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Dear Mr Jones

## Focused visit to Oldham children's services

This letter summarises the findings of the focused visit to Oldham children's services on 30 November and 1 December 2021. Her Majesty's Inspectors for this visit were Lorna Schlechte and Rebecca Quested.

Inspectors looked at the local authority's arrangements for children in need, including those who are subject to a child protection plan.

This visit was carried out in line with the inspection of local authority children's services (ILACS) framework.

## **Headline findings**

Since the last focused assurance visit in October 2020, senior leaders have maintained a clear focus on keeping children safe and improving the quality of social work practice in Oldham. Children benefit from an effective range of support and services, despite the continued disruption caused by high rates of COVID-19 across the borough. Social work is often purposeful and makes a difference to vulnerable children's lives. Senior leaders are ambitious and know themselves well. They understand that further work is required to ensure a more consistent approach to the quality of practice across the service.

## What needs to improve in this area of social work practice?

- The consistent quality of plans so that they are up to date and contain contingencies if progress is not made.
- The impact of quality assurance activity on social work practice.
- The frequency of formal supervision so that management oversight has the appropriate impact on improving the consistency of practice.



## **Main findings**

There has been an extremely high rate of COVID-19 infection in Oldham during the pandemic. This has led to additional lockdowns and restrictions since early 2020 and children have experienced significant disruption to their education. There has been increased pressure across the system over the last year, associated with a rise in referrals for domestic abuse, neglect and mental health concerns. The impact of COVID-19 in some of the most diverse and deprived communities continues to be well understood. This has ensured that appropriately targeted partnership support, built up at the start of the pandemic, has been sustained and is directed to the most vulnerable families.

Children in Oldham are seen regularly by social workers who know them well. This has continued despite the various lockdown restrictions and an increase in children subject to child in need and child protection plans.

Assessments are completed in a timely way and most are comprehensive in capturing children's lived experiences. Social workers consider historical risk factors appropriately and gain information from partner agencies to build up a picture of children's lives. The wishes and feelings of children are sensitively considered alongside their individual characteristics and cultural identities. Parental capacity to sustain change is mostly well considered in assessments, and this contributes to thinking about next steps. However, the impact of neglect on children is not always as clearly considered.

When children are at risk of harm, risk is recognised and there is a timely response, although children's plans are of variable quality. The stronger plans are detailed and clear about what needs to change in order for risk to be reduced and for children's needs to be met in a timely way. This has led to some effective and purposeful social work, where there has been an improvement in children's outcomes. However, some plans do not reflect current circumstances clearly or capture the voice of the child sufficiently in relation to their lived experience. Plans can sometimes be too vague about who does what, and by when, against specific actions. Despite clearly stating the overarching priority and safety goals, there is a lack of clear contingency planning. This means that parents will not always understand what actions will be taken if progress is not achieved within the child's timeframe. Senior leaders understand that this is an area for improvement, and have appropriate plans to fully embed the new practice standards and a systemic model of practice.

Most children benefit from regular, timely reviews of their plans through child in need and child protection reviews, and core groups. Partner attendance is mostly appropriate, and partners contribute effectively to discussions about the child and progress made by parents in relation to safety goals and bottom lines. Child protection conference chairs offer more appropriate scrutiny and challenge when children are subject to child protection plans. They map priorities well prior to conferences, which enables conferences to be tailored to the individual needs of children and families. Child protection conference chairs are child focused in their



approach, and have developed a child-friendly plan which is shared with some children, which ensures that they understand what support will be put in place to help their family. This has not been implemented consistently across the service, due to workforce pressures. However, additional capacity has recently been sourced in this service with two extra child protection conference chairs and a team manager appointed to address high caseloads and develop such practice initiatives.

