Manchester City Council
Report for Resolution

Report to: Ofsted Subgroup - 12 September 2017

Subject: Ofsted Monitoring Visit Feedback and Action Planning

Report of: Strategic Director of Children's Services

Summary

This report provides a further commentary and detail on the progress of action plans and strategies to address the issues and areas for improvement highlighted in the most recent letter from Ofsted following the Monitoring Visit undertaken in June 2017.

Recommendations

The Subgroup are asked to note the report and provide comments.

Wards Affected: All

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Background documents (available for public inspection):

The following documents disclose important facts on which the report is based and have been relied upon in preparing the report. Copies of the background documents are available up to 4 years after the date of the meeting. If you would like a copy please contact one of the contact officers above.

Report to Children & Young People Scrutiny Committee - 18 July 2017 - Ofsted's Monitoring Visit undertaken 6th and 7th June 2017.

1.0 Introduction

1.1 At its meeting on the 18th July 2017 the Children and Young People Committee recommended an extraordinary meeting of the Ofsted subgroup be convened to review the post-monitoring visit report, ofsted letter and subsequent improvement action plan in more detail.

1.2 The original Committee report focusses on the background and process of the undertaking of the Monitoring Visit, and the detail of the key findings contained within the Ofsted Letter.

1.3 This subsequent report is focussed on the actions and strategies to improve against the deficits and issues raised in that letter and to provide members with assurance that the service is working to address these challenges. In order to provide further contextual insight the report briefly acknowledges other areas of improvement activity in response to previous Ofsted Monitoring Visits; which have been a feature of previous Scrutiny Committee meetings.

2.0 Key Challenges

2.1 As noted in the previous report to the committee (18th July 2017) the key areas identified by Ofsted during the recent visit were:

- The MASH is safe and decision making is timely, however, there is some ***duplication in decision making*** - particularly in the interface between the MASH and Locality Assessment Teams.

- Understanding and application of ***thresholds*** across the partnership

- ***Strategy meetings*** are well informed and decision making is sound but recording is poor and does not meet statutory guidelines

- There is evidence of positive improvement in Social Work practice, particularly in timeliness of allocation and the understanding of children's wishes and feelings. However, managers ***identification of deficits in case work*** and subsequent drive on ***practice improvement*** is less effective.

- ***Chronologies*** were not routinely updated and child in need assessments were too narrow in their focus and reliant on ***parental self reporting***; and lacked ***SMART planning***.

- The visit confirmed the strength and visibility of the Services audit and learning framework and self assessment that we still have ***variable practice*** and there is more to be done to ensure 'expected practice is more consistent across the service.

- Whilst noting that the Manchester NEET figure for care leavers is better than national average (31% against 40% across England) there is a need for better/clearer ***pathway planning and management***

oversight of plans.

- Ensuring ***suitable accommodation*** for Care Leavers

3.0 Service Response and Action Plan

Duplication in Decision Making

3.1 Duplication and over process in the MASH was already an area of focussed improvement for the service. Recent changes have reduced the decision making process from a 5 stage process to 3 stages, with revised guidance recently put in place.

3.2 The revised guidance sets out more clearly the definitions and criteria for decision making and has been devised across the MASH and locality to ensure consistency of understanding and development.

3.3 To ensure deeper oversight and continued cycle of learning and improvement in this area the MASH leadership team have developed a focussed programme of systematic auditing and dip sampling of MASH decision making, and adherence to the newly implement processes. This auditing, finding of trends and themes will be reported monthly to the whole service performance group and any necessary actions and strategies to challenge consistent themes and issues fed into the whole service quality assurance and learning framework for improvement and workforce development.

It should be noted, the overall feedback was positive in respect of the MASH and this was confirmed by the recent CQC Safeguarding and Looked After Children visit. In addition, there is an expectation all 'decisions' are made by the MASH within 24 hours. The percentage of 'No Further Action' has significantly improved since 2014 and is comparable to most other local authorities.

The service is currently considering how the effectiveness and efficiency of the MASH can be further improved alongside the development of a Complex Safeguarding Hub. This is planned for the end of 2017; to do any service/structural changes before this time would not be sensible.

Thresholds

3.4 The issue of understanding and application of thresholds is an issue wider than Children' Services and one that is recognised across the partnership already; having been raised at the Manchester Safeguarding Children Board (MSCB). Consequently this area of improvement continues to be a major focus of the MSCB. The MSCB has developed a detailed action plan to address this issue. This will included a targeted range of local workshops, and a city wide summit session to be held in September 2017.

