services for vulnerable children and families, and her capacity to deliver prioritised, timely improvements. This has clouded her line of sight of the performance of frontline services. A carefully prioritised urgent improvement plan is being implemented by the current interim head of service, quickly addressing improved management oversight and decision making in the multi-agency safeguarding hub (MASH).
107. Middle and frontline managers are increasingly being engaged in evaluating performance in their services and implementing corrective actions. There are established and frequent arrangements for senior leaders, the lead member and the Local Safeguarding Children Board (LSCB) chair to meet and review service performance. There is a clear, determined intent to scrutinise performance, illustrated through regular, formal meetings at appropriate intervals involving the Chief Executive, strategic director, DCS, Chair of the Wirral Safeguarding Board and the lead member for children's services. However, despite a common recognition within the local authority that improvements are urgently required, recommendations for service improvement do not subsequently result in demonstrable, widespread practice improvements. This indicates a fragile, ineffectual link between leadership, governance and the management of children's services. (Recommendation)
108. Quality assurance activity largely comprises single-agency audits of practice. Audit findings inform managers and leaders of serious shortcomings in social work practice, including, for example, poor care and child protection plans, weak compliance with child protection conference recommendations, and delays in implementing legal advice for children when their circumstances are not improving. A thread of weak middle and frontline management compliance is also revealed in the failure of managers to complete the number of audits requested, diluting the volume of evidence produced.
109. Despite these shortcomings, senior managers can demonstrate a narrowing gap between the audit evaluations of middle and frontline managers and senior management moderators in recent months, and improving compliance. This

trend is further exemplified by inspectors, who agreed with the findings of the moderated local authority audits provided during the inspection.

110. Political scrutiny of children's services is frequent and prominent. Performance reports are regularly examined by the lead member for children's services and at two scrutiny sub-committees. One sub-committee has undertaken wide-ranging reviews of the quality of social work support for children requiring safeguarding and children looked after. The impact of recommendations is not yet leading to timely and substantial practice improvements. Challenge was taken up by the chief executive during the inspection, but concerns should have been escalated to him earlier and has not yet resulted in improvements in attendance. A clear response from a senior police officer to poor police attendance at child protection strategy meetings, a feature that inspectors also found in case tracking and sampling, was triggered by the chief executive's intervention during the inspection, not by the local authority's earlier efforts, and has not yet led to improvements in practice.
111. The Children's Trust has recently agreed a review and refresh of its role and key functions, to underpin the commitment to joint commissioning between the local authority and its partners to deliver the new strategic plan for children, young people and families through the children's joint commissioning group. This will include a review of the governance arrangements between the Children's Trust, the Health and Well-being Board and the Local Safeguarding Children's Board.
112. An urgent service improvement plan to strengthen social work practice, reflecting many of the inspection findings, was launched shortly prior to the inspection being announced. This further illustrates the local authority's clear intent to implement reforms, for example in the MASH, to hold timely and well-attended strategy meetings, but an ingrained pattern of poor middle and frontline management engagement has yet to be determinedly overcome.
113. The local authority has focused strongly on recruiting and retaining a balanced blend of experienced and more recently qualified social workers. The salary range was regraded upwards in 2015 to match that of local authorities nearby. Vacancy levels are relatively low, with 17 unfilled social work and four team manager posts. Agency use is high for a number of reasons, including vacancies, sickness and maternity cover and temporary posts, raising the number of locum social workers employed to approximately 27% of the total staff establishment. The majority of agency social workers are in the child protection and child in need teams. This results in frequent changes of social workers for children, causing disruption that impedes building trusting relationships and progressing their plans.
114. Senior managers have only recently commenced addressing long-term sickness with a rigorous project plan. The numbers of children allocated to social workers are not unduly excessive in the majority of teams, but there are significant pockets of higher workloads in some child protection and children in

need teams, and much of the work is complex. Sickness rates in children's social work teams are higher than elsewhere in children's services, particularly in child in need and child protection teams. Averages of 30, 27 or 20 days' sick leave per annum are not uncommon. The average outside of these teams is 12 days. These differences in workload and high sickness levels indicate that management deployment of social worker resources has not been effective. Senior managers and political leaders have recently tackled this issue, providing significant additional financial resource through an 'invest to save' model. Ten permanent peripatetic social workers are being recruited to cover the majority of unplanned vacancies, reducing the reliance on agency social workers. (Recommendation)

