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Dear Jayne Ludlum

Focused visit to Sheffield local authority children's services

This letter summarises the findings of a focused visit to Sheffield local authority children's services on 30 October 2018. The visit was carried out by Her Majesty's Inspectors, Neil Penswick and Dawn Godfrey.

Inspectors looked at the local authority's arrangements for children in need and those subject to a child protection plan, with a specific focus on children on the edge of care.

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

Overview

The local authority has been working to improve its children's services since an internal review in the latter part of 2017 identified inconsistent service-wide social work practice and management oversight that was resulting in ineffective support to improve children's lives. An improvement plan was implemented with an initial focus on the 'front door'. These issues were shared with Ofsted in February 2018 at the first annual engagement meeting held under the ILACS framework. A focused visit in April 2018 identified that responses to immediate safeguarding issues and to requests for support to families were timely and thorough.

This second focused visit, to further assist the local authority in its improvement work, continued to see senior managers appropriately focusing on improving

services. A recognised model of social work practice has been implemented and a new electronic recording system has been introduced, although it is too early to see the full impact of these developments.

Overall, inspectors saw some effective work in supporting children on the edge of care, underpinned by increased staffing and strengthened formal decision-making processes. This is done, for example, through focused panels chaired by senior managers and supported by legal services.

Immediate safeguarding issues are responded to well. However, the quality of social work practice remains too variable. There are delays experienced by a small number of children where the cumulative effects of poor parenting are not identified soon enough so children do not always receive the support they need in a timely way. Senior managers are tightening their grip effectively on the consistency of social work practice. This is leading to improved outcomes for most children, but the quality of the service response is not yet good for all children.

What needs to improve in this area of social work practice

- Consistency in the quality of assessments, including them being updated regularly, being focused on the lived experience of the child, and taking into account the accumulative impact of poor parenting.
- The provision of support to children and families commensurate with their needs.
- The understanding and use of the model of social work practice.
- The quality of legal planning minutes and pre-proceedings letters, which should identify concerns clearly, and detail what has been done to assist parents and children, how further support will be offered and by when.
- The quality of supervision and management direction in steering case progression, challenging delay and promoting high-quality social work.
- The quality of audits so that they focus on outcomes for children, and how they are used to evaluate social work practice and promote learning.

Findings

- Senior managers produced a self-assessment in January 2018 ahead of the first scheduled annual engagement meeting with Ofsted under the new ILACS framework. The assessment reported that serious concerns had been identified over the previous year about the quality of social work practice, in part because of significant issues about the stability of the workforce. For example, almost all of the management tier below the statutory director of children's services changed in 2017, alongside the loss of a significant number of experienced workers.

- The statutory director of children's services (DCS) and the lead member appointed the director of children and families as part of the improvement programme. Collectively, they commissioned a wholesale review of the support for vulnerable children in Sheffield, including an audit of all open cases. This led to a comprehensive improvement plan, overseen by an improvement board, led by the DCS and supported by significant additional corporate investment. Resultant action undertaken included the introduction of a robust performance management system, the commissioning of a new electronic recording system and an established model of social work practice, and the recruitment of additional social workers and consultants to reduce caseloads. The local authority commenced the service-wide improvements by focusing on the 'front door' to its services, including the response when safeguarding issues were identified.

- In the last four months, the local authority has received approximately 60 children into care. There are a further 60 children who are currently being worked with prior to care proceedings being initiated. A small number of children are being supported through a recently created edge of care service. Overall, inspectors saw variable practice across the social work teams. Effective work ensures that children are being protected. However, social work practice and management oversight is not yet consistent, and this has led to some children not having their needs met in a timely way. A new model of social work practice was introduced 11 months ago and is being systematically rolled out across all services. It is not fully embedded and does not yet support high-quality planning in all cases.

- Assessments are not always up to date. Significant history and events are not always evaluated and assessed to enable robust planning. Often assessments are too adult focused, without explicitly analysing the impact on the child. They do not always include a child's view and understanding of their life, and what they want to happen next. This has led to some children not having their needs recognised and responded to in a timely way. Inspectors also identified that there was confusion for some social workers, who thought that children could not be subject to a child protection plan for a second period. This had resulted in some children not receiving an appropriate level of multi-agency support to address their needs.

- There are clear processes in place to make decisions about whether a child needs to be in care. These have been introduced over the past year and ensure good-quality consideration of the risks faced by the children and what actions need to be taken. However, often these decisions are made in response to a critical issue. In some cases seen, there is a lack of sufficient consideration of the long-term cumulative impact of poor parenting, including neglect, and of domestic abuse on children's well-being. This results in poorer proactive work to address needs at an earlier stage.

- Legal gateway meetings, and subsequent letters to parents, are clear about the general concerns, but do not always sufficiently prioritise the issues that need to be addressed. Identified actions are not always specific enough for the parents to know what needs to happen, by when, and what children's services will be doing to help to support them to sustain those changes. Inspectors also saw in some cases an over-optimism by social workers who failed to recognise underlying and serious issues which continued to impact on children's lives. Most pre-proceedings work occurs in a timely manner. However, there are delays in completing this work on a small number of cases. In the main, while there are meetings with parents to explain concerns, a lack of formal progress review with them is contributing to drift in some cases.

- The social workers who met inspectors were enthusiastic, committed and knew the families well. This has enabled them to be open and transparent with parents and carers and to build good relationships with children. Social workers reflect thoughtfully on their work, the risks faced by children and the activities being undertaken. The quality of the case recording, and documentation, is inconsistent, and there is insufficient focus on the experience of children. A new electronic recording system was introduced in July 2018 to improve the quality of recording. However, there are currently issues relating to the transfer of previous documentation, and there is a lack of focus on improving the brevity of much of the current recording. Senior managers acknowledge the issues and are confident that the full implementation of the model of social work practice will contribute to much improved recording.

- All of the children who had come into care recently needed to be in care. However, a small number of those children could have come into care sooner if there had been a better focus on their day-to-day experience in their assessments and plans rather than a response to a presenting issue.

- Social work management oversight is variable and does not always identify key tasks to be undertaken and ensure that these are completed. Supervision is regular for most social workers, but the recording of these meetings does not always assist a shared understanding of the risks to children and consider whether actions are sufficiently protective.

- On the small number of relevant cases seen by inspectors, when the children needed to remain in care, good-quality placements were identified promptly, and

these met the children's needs. Children benefit from high-quality support from foster carers. Children's looked after reviews are timely, considering all of the children's needs, including long-term permanency arrangements. Inspectors saw work being undertaken to safely return children to their parents and families. They also saw 'twin-tracking', with appropriate consideration being given to adoption.

- A new edge of care service has been established. This builds on the existing family group conference service, the reunification team and the multi-systemic therapy (MST) team. Inspectors saw skilled work that resulted in children being able to return to their families based on sound risk assessment and the development of multi-agency support plans. The existing focus has been on supporting children to exit care and return to their families. The service has now been extended to include a focus on prevention, but it is too soon to measure any impact.

- Audits undertaken in relation to children on the edge of care appropriately identify the variable quality of casework. However, these are very lengthy and descriptive and would benefit from sharper analysis and focus on the impact and outcomes for the child to aid individual and service-wide learning. The auditors make individual judgement on the work undertaken but these are not always consistent with the concerns identified about the quality of the work. This does not promote a full understanding of this area of work.

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

Yours sincerely

Neil Penswick
Her Majesty's Inspector