Manchester City Council
Report for Information

Report to: Ofsted Sub Group – 10 November 2015

Subject: Ofsted Inspection into Help, Protection and Care of Children: Quality of Practise and Caseloads

Report of: Interim Director for Children's Services.

1.0 Introduction

1.1 Following the Ofsted inspection in July 2014 there has been significant activity and investment undertaken to stabilise the social care workforce and reduce caseloads; which at the time of inspection were too high and compromising the quality of practice.

1.2 In recent months we have begun to see the workforce stabilise and average caseloads reduce to the target numbers of twenty for NQSWs and twenty five for more experienced social workers.

1.3 However, whilst the reduction in caseloads is very positive, it has also allowed the senior management team to intensively interrogate the quality of practice through their audit activity and it is that quality of practice that is the focus of this initial findings report.

1.4 This report collates the initial findings part way through the audit activity highlighting key themes and will be supplemented by a comprehensive report following the completion of the activity. This will include an audit of 5 cases from across each Team, which will provide a more balanced perspective on quality across the whole Service and a detailed action plan will be available based on these findings.

2.0 Activity on Caseloads

2.1 Since March 2015 there has been significant activity to recruit additional Children's Social Workers to increase capacity within the Service and support a programme of reducing caseloads to the recommended numbers of 20 (Newly Qualified) and 25. A total of 73 new Social Workers have started since March 2013.

2.2 As a result of the increased capacity the Service has moved from a position where there were 94 Social Workers holding caseloads which were above the recommended numbers of 20/25, to 67 in October. However, it should also be noted, that when the figure was 94, these individuals were holding an average of 5 cases over recommended numbers. This has now decreased to an average of 3 cases over for the 67 in October.

2.3 There are currently 21 Newly Qualified Social Workers who are due to complete their first year of employment in the next few weeks and at that point their maximum caseload can increase to 25. Of these 21, there are 13 who are already holding a caseload which is higher than the recommended 20 but less than 25. The progression of this large group of Newly Qualified Social Workers will have a positive impact of the average caseload figure, significantly reducing the numbers of staff holding caseloads above recommended numbers.

2.4 It should be noted that there are also a group of Social Workers who are holding caseloads which are below recommended numbers and in most cases this is as a result of either performance issues which are being appropriately managed, returns from long term absence (e.g. sickness or maternity leave) or very recent new starters. For each of these individuals there is a plan in place to safely increase caseloads incrementally which in turn will have a positive impact on overall caseload numbers. Formal action will be taken with those staff where caseloads cannot be safely increased.

3.0 Audit Activity Undertaken

3.1 Throughout the last three months there has been a considerable amount of audit activity undertaken and this report is based on the findings of the following;

- 30 cases reviewed as part of a deep dive into Looked After Children.
- Section 11 audits of 13 cases across early help and missing from home.
- 40 cases, recently audited, as part of a deep dive into practice quality across children's social care as a whole.
- Investigation of a case subject to a serious case review.

3.2 This is not intended as a definitive report but given the initial findings it is critical that we take immediate action to address some of the concerns we have, related to these audit findings

3.3 We have referred to both the audit framework and subsequently the Terms of Reference in undertaking the practice audit. Micare numbers are evidenced within the text of this report to substantiate the findings. The numbers provided under each heading are not exhaustive but provided to give reassurance of the evidential base. In summary, the audits seek to answer the following questions.

- Where children known to Children's Social Care are identified as being at risk, is there evidence that risk is identified in line with legal, statutory and local protocols?
- Is there evidence of continuous, active work with families that improves outcomes?
- Is practice focused on the needs and experiences of children and influenced by their wishes and feelings?
- What is the nature of the relationship between children and families and their social workers? Are children and families engaged in all actions and decisions relating to them and do they understand the intentions of the help they receive?

- Do children and young people receive help that is proportionate to risk?
- Do assessments result in direct work with families that addresses identified need?
- Is all activity described by the social worker reflected in the case recording?
- Is there evidence of management decision making and oversight?

3.4 Alongside this, each of the audits undertaken received a judgement against the Ofsted gradings.

3.5 Where the audit team were concerned about the wellbeing of a child, the case was escalated for immediate actions to be undertaken.

4.0 Findings

4.1 The following is a summary of the key themes identified from the audits concluded to date. This has been collated using the key considerations with the audit framework.

4.2 Summary of key themes:

Has decision-making been effective and timely?

4.3 Timely decision making is not consistently evident. Where decision making has been clear, there is no case footprint that evidences that case plans are progressed and managed in line with the original decision.

4.4 For example when cases progress from MASH to localities following referral, clear management oversight is not always evident and it is often not recorded why a particular threshold has been applied.

4.5 Where a case comes into social care because it meets the section 47 criteria, there is some evidence of a lack of understanding and compliance with statutory and legal frameworks. At times Strategy discussions take place after the initial safeguarding actions have been taken which defeats the whole purpose of the strategy meeting.

4.6 Some strategy discussions did not take place until a number of days after the referral was received. In one case the strategy meeting was not convened until 20 days after the initial receipt of the referral. Further enquiries are being undertaken to ascertain the rational behind this.

4.7 It was also evident that in some cases the manager had failed to identify and respond to child protection cases that clearly met the threshold for significant harm. Again this issue is being scrutinised by more senior managers to understand why this happened.

4.8 There is some evidence that un-assessed risk has been held in the MASH for an inappropriate amount of time. Evidence that decisions had been made within one working day was absent on some cases which is contrary to Working Together Guidance.