115. The principal social worker and the workforce development team are engaged in effective arrangements with local universities and neighbouring local authorities that provide comprehensive social work learning and development programmes based on the professional capabilities framework. Importantly, workforce development is not solely targeted at newly qualified social workers, but includes experienced social workers and programmes for frontline and middle managers, and independent reviewing officers. However, this learning has yet to assist managers to drive up standards in frontline practice. A minority of newly qualified social workers in their first year of assessed practice hold too many complex cases, reflecting the workload pressures in some teams.
116. Management oversight of social workers is of variable frequency and quality. There is limited evidence of reflective supervision in accordance with the local authority's supervision policy. Supervision is predominantly task focused and does not rigorously address delays in implementing recommendations and plans. A recent local authority audit judged the quality of supervision as ineffective in nearly 40% of cases, and this broadly reflects the findings of inspectors. (Recommendation)
117. While there are established links between the Health and Well-being Board, LSCB and the Children's Trust, a review of governance arrangements at the time of the inspection indicates that the local authority recognises that some strategic partnerships require refocusing. The influence of the LSCB within the Children's Trust, in calling it to account for the quality of multi-agency safeguarding, is not strongly apparent and the trust has not closely examined the board's limitations in influencing improvements in safeguarding arrangements across partnership agencies. The inclusion of children's data in the Health and Well-being Board is too limited to standard public health datasets.
118. The lead member for children chairs the corporate parenting board. It is well attended by relevant agencies and has a substantive action plan. However, while the board reviews a comprehensive range of outcome indicators for children who are looked after, its impact in challenging weaker outcomes requires strengthening. The board recognises that it would benefit from clearer performance data on which to base prioritised actions, including improving the

quality of personal education plans, permanency planning, emotional and mental health support services and increasing the limited number of council apprenticeships for care leavers.

119. The inclusion service works closely with the Children in Care Council to provide strong, consistent representation of children and young people's feedback and views on service provision. Inclusion of children's views in reviewing and planning services is highly developed in this local authority. Their impact is demonstrated in shaping the specialist service structure implemented in June 2015 and the Children, Young People and Families' strategy, April 2016.
120. The learning derived from complaints is too limited. The large majority of complaints are quickly resolved at informal stages and a very small number are escalated to formal stages. While this is positive, there is little evidence of focused management efforts to inform subsequent service provision, including a lack of analysis of a notably higher volume of complaints at one district office.
121. A web-based joint strategic needs analysis provides a dynamic and informative account of local needs. There are clear plans to evolve it further to inform outcome-led, evidence-based joint commissioning plans for the most vulnerable children over the next four years, although evidence of existing jointly commissioned services is limited. A considerable range of existing single local authority commissioned services deliver a spectrum of services which are well monitored through an outcome-based contract framework and regular compliance visits to providers.
122. Strategic planning and oversight of child sexual exploitation provides clear direction through effective cooperation and coordination of senior leaders across local authority partnerships and with other Merseyside local authorities. At an operational level, work with young people affected by child sexual exploitation requires a greater focus on the underlying causes that increase their vulnerability.
123. The local authority has constructive relationships with the local family justice board and the Children and Family Court Advisory and Support Service. Social workers attend the training provided to improve the quality of evidence preparation, and local authority managers contribute constructively to family justice board meetings and court user groups.

The Local Safeguarding Children Board (LSCB)

The Local Safeguarding Children Board is inadequate

Executive summary

Wirral Safeguarding Children Board (WSCB) is judged to be inadequate, as it is not discharging all of its statutory functions. Its governance arrangements do not ensure that it is independent of influence, as required by statutory guidance.

While the WSCB consults appropriately with the serious case review national panel, in one case there was a delay of three months in making a recommendation. It does not always notify Ofsted of serious incidents within the required timescales. Two incidents notified to Ofsted during the inspection were significantly late and one did not reflect accurately the child's involvement with the local authority. This means that, when a child has been harmed, a full external scrutiny of incidents is delayed and is not always based on complete information.

Statutory partners are not contributing to the financial resourcing of the board, and this results in it being overly dependent on the finances of the local authority. The board has not challenged partners sufficiently in some key areas of safeguarding practice, and board members have not been influential in progressing shared priorities and improvements within their own organisations.

