Oldham Metropolitan Borough Council

Inspection of children's social care services

Inspection dates: 21 January 2019 to 1 February 2019

Lead inspector: Paula Thomson-Jones
Her Majesty's Inspector

Judgement	Grade
The impact of leaders on social work practice with children and families	Requires improvement to be good
The experiences and progress of children who need help and protection	Requires improvement to be good
The experiences and progress of children in care and care leavers	Requires improvement to be good
Overall effectiveness	Requires improvement to be good

Since the last inspection in 2015, strategic leadership has not delivered continuous improvement of services for children. During 2016–17, although leaders had access to performance data, they had insufficient understanding of the quality of social work practice. While they recognised that the demand for services was increasing substantially and acted to increase the capacity of frontline staff, this was not sufficient to improve services for children. The Ofsted inspection of the local area's effectiveness in identifying and meeting the needs of children and young people with special educational needs and/or disabilities (SEND) in October 2017, which revealed significant concerns about services to children, led to the chief executive separating the posts of director of adults' services (DAS) and director of children's services (DCS) in order to facilitate a stronger oversight of services for children.

Since the appointment of an interim DCS in March 2018, the local authority has developed an accurate evaluation of the quality of social work practice. Extensive independent auditing revealed that services had deteriorated since the inspection in 2015, and that significant improvement was required. The DCS developed strategic plans for transformation of services, including a structural investment plan and a new operating model. Some significant investment in new posts has already

taken place, with further transformation planned for 2019. Although work has begun to improve services, this has not had an impact for most children.

Children in Oldham who are at immediate risk of harm receive services that keep them safe. For other children in need of help, the quality of social work practice across all teams is inconsistent. Although a minority of children experience good assessment and planning, for others, assessments are ineffective because they do not analyse children's needs well. This leads to ineffective planning and intervention, and a lack of improvement in children's lives, with some experiencing repeat periods of statutory involvement with little change. Although some groups of vulnerable children receive support that helps them, others wait too long to get a service that meets their needs.

Most children in care in Oldham live in stable placements with people who look after them well. Many children make good progress at school or college and receive appropriate support to meet their needs, including their emotional health and