5.0 Have all risks to the child been assessed, are they current and clearly identified?

5.1 Some risk management activity had taken place but it is not sufficiently reflected in recordings both from the social worker and the Team Manager.

5.2 There is evidence to suggest that risk management decisions on cases are at times not made in a timely manner and risk management plans are, in some cases not holistic or robust.

5.3. Evidence shows that some minutes of strategy meetings would indicate that they do not consistently consider all children within the immediate and extended family.

5.4 Despite domestic violence being the key presenting issue in a significant proportion of the cases audited, there is can be a lack of analysis of the impact of domestic violence on families.

5.5 Cases are regularly de-escalated or closed where domestic violence perpetrators are deemed to be no longer residing with partners. The decisions are often made based on self reporting from the victim without evidence that there has been full exploration that relationships have in fact ended. There is often insufficient analysis and assessment of the vulnerabilities of the victim and the impact of these vulnerabilities on parenting capacity.

5.6 Fathers who do not reside with their children are regularly missing from social work analysis, and activity.

5.7 The “missing from home” episode within Micare is often not updated by the social worker and so does not clearly reflect when a child is missing and when they return. This can cause confusion and misinterpretation.

6.0 Does the file contain evidence of appropriate involvement of children, young people and families?

6.1 Recording is generally adult focused and it is difficult to ascertain the child’s voice. Observations and analysis of the child’s lived experience is often missing from records and direct work with children is inconsistently recorded.

6.2 In many LAC cases the child does not consistently appear to have any influence over their care plan.

6.3 Parents self reporting is often accepted without challenge.

6.4 The workflow in Micare presents information in a sporadic manner which does not allow the reader / auditor to easily understand the child’s story.

6.5 There is a lack of evidence that parents and young people are routinely consulted in a meaningful way prior to plans being formulated.

7.0 Have assessments been timely, comprehensive, analytical and of high quality?

7.1 A significant proportion of assessments considered have lacked robust and meaningful analysis that is based on a comprehensive and holistic assessment.

7.2 A number of assessments are “single issue” assessments that consider presenting issues within referrals but lack clear analysis of previous presenting issues and cycles of concern (DV, parental mental health, cyclical CP intervention). There is often information within the case files that is not considered within updated assessments.

7.3 It is not routinely recorded within the file that consent has been gained to gather and share information where appropriate.

7.4 Evidence of management oversight and input into assessments and challenge to inadequate assessments is limited.

7.5 Where assessments do identify plans to keep children safe, there is a lack of evidence within recording that the plan is appropriately implemented.

7.6 Most files do not contain a chronology or genogram other than a basic document that can be generated from the micare functionality. Significant individuals are not considered with the analysis of the assessment and the impact of wider family networks is not routinely considered.

8.0 Are plans up to date, appropriate and SMART and could they be understood by a parent?

8.1 Overall there is evidence that child protection planning is more structured and developed than in other cohorts such as child in need. However, there is limited evidence that outline child protection plans are developed within the first and subsequent Core Groups.

8.2 In Child in Need cases there was a lack of formal planning for children in a significant amount of cases considered.

8.3 There is limited evidence of compliance with Child in Need processes. It has not been established whether this relates to inadequate recording or a lack of compliance.

8.4 The PLO and legal planning process are not being recorded in the majority of cases and therefore it is not often clear that a case is subject to PLO planning. The minutes of legal planning meetings and PLO meetings are also not recorded, which makes it particularly difficult to understand whether or not, where a case has de-escalated from PLO planning, this has been done safely with reduced risk.

8.5 In the recent deep dive into LAC cases, a significant number of children did not have an up to date care plan.

9.0 Has there been effective coordination between agencies and good quality joint working?

9.1 As in 3.1 section 47 strategy meetings and processes some are being delayed due to lack of multi agency availability, in particular GMP availability.

9.2 Generally recording demonstrates a range of activity from a number of agencies surrounding the child but can lack evidence of continued co-ordination in sufficiently progressing plans particularly for child in need planning.

9.3 There is clear evidence of “starting again” when cases are transferred between teams, in particular evidence that duty social workers are repeating checks completed by MASH workers which can results in a lack of timely decision making.

10.0 Conclusions and Next Steps

10.1 The audits have demonstrated that some practice needs to be more consistently compliant with practise standards. Now that caseloads have been reduced further work and training can be undertaken to ensure these standards are met across the service.

10.2 Action needs to be taken to ensure practice consistently evidences the safeguarding and wellbeing of children. The learning from these audits will inform our training and workforce development strategy.

11.0 Recommendations

1. Implement a Social Work practise model which will provide a coherent framework in which practitioners can operate, this will embed consistency in practise across the service. Current negotiations are taking place to implement Signs of Safety as the preferred model for Manchester.
2. Revise the current Quality Assurance framework and audit tools to ensure a focus on risk and decision making.
3. Findings from the audits to be shared with all relevant staff, including the safeguarding unit to raise awareness of the key practice issues.
4. Once the full audit has been completed, further analysis should be undertaken to identify any patterns across service areas, which should include any concerns regarding individuals fitness to practice across the workforce.
5. Review audits to be undertaken to ensure audit recommendations have been completed.
6. Training to be delivered to social care staff and police in relation to the statutory guidance relating to strategy discussions and safeguarding children.
7. Locality Managers to undertake regular dip sampling of cases to ensure the practice standards are being achieved in relation to safeguarding.
8. GMP PPIU staff to receive regular feedback in relation to compliance.
9. Training workshops to be delivered in relation to the assessment and impact of domestic abuse and understanding and assessing risk.