WSCB has not focused sufficiently on core child protection business to determine the effectiveness and outcomes of children's experiences at all key points. The most recent published annual report (2014–15) does not provide an analysis of patterns and trends to form an accurate assessment of the effectiveness of safeguarding children.

The quality of performance data received by the board is not sufficiently accurate, and the board has neither consistently and explicitly challenged this nor recognised where data is not correct or current.

WSCB has a regular programme of audits undertaken by the performance sub-committee. These produce some important key findings in priority areas such as countering child sexual exploitation. The quality of the auditing requires improvement to focus on outcomes for children, the quality of practice and its impact, and to include the perspective of managers and practitioners.

The WSCB now oversees an effective strategy for responding to child sexual exploitation, following initial slow progress. The supporting action plan is updated regularly and kept under timely review. The board is creative in seeking ways to engage children and young people, and all partners are committed to strengthening children's participation further.

Recommendations

124. WSCB should urgently review its governance and business arrangements to ensure that the board is independent of influence, as required by statutory guidance, and that it has the capacity and shared resourcing to meet business needs.
125. Ensure that the chair of WSCB has sufficient influence to meet WSCB priorities and that statutory partners are held to account for influencing WSCB priorities within their agencies.
126. WSCB should ensure that any challenges from the board are explicitly recorded and that there is a mechanism for effectively tracking progress and resolutions.
127. Ensure that the board has oversight of how well the needs both of children living in the area who were placed by other local authorities and of children who are privately fostered are being met in Wirral.
128. Ensure that all serious incidents are notified to Ofsted within the timeframe set out in statutory guidance.
129. Ensure that the board uses accurate data to inform conclusions about the safeguarding of children, and publishes an annual report with an informed assessment of the effectiveness of child safeguarding and the performance of local services.
130. Ensure that multi-agency audits focus on the outcomes and experiences of children and families, form clear actions from findings, and include managers and practitioners to develop the workforce and share learning.

Inspection findings – the Local Safeguarding Children Board

131. Wirral Safeguarding Children Board (WSCB) is judged to be inadequate, as it is not discharging all of its statutory functions as set out in 'Working together to safeguard children 2015', the Children Act 2004 and the LSCB regulations 2006.
132. The governance arrangements and the running of board business are not sufficiently independent of the local authority. The executive board, which is chaired by the director of children services, is held prior to WSCB board meetings. The executive board receives all the progress reports and updates from the work of the board's sub-committees and critical work such as the action plans from serious case reviews. The executive board then makes decisions about WSCB board business and sets the agenda for WSCB meetings. This compromises the independence of the board, its priorities, focus and planning. These compromising arrangements, which impact on the independence of the board, have not been recognised through the formal governance arrangements of WSCB, and are confirmed by the terms of reference document for the executive board.

133. The volume of WSCB business, combined with the executive board's role in filtering the WSCB business agenda, means that WSCB is not always consistently tracking progress across all work streams. For example, the executive board reviews the work of sub-groups and decides what needs to go to WSCB. This means that WSCB does not have a consistent overview. Although the lack of capacity to meet volume has been recognised by the board and the number of board meetings has recently been increased, this is not yet having a notable impact.
134. The financial resources of the board are very uncertain and although statutory partners do make a contribution, the board is significantly subsidised by the local authority. This is, for the right intentions, to keep the board functioning and operational, yet has the potential to compromise further the independence of the board. Statutory partners contribute some additional funding to individual pieces of work such as the virtual college but are not meeting and sharing the responsibility for finances to maintain an agreed annual budget despite a projected overspend. The financial position of the board is precarious and, without an agreed budget, forward planning in the medium and longer term is compromised. (Recommendation)
135. The board is chaired by an independent chair who is stepping down following the end of his tenure, and recruitment to the post is underway. The board is well attended by local agencies, although there has not been a consistent representative for special schools. There is only one lay member, and this reduces the benefits of having two independent perspectives.
136. The board has an established business manager, who maintains regular tracking of the business plan, but has not recognised some of the compromises of WSCB's independence. From the findings of this inspection, the chair has neither maintained sufficient influence or challenge nor ensured the independence of the board. (Recommendation)
137. WSCB has focused on some aspects of practice, but there is insufficient focus on some core child protection activity to determine the effectiveness and outcomes of children's experiences at all key points. The last annual report produced by the board for 2014–15 did not include analysis of patterns and trends to measure fully the effectiveness of child protection. For example, there has been no analysis of the increasing referrals during 2014, which spiked in September to November 2014, or the significant reduction in children subject to child protection plans in this period. More recent performance data shows a high rate of 40% of children having a child protection plan for less than three months. The board has not undertaken activity to understand what this means for the understanding and application of thresholds across the partnership.
138. The quality of the performance data received by the board is not sufficiently accurate to measure the effectiveness of services. The analysis of data to understand performance is completed manually and requires improvement. Despite recognising this, the board has not proactively challenged the quality of