3.5 Additionally, the initial anecdotal feedback from partners and referrers on the newly instituted consultation line within the MASH is very positive. The

consultation line provides referrers with an opportunity to engage in a pre-referral professional conversation about the presenting issues for professionals and the most appropriate way to meet those needs without necessary recourse to social care assessment and intervention, and where this is appropriate to ensure full understanding and detail of the referral is in place to support this in a more timely and effective way.

3.6 The social care and early help services have also held, and will continue to hold, workshop sessions and briefings with key partners, which will be reviewing actual examples of inappropriate referrals from their peers and supporting learning discussions to improve application of thresholds.The output of these sessions will be shared internally within the service and across the partnership. In addition to this work we have agreed an approach with schools to ensure children get the right help when they need it. Schools in Manchester have been written to reminding them of the early help service whilst service managers have been tasked to speak directly to head teachers to provide advice and guidance to them if they have concerns regarding individual children.

3.7 It should be noted, that this has been a long-standing challenge in Manchester and whilst there has been a reduction in referrals to Children's Social Care since 2013/14, they remain too high. Consequently, together with the consultation line approach and targeted single agency engagement, supported by analysis of referrals to identify services and hotspots of inappropriate application of thresholds, the service and the MSCB will lead a holistic approach to build confidence in managing 'risk' across the partnership; cultivating sustainable behavioural/practice change on this issue.

Strategy Meeting Recording Standards

3.8 The practice guidance for Section 47 Child Protection Strategy Meetings is in the process of being revised and reissued to take a greater focus on the key aspects of good practice contained within the Working Together 2015 national guidance.

3.9 Alongside this practical change, Locality Service Managers and Social Work Consultants have been tasked to complete additional 'dip sampling' of 10 strategy meeting records on a weekly basis to support the drive for improving the quality and compliance with practice standards. Progress is reported to the social care service weekly performance meeting; chaired by the Strategic lead for Children's Social Care. In addition, themes, issues and good practice examples identified through the dip sampling activity will be fed into the quality assurance and learning cycle to support the embedding of good practice.

Identification of deficits in case work, driving improvement, SMART Planning and variability in practice

3.10 Social Work Consultants are now placed permanently into the Locality based Social Work teams and are offering regular briefings to social workers on a

number of practice issues; starting with a series of 7 minute good practice briefings.

3.11 A practice quality check tool has been developed and is being used by all staff and managers as a tool to support consistent standards across all cases.

3.12 The service have sourced the support of a consultant for the short-term to increase the pace of improvement within the ‘duty and assessment’ teams; where caseload pressures exist. The focus of this, is strengthening the quality and completion of ‘proportionate assessments’ and management decisions.

3.13 Practice guidance has been developed regarding SMART planning and is currently being published. This along with ‘good practice’ examples which are being shared will be used with teams to embed good practice more consistently.

Parental Self-Reporting & Chronologies

3.14 Again this is an area of pre-existing focus for the service. A revised assessment format was reissued in April 2017 and initial indicators from the audit programme are showing positive improvements in this area. Similarly the duty & assessment team practice guidance was revised in June 2017 to reflect the issue and promote social work staff to develop an increased sense of professional curiosity.

3.15 We have also introduced an experienced consultant to work intensely with Team Managers and Consultant Social Workers on the application of ‘appreciative enquiry & respectful curiosity’ and how they can apply that oversight to case work and the development of front line practice.

3.16 Pivotal to supporting social workers to challenge familial reporting and take a professionally curious approach, is ensuring detailed and consistent chronologies are in place, which supports the ability to place the current issues in the context of family history of issues and engagement with services.

3.17 Social Work Consultants have already delivered targeted briefings to all locality teams on the importance and purposefulness of a good chronology to informing effective social work intervention.

3.18 A management direction was given to all staff and team managers to ensure that all children’s case files had an up to date and comprehensive chronology by the beginning of August 2017. Progress against this direction has been steady however we have yet to systematically embed chronologies in all cases. Continuing oversight of the issue sits within both the audit cycle and management.

Pathway Planning and Management Oversight

3.19 Significant progress has been made since 2014 in relation to data accuracy and the understanding of the role and relationships between children’s social

care and the Leaving Care Service.

3.20 As with many of the areas for improvement since 2014, the focus is moving from driving compliance towards quality. Practically a new process of quality assurance, scrutiny and challenge has been instituted. whereby the Looked After Children's Independent Reviewing Officer will chair the first post-16 review meeting of a young person's transition plan, to ensure that the planning is effective and any concerns can be escalated. This extends the oversight of looked after children deeper into the care leaving experience and the transition to adulthood.