When children are subject to child protection plans, there is now more appropriate oversight of progress, challenge from child protection conference chairs in relation to practice shortfalls, and an escalation of concerns when there are signs of drift. Systems are now in place for senior managers to review children on child protection plans after 18 months, which ensures closer scrutiny of work undertaken with the most vulnerable families to avoid drift and delay. Appropriate decisions are made to continue with child protection planning in the light of historical concerns, rather than stepping down prematurely to a child in need plan. When child protection planning ends, the child protection conference considers what has changed for children, and is not overly focused on self-reported accounts of progress by parents. This supports a clear rationale for decision-making and next steps.

Direct work with children is sometimes completed well and informs future planning, but this is not consistently the case. Observations of family interactions are carefully considered and the impact of changing circumstances on children's emotional well-being is appropriately detailed in the child's record. Social work is often purposeful, especially in relation to domestic abuse. Appropriate support is offered to families, through targeted interventions by support workers in the domestic abuse team, which includes an honour-based violence IDVA, the only such role in Greater Manchester. Parents are also supported to access courses on healthy relationships or temporary accommodation for victims who have no recourse to public funds.

For those children living in crisis who are on the edge of care, there is a well-coordinated multi-agency response from the Adolescent Support Unit to help them to remain living at home. Direct work with children to capture their views is well recorded in this part of the service. As a result, individualised plans are developed to provide wrap-around intensive support, to ensure that children's needs are met and the risks of them becoming looked after are reduced. This has led to some positive outcomes for the most vulnerable children, and senior leaders are ambitious to broaden the offer to manage demand.

Since the last focused visit, cases in pre-proceedings under the Public Law Outline (PLO) have continued to be robustly monitored. PLO arrangements are reviewed more frequently and decision-making is appropriately child focused, with regular updates of progress from social workers about the lived experience of children. This ensures there is a clear rationale for critical decisions. Timely authoritative action is taken when children's circumstances do not improve and there is a need to initiate care proceedings due to escalating risk. Delays are well understood and purposeful to ensure that appropriate assessments are commissioned and front-loaded to avoid



drift and delay for children. There is an appropriate consideration of early permanence planning, as fostering and adoption managers contribute to PLO discussions. Letters before proceedings are sufficiently detailed, are mostly written to the family, and identify the seriousness of LA concerns and the level of support which has been provided. This area of practice has been strengthened since the last focused visit.

There is some evidence of management oversight in children's records, which provides an effective rationale for next steps. Social workers report being well supported both formally and informally by their managers. They value supervision, which is often reflective and detailed, although there are sometimes gaps in the frequency of supervision, which limits the impact of management oversight on improving the consistency of social work practice. Social workers value the training opportunities available to them. They are enthusiastic about the planned new systemic practice approach, although busy workloads have prevented some from attending all the training opportunities available. Senior leaders are focused on becoming a learning organisation where work is planned with other local authorities to roll out more training on systemic practice in the coming months.

There continues to be significant financial investment in the children's social care workforce to increase capacity in response to increased demand experienced throughout the pandemic. This includes the recruitment of 15 additional agency social workers, two child protection conference chairs, a second Frontline team in children with complex and additional needs service, and two workers to address the very high levels of domestic abuse in the borough. Caseloads have reduced as a consequence of this additional investment. However, senior leaders are appropriately sighted on, and transparent about, the need to reduce caseloads further and recruit more permanent staff, to ensure that the roll-out of a new systemic model can be fully implemented across the workforce.

Performance information is regularly scrutinised and provides a useful narrative for the children's assurance board and a new 'getting to good' board in order for learning and key trends to be incorporated into improvement planning. Since the last focused visit, the quality assurance framework has been reviewed and practice reviews (audits) continue to be regularly undertaken by all tiers of management, including the director of children's services. Audits highlight appropriate practice deficits and are moderated to ensure there is less over-optimism in the evaluations of social work practice than was previously the case. Key themes from audit are disseminated within closing the loop sessions and a valued social work forum. However, it is acknowledged that this does not have a sufficient enough impact on the quality of social work practice to support greater consistency. More work is required to fully embed the learning from quality assurance activity.



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

Yours sincerely

Lorna Schlechte **Her Majesty's Inspector**