performance data. Importantly, the board has not recognised when the data that it is using is not accurate. For example, the data on referrals quoted for 2014–15 is actually 2013–14 data. This means that the reported rate of referrals was not correct in being lower than that of its neighbours and national comparisons. The referrals for Wirral were substantially higher than comparators in 2014–15. This important picture was therefore not understood by the board.

139. The current structure of the board includes sub-committees to take forward the key priorities, three recently formed groups for oversight of the performance of the multi-agency safeguarding hub and the quality of registered children's homes in the area, and a frontline practitioner group. There is a project group for supporting families and enhancing futures. This is in line with the shared priority across the partnership to improve early help for children and families and to implement a recognised, tailored model and approach for working with children and families in Wirral.
140. Two work streams are shared arrangements with the adult safeguarding board, which the independent chair of WSCB also chairs. There is also a newly launched website, also shared with the adult safeguarding board, which is clear, accessible and a good resource. There is a joint strategy for domestic abuse and, under the learning and development strategy, for joint training. A wide range of theatre performances targeted at young people to raise awareness of domestic abuse is a positive step in early prevention. Some groups have achieved better attendance and consistency than others, mainly due to changes in post holders and changes at senior level in the children's services. This has very recently improved.
141. While the board can evidence challenge in some areas, such as delay in transition planning for children with disabilities, poor attendance at training events, and poor attendance of key partner agencies at some sub group meetings there has been insufficient challenge in a number of key areas. These include:
 - The quality and accuracy of performance data submitted to WSCB.
 - Maintaining oversight of young carers, children living in Wirral from other areas and exploring the reasons why the numbers of children privately fostered has reduced in the last year, despite activity to raise awareness.
 - Ensuring timely progress with action plans from learning reviews; for example, a significant delay in ensuring planning for transition for children with disabilities.
 - Ensuring that the local authority designated officer annual report is of sufficient quality to analyse the effectiveness of safeguarding responses for children.

- Ensuring that any challenges from the board are explicitly recorded, effectively logged and tracked for timely progress.
 - The slow response to tackle poor attendance at training events and the lack of representation by children’s social care on sub-committees.
 - All board members actively influencing and progressing priorities within their respective organisations and demonstrating this; for example, using the graded care profile to assess neglect.
 - Ensuring a commitment from organisations to resource the multi-agency training pool.
142. WSCB commissions and delivers a variety of training courses relating to safeguarding. During 2015–16, 65 events were held with varied attendance rates, namely poor attendance from children services and no attendance from domestic abuse specialist services in 12 months. The board introduced a charging policy from April 2016 for staff who registered for courses yet failed to attend, but it is too early to evaluate what impact this has had.
143. Despite poor take-up of some courses, 1,800 workers across children and adult services have been trained in safeguarding during the past two years and 600 have had training to counter child sexual exploitation. The core training programme is appropriately tailored to the relevant key priorities for the board. The events for 2016–17 focus on thresholds, and countering radicalisation and female genital mutilation, in line with forward priorities. Free and ongoing training on homophobic, bi-phobic and transphobic bullying is provided and is very well accepted by schools.
144. WSCB collects feedback on training at the event, but does not yet evaluate the learning or revisit the impact on practice with participants at later stages. This is slow progress, as the strategy to implement this was launched in April 2015.
145. WSCB recognises that the pool of trainers is not sufficient and, on four occasions in the last 12 months, training was cancelled at the last minute. WSCB is yet to gain commitment from partner agencies to release professionals to deliver the multi-agency training programme and to ensure sufficient resources. (Recommendation)
146. WSCB has focused on improving partnership working to identify and respond to child sexual exploitation in the last two business plans. Progress has accelerated in the last nine months, following the outcomes of a safeguarding scrutiny review which identified a number of areas for improvement. A subsequent activity for all agencies to assess their readiness to address and respond to child sexual exploitation is complete. The partnership-wide findings are currently being reviewed to inform a refreshed multi-agency action plan. It is too early to assess the impact of the plan and this is under regular review by the board. WSCB is coordinating relevant activities to support the ‘refresh’ launch and the revised practice materials.

