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Dear Paul

Focused visit to Manchester local authority children's services

This letter summarises the findings of a focused visit to Manchester local authority children's services on 17 and 18 September 2018. The inspectors were Shabana Abasi and Lorna Schlechte, both Her Majesty's Inspectors.

Inspectors looked at the local authority's arrangements for achieving permanence, in accordance with the inspection of local authority children's services (ILACS) framework. Specifically, they considered children whose permanence is secured by returning to their birth families, or through being placed with connected carers, long-term foster carers and residential care. Children waiting to be adopted were not considered during this visit.

Inspectors also evaluated the effectiveness of management oversight, supervision and quality assurance.

Inspectors considered a range of evidence, including case discussions with social workers. They also looked at local authority performance management and quality assurance information and children's case records.

Overview

The local authority's self-evaluation in April 2018 recognises that it is still on an improvement journey to be good. Senior leaders have a good understanding of service strengths and of areas where the quality and impact of practice are not yet sufficient.

Through the self-evaluation process, the local authority has accurately identified the key areas for improvement within the service for children looked after. Findings from this focused visit mirror many elements of the local authority's own evaluation of services to children in care.

Since their last inspection, the local authority has made improvements to the timeliness of statutory requirements, such as reviews, visits to children and completion of personal educational plans. Further work is needed to address inconsistencies in the quality of chronologies, assessments, effective planning, timeliness of permanence decisions, contingency planning and management oversight and direction. Many of these areas were highlighted as requiring improvement in the Ofsted inspection in December 2017. Since the last inspection, there has been a strengthening in the approach to securing permanency for children. However, it was too soon to see the impact of this for all children. There is more to do in planning for children's permanence when the plan is for something other than adoption.

Social workers' morale was found to be high in Manchester children's services. Social workers describe caseloads as manageable and ranging from 22 to 24. Staff are positive about working in Manchester. They say they feel listened to and supported, and they demonstrate passion and commitment to improving the lives of vulnerable children. Senior managers have been successful in creating an environment which is conducive to continued improvement.

What needs to improve in this area of social work practice

- Timeliness of permanence planning for all children in care, where the plan is not for adoption.
- The frequency with which assessments are updated to inform care planning.
- Care plans which set out clear and measurable outcomes and which are updated regularly.
- Life-story work with all children in care.
- Quality of supervision and management oversight.

Findings

- The threshold for bringing children into care is appropriate. No children were seen who should not have come into care. In a small number of cases, there were missed opportunities to take more timely action to address escalating concerns for children.

- Decisions for children to become looked after are based on thorough and well-written child and family assessments. Following these, assessments are not then routinely updated when children's circumstances change. The absence of up-to-date assessments blunts the focus, and undermines the effectiveness, of plans and interventions. Child impact chronologies were seen in a small number of cases, and these provided a clear analysis of significant events in children's lives. Unfortunately, it was not evident how these strong overviews of the histories of children and their families were used to inform assessment and planning. A programme of training and coaching has been implemented to increase the use of, as well as to increase the quality and consistency of, impact chronologies throughout the service.

- Children's care plans are weak. They lack sufficient detail about the child's needs, interventions, aspirations, overall plans for permanence and contingency arrangements. Plans are not consistently up to date. This means that planning for some children is based on out-of-date information and the child's plan is not reflective of their current situation. Overall care planning fails to focus on the long-term plans for the child.

- Children are visited regularly and are seen alone. Social workers know children well and are able to articulate their needs and views. Recordings of visits are detailed, and the voice of the child is evident. The lack of long-term thinking within plans means that social workers are not consistently undertaking purposeful direct work to help children to move towards their targets. This reduces social workers' abilities to measure children's progress or to take full account of their changing experiences.

- Life-story work is not undertaken with all children looked after. Children wait too long to understand the changes and transitions that they have experienced and the decisions that have been made for them. Senior managers recognise this as an area of improvement, and training is being provided to support social workers to gain the skills and confidence to undertake this work.

- Permanence planning is not robust and does not consistently take place within a child's timescale. Drift in care planning has led to some children remaining in long-term foster placements by default rather than through effective and focused planning.

- Placements are meeting children's needs. However, delays in formally matching foster placements mean that children remain uncertain about their futures. Senior

managers are aware of the delays in permanence planning and have undertaken work with an external agency that has resulted in the revision and relaunch of the permanence guidance. This is due for implementation during September and October 2018.

- Disruption meetings do not always take place for children when placements break down. This means that learning is not routinely considered and so does not inform decisions about future placements for children or identify potential needs that will require support in order to promote placement stability.

- The majority of children's statutory reviews are held regularly and are attended by the relevant professionals. Children are actively encouraged to participate in their reviews and some attend. Review minutes are detailed and include the child's views. Recordings of recommendations are clear and measurable. This means that partner agencies and carers are clear about what is expected of them in order to improve outcomes for children. Independent reviewing officers' (IROs') reports are written directly to children. The language used and the sensitivity with which circumstances and decisions are explained evidences excellent child-centred practice.

- Multi-agency working is effective. Timely information-sharing informs decision-making and this leads to appropriate services being provided to children and families. Working relationships with schools are a strength. Personal education plans are timely, set clear targets and are written in the first person. They effectively capture the voice of the child. Children's emotional health and well-being is well supported by the child and adolescent mental health looked after children service.

- Family group conferences are used well to identify potential connected carers at an early stage. This leads to timely completion of connected carers' assessments. These are well written and inform decision-making. Contact plans are informed by appropriate risk assessments and, in the majority of cases, contact arrangements are well managed and led by the child's needs and wishes. Brother-and-sister contact is sensitively considered and arranged.

- Management oversight is evident in children's case records. However, the rationale for managers' decisions is not always clear, and the impact of management oversight on children's plans is not consistently evident. Social workers spoke of regular reflective supervision, but supervision recordings do not sufficiently demonstrate clear direction or reflective practice. Senior managers are seeking to address these weaknesses by providing supervision workshops and a management development programme. Senior managers are using the findings from a recent thematic audit on management supervision and oversight to inform further action planning.

- Strengthened quality assurance processes mean that leaders have an accurate analysis and understanding of key priorities. Individual and thematic audits have

identified gaps in the quality of practice, all of which reflects the findings of this focused visit.

Ofsted will take the findings from this focused visit into account when planning your next inspection or visit.

Yours sincerely

Shabana Abasi
Her Majesty's Inspector