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Dear Mr Marshall

Monitoring visit of Manchester City Council children's services

This letter summarises the findings of the monitoring visit to Manchester City Council children's services on 6 and 7 June 2017. The visit was the fourth monitoring visit since the local authority was judged to be inadequate in June 2014. The inspectors were Shabana Abasi Ofsted inspector, Shirley Bailey HMI and Andy Whippey HMI.

The pace of change since the inspection in June 2014 has been too slow. In the past 12 months, the pace of improvement has accelerated.

Areas covered by the visit

Inspectors reviewed the progress made in help and protection, an area judged to be inadequate in the 2014 inspection. The inspectors focused on contact, referral and assessments, strategy meetings, child protection investigations (Section 47) and child in need (CiN) cases. Inspectors also reviewed the progress made in the care leaver service, which was judged as requires improvement in the 2014 inspection.

The visit considered a range of evidence, including electronic case records, observations of social workers undertaking referral and assessment duties, performance data and findings from quality assurance work. In addition, inspectors spoke to social workers, managers and senior leaders, and met with a group of care leavers.

Overview

Compliance in achieving timescales has improved. However, the quality of practice has not improved enough to make a positive difference to outcomes for those children whose cases were reviewed at this monitoring visit.

The multi-agency safeguarding hub (MASH) has sustained the progress made and seen in previous monitoring visits. The quality of social work practice seen in CiN cases is too variable, and some inappropriate application of thresholds is leading to

delay for children. The care leaver service has some weaknesses which are impinging on the capacity to produce good outcomes for care leavers.

Findings and evaluation of progress

The MASH is operating a safe, timely service and has maintained steady progress since the first monitoring visit in January 2016. The MASH is now meeting expected timescales. Decisions about next steps were appropriate and proportionate, signed off by social workers and endorsed by team managers.

Inspectors found duplication with systems used for the oversight of decision-making within the MASH. The operational manager 'dip samples' cases, but the findings are neither recorded nor reported. This is a missed learning opportunity for staff.

Thresholds are not well understood by partners, and this means that there is a delay in providing a service to some children. Partners are too dependent on the local authority to determine the level of intervention that is most appropriate for the child. The lack of a shared multi-agency understanding and application of agreed thresholds seen in the visit in January 2016 remains a concern. The local authority has taken some action. For example, a social worker has recently been reintroduced to the contact centre to oversee contacts and a consultation helpline has been introduced for other professionals. Along with targeted learning events with partners, these actions are helping to create a better understanding of thresholds.

Performance management information shows that since the inspection in 2014, there has been improvement in reducing the number of referrals with no further action as the outcome; even so, high numbers of the referrals are still sent to districts (30 to 100) that are reassessed and found to require no further action. At the time of this monitoring visit, the local authority was unsure of the underlying reasons for these figures. This lack of analysis is further evidence that managers do not have a clear understanding of how thresholds are applied.

Inspectors found that five of the seven strategy meetings sampled were not compliant with the expectations set out in the statutory guidance 'Working together to safeguard children'. Strategy discussions had taken place due to an accumulation of concerns, rather than a specific incident, and were conducted as telephone calls between social workers and the police. Strategy discussions were informed by sufficient information, including that from other agencies, to enable them to make appropriate decisions about Section 47 enquiries. However, poor recording of the meeting and failure to update the child's electronic case record leave services vulnerable to missing important information in the future.

Section 47 enquiries seen by inspectors were timely, children were spoken to alone and decisions about whether an initial child protection conference was required were sound. This was not always the case, historically, and shows improvement.

Social work practice remains variable when cases transfer from the MASH to the district teams for a CiN assessment. While recording in case notes is timely,

chronologies are not updated and therefore are not comprehensive, limiting their usefulness to inform assessment and planning. Genograms are not consistently completed and therefore are not used to help to understand family and social relationships.

Social workers complete assessments in a timely manner, but the quality is variable. Inspectors found that assessments often focus on the presenting issue and do not take enough account of previous concerns or wider circumstances when analysing current risk and assessing what life is like for that child.

The quality of CiN planning is variable and the quality of written CiN plans seen is of poor quality. Plans do not have measurable, specific targets or timescales and they are not reviewed regularly. As a result, the support for children is delayed. Social workers' over-reliance on parents' self-reporting, over-optimism about their ability to change and a lack of professional curiosity resulted in some referrals to early help being referred back to children's social care, creating further delay for children.

The local authority audit template, while making some reference to quality, is not outcome-focused, and largely measures compliance, processes and timescales. Some audits of the tracked cases missed important issues in relation to the quality of practice. The local authority graded two of the six cases that it audited as inadequate. It took immediate safeguarding action on one case following the audit. This case was referred back to the local authority when the inspector identified a further potential safeguarding issue.

The local authority undertook a file audit of 15 CiN cases in April 2017. Its findings raised significant concerns about the quality of practice and performance. Inspectors found similar poor practice during their visit in June. Plans were not up to date and did not have clear objectives.

The local authority provided inspectors with some examples of records that it considered to be better reflective of good practice. History was taken into account in these assessments, and there was clear evidence of engagement with significant others. These examples were of better quality than others seen by inspectors. The inspectors concluded that these cases were mostly demonstrating expected practice.

Inspectors saw evidence of compliance with the timely allocation of cases to social workers, with children being seen and seen alone within required timescales. Direct work is completed, and children's wishes and feelings are sought and recorded well. Although managers monitor timeliness effectively, they are less effective in identifying deficits in casework and driving forward the quality of social work practice.

The focus on the care leaver service identified some areas of concern. The majority of pathway plans seen had considerable weaknesses. They lacked detail, for instance insufficient health information, no contingency planning, a lack of clear actions following reviews and little evidence of care leaver involvement or contribution to the

plan. Plans are not always reviewed when circumstances change significantly for care leavers. Plans were not aspirational enough, and it was not always clear what understanding the care leavers had of their entitlements. The lack of clear, decisive, pathway planning is affecting outcomes for care leavers, such as education, employment and training, and their commitment to and involvement in the process. Although the figures for those not in education, employment or training (NEET) are decreasing, they are still too high, with one in three care leavers being NEET. A lack of effective pathway planning and management oversight means that many care leavers do not have a clear plan with measurable actions and timescales for how to engage them into education, employment or training activities.

Care leavers spoke positively of the relationships with their personal advisers and the support received from them. The service has made positive links with the local health centre to enable care leavers to have access to medical advice, even if they are not registered with a general practitioner. The healthcare 'passport' provides insufficient information relating to their health histories and healthcare provision in the area in which they live for it to be a meaningful document for the young person.

Care leavers stated that a lack of choice of suitable accommodation is a real concern. Senior managers and the lead cabinet member acknowledge that availability of suitable accommodation is one of their biggest challenges, but they are committed to remedying this and it is a key priority in the children looked after and care leavers placement sufficiency strategy 2016–2019.

Bed and breakfast accommodation has been and is still being used for a small number of care leavers. At the time of the monitoring visit, there were five care leavers in such accommodation, with one care leaver living in a bed and breakfast since February 2017 and another since March 2017. Senior managers acknowledge that this is inappropriate, and there are plans in place to move four of the young people to suitable accommodation. The arrangements for managing such provision at the time of the visit were weak, with deficits in the risk assessments, quality assurance arrangements and specific support plans for these young people.

The introduction of the Suitable Accommodation and Complex Needs Panel is positive, but in some cases, its minutes describe the support and accommodation needs of the young person rather than define how these needs are to be met.

I am copying this letter to the Department for Education. This letter will be published on the Ofsted website.

Yours sincerely

Shabana Abasi

Ofsted Inspector