147. With public health, WSCB has jointly funded six 'On one condition' performances by the youth theatre on child sexual exploitation, in addition to short films and performances, reaching 2,000 children and 400 professionals in schools on the signs and risks relating to child sexual exploitation. These events have had some direct impact, with some children making disclosures to supporting professionals attending events and a noted rise in referrals from professionals after events.
148. WSCB is creative in seeking ways to engage children and young people. This is a shared and important focus across the partnership. Children and young people have been widely consulted on the WSCB priorities and the '20/20' pledge. The new website has informative, relevant and accessible areas tailored to children and young people. A recent appointment of a youth engagement officer further supports the commitment to a meaningful link between WSCB and children. The board has good links with the Children in Care Council, which shares its views with the board, for example, on the impact of changes in social workers.
149. WSCB publishes clear policies and procedures which are kept under review by the relevant sub-committee. There are effective arrangements for reviewing the practice guidance, policies and procedures from the learning from activities, case reviews and auditing activity. These are timely and are tracked effectively until completed.
150. WSCB has a regular programme of auditing multi-agency practice, and this produces some important key findings in priority areas, such as countering child sexual exploitation, which are taken forward for action. The quality of auditing activity overall requires improvement to maintain the focus on children, families and outcomes, and not on processes and systems. Currently, opportunities are missed to test out key areas such as thresholds and the quality of practice in auditing activity. Some audits identified good learning points for practice which did not follow through into actions. Practitioners and managers are not involved in auditing, which misses this connection with frontline practice and the opportunity to strengthen learning. (Recommendation)
151. The case review group reviews all incidents and notifications. There has been no serious case review published since 2012, although one is currently being commissioned. Positively, the national panel has agreed with all the recommendations that WSCB has put forward. A number of late notifications were made to Ofsted in 2015 and action was taken to ensure that the board understood the criteria for notifying incidents. This is not yet resolved, as during this inspection two further incidents were notified to Ofsted which were significantly overdue. One notification did not give an accurate picture of the local authority's involvement with the family, and there had been a delay of three months in reviewing the information and making a recommendation to the national panel. Learning from reviews is disseminated through the website, posters, briefings, training and weekly updates. (Recommendation)

152. The Merseyside child death overview panel (CDOP) has fully resolved a significant backlog of cases that were reported to WSCB at the end of 2015. The panel has a new interim chair, and the work is now timely and completed to a good standard. WSCB is fully complying with CDOP procedures and has dedicated posts to ensure that compliance is timely. The themes and learning identified by CDOP are delivered through Merseyside community learning programmes, supported by guidance and posters. CDOP reviewed 115 deaths in the last business year, of which 31 related to Wirral children. There were modifiable factors in five of the deaths which did not raise any specific learning. The panel has appropriate links with the case review group, and reporting arrangements to WSCB are sound.

Information about this inspection

Inspectors have looked closely at the experiences of children and young people who have needed or still need help and/or protection. This also includes children and young people who are looked after and young people who are leaving care and starting their lives as young adults.

Inspectors considered the quality of work and the difference that adults make to the lives of children, young people and families. They read case files, watched how professional staff work with families and each other and discussed the effectiveness of help and care given to children and young people. Wherever possible, they talked to children, young people and their families. In addition, the inspectors have tried to understand what the local authority knows about how well it is performing, how well it is doing and what difference it is making for the people who it is trying to help, protect and look after.

The inspection of the local authority was carried out under section 136 of the Education and Inspections Act 2006.

The review of the Local Safeguarding Children Board was carried out under section 15A of the Children Act 2004.

Ofsted produces this report of the inspection of local authority functions and the review of the local safeguarding children board under its power to combine reports in accordance with section 152 of the Education and Inspections Act 2006.

The inspection team consisted of 6 of Her Majesty's Inspectors (HMI) from Ofsted and four additional inspectors.

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