3.21 Joint training and development session have been held with Team Managers and Service Managers to build stronger relationships in services across the transition from LAC to Care Leaver. This also includes developing the services quality assurance framework to integrate the care leavers service. This process will be subject to our ongoing sampling and auditing activity which in turn would identify ongoing training for staff in this practice area.

Suitable Accommodation

3.22 The issues of suitable accommodation for young people is a challenge in Manchester and care leavers are no exception. Subsequently we have secured the support of the Strategic Housing Board and a task and finish group that reports to the Corporate Parenting Panel to develop a programme of activity that both better prepares looked after children for independence and increases the range and choice of suitable accommodation for Care Leavers.

A specific area of focus has been to robustly address the number of Care Leavers in temporary accommodation. This seeking develop new pathways, procedures and provision across the council. Including engagement with the Strategic Housing Board to develop more detailed analysis of need and ensure sufficiency. As well as developing a revised referral pathway through Adult Services whereby all care leavers who may have additional vulnerabilities associated with substance use and/or their mental health will be guaranteed a service on contact with the adults 'front door'.

3.23 To maintain the focus on this important issue, a Care Leavers Unsuitable Accommodation panel has been convened which meets fortnightly to scrutinise the plans to find permanent solution and support for these vulnerable young people. At the time of writing it is noteworthy on progress to say that only 1 young person is in Bed & Breakfast Accommodation; who has had a series of unsuccessful tenancies and declined 2 offers of accommodation. Subsequently the services continue to work with this particularly challenging young person to engage and support them secure and sustain a tenancy.

4.0 Previous Monitoring Visits

4.1 In addition to the monitoring visit in June 2017, Ofsted have conducted three previous visits. The three areas covered by the previous visits were:

- Progress against a number of recommendations from the 2014 inspection;
- the functioning of the Safeguarding Improvement Unit particularly the effectiveness of child protection chairs and independent reviewing officers to oversee and monitor the progress of planning for children;
- the performance of the adoption service.

4.2 Each of the previous visits has received a similar published formal response from the inspectorate and been supported by a response action plan for improvement against the issues and challenges raised.

4.3 The most recent monitoring visit had a greater sense of 'inspection' rather than 'monitoring progress' and had a greater focus on the 'quality of practice' than all of the past visits. The consistent message across the first three monitoring visit reports is that significant progress has been made in all areas against the 2014 inspection recommendations and that whilst the service has not progressed as far in improving as might be expected at this stage post-inspection, the improvements are evident, significant and the pace of improvement is increasing and has increased over the last 18 months. The previous monitoring visit in particular noted practice was variable and that the service has succeeded in achieving a culture of compliance; which further strengthens a sound basis to now push on to improving quality, also that the service is 'creating the environment in which great social work can flourish.'

Progress against a number of priority areas - September 2016

4.4 The first visits focused on a number of key findings from the 2014 report, with particular focus on social work caseloads and capacity to deal with demand, management oversight of the single assessment process, attendance and reports for child protection conferences, and supervision and management oversight.

4.5 The report found improvements had been made in relation to many of these areas;

- caseloads had reduced but remained variable, with a recognition across leadership that caseloads needed to reduce further to ensure good quality practice was embedded. The decision to increase by 40% our social work staffing complement was seen as a positive response;
- management oversight of single social work assessments were found to have improved from the full inspection, with timely allocation and completion within 45 days being noted. However inspectors felt that too many assessments continue to take 45 days when shorter, proportionate, assessments may be appropriate for some children and families;
- Social work attendance at child protection conference was noted as significantly improved, with good levels of attendance. inspectors felt the review process could offer more rigour and that some children's plans continued to drift;

- supervision was noted to have improved, with social workers being found to be having more regular supervision, however inspectors felt supervision was not always reflective, with management oversight not always being robust.

4.6 To address the issues raised by inspectors on this visit a number of actions have been taken and achieved, including:

- our recruitment campaign has continued and we have appointed over 180 new social workers into the service now since July 2016. Generally we have seen caseloads continue to reduce although variability across service areas and teams remains a challenge. Case loads are monitored on a weekly basis up to and included Director level. As previously noted by Children's Scrutiny Committee members, there has been an increase in referrals received by Children's Social Care since May 2017. Consequently staff have been supported by the leadership team to develop a robust response to address the subsequent rise in caseloads. This has been positive and whilst work continues to ensure manageable workloads, overall they remain at much reduced level with the overall average caseload reported to be 20.
- targeted work is ongoing to ensure proportionate assessments, teams are aiming to work to a 35 day standard competition timescale. A duty manual and good practice in Child and Family Assessments tool has been developed and promoted to social workers;
- we have improved liaison arrangements with the Safeguarding and Improvement Unit and any cases where there is drift, insufficient planning or where children have been subject to child protection plans for over 18 months are subject to escalation and solution focussed meetings. Our quality assurance and audit learning and development cycle evidences improving practice in this area;
- Supervision is monitored on a monthly basis and we are confident social workers are generally offered supervision on a regular basis. Our Consultant Social Workers are supportive reflective learning on a team, locality basis and additional training to managers has been provided on 'quality social work supervision'.

Safeguarding Improvement Unit - December 2016

4.7 The key issues identified in the visit to review the functioning of the safeguarding service were:

- To refocus the drive from the safeguarding unit towards driving up quality, following the successes in improving compliance
- Strengthening the challenge from the safeguarding unit when children are not listened to or involved sufficiently in decisions made about them
- Embed signs of safety in child protection conferences
- Ensure that all agencies are providing timely reports to conferences and take an active role in progressing plans

4.8 To address the focus on practice and quality improvement, and strengthen the

challenge afforded by the unit, a number of actions have been taken and achieved, including:

- Improvements to the escalations process and guidance to ensure a greater focus on challenging outcomes for the child. Also including routine senior level audit of escalations to target issues, themes and individuals identified for development in their ability to challenge poor practice robustly
- Child in need guidance has been refreshed and training delivered to key staff on the step down process from child protection to ensure more robust and consistent planning for de escalation. This is accompanied by routine dip sampling of previously stepped down cases.
- Attendance and submission of reports to conferences are reported to the MSCB; where under representation has been successfully challenged and overall improvements noted.
- The unit recognised that more needed to be done to address the depth of understanding and training of unit staff in signs of safety. The service is part way through a full roll out across all services area on the training programme and a Social Work Consultant has been directed to work full time on systems and process, and embedding signs of safety across children's services.

Adoption Service - March 2017

4.9 The monitoring visit was generally positive and sited many areas of practice improvement within the Adoption service. However here is a summary of areas of practice that need further improvement:

- The time taken from a child being received into care to being placed for adoption needs to improve further.
- The voice of the child is not always evident in written records.
- The quality of child permanence reports requires further work.
- Life-story work, life-story books and later-life letters are not sufficiently prioritised.
- Adoption support assessments and plans are not yet of good quality and financial support needs to be clarified.
- Supervision is not consistently regular and is variable in quality.

4.10 To address the areas identified by the Inspectors, a number of actions have been taken and achieved, including:

- continued focus on timescales for children being placed for adoption with further improvements made;
- training on child permanence reports has been provided to social work teams to ensure the child's voice is more evident
- Since June 2017 any agency decision is only being made where there is evidence of life story work for the child, this is having a very positive impact and we have seen some powerful examples of direct work and life story work with children;

- a new adoption support and financial support policy has been agreed as we have moved to the new Regional Adoption Agency arrangement, Adoption Counts;
- a new Special Guardianship policy has been agreed, and is continuing to be revised to improve our offer;
- monitoring of supervision compliance has been extended to our Adoption team and the supervision training has extended to Adoption Managers also.

5.0 Conclusion

5.1 The Ofsted inspection regime through the monitoring meetings have monitored the areas judged to be ‘inadequate’ in the 2014 Inspection; overall progress is evident and there have been no children found to be ‘at risk’ or any widespread failure reported.

5.2 In accordance with Ofsted’s framework for monitoring Children’s Services judged to be inadequate Manchester’s Children’s Services are now on notice for inspection. This full inspection can occur anytime after 11th of September 2017, which is when the inspection cycle resumes.

5.3 As outlined in this report, the service continues to work tirelessly both internally and with partners to address areas for improvement. In addition to the actions set out in this report a communication strategy has been developed in order to engage all staff, elected members and partners understand and articulate our journey and progress since the inspection in 2014.

5.4 The Children’s Services self assessment which is regularly reviewed against the Ofsted Inspection framework clearly evidences significant progress has been made since 2014; positively where we have identified areas which require ongoing/improvement senior leaders are sighted on those areas, the quality of practice and action is being taken and/or there is a plan in place to deliver positive changes.

5.5 In conclusion, the evidence points to children and young people are safe in Manchester, that services are increasingly effective, efficient and focussed on listening, responding to and improving the experiences and outcomes for our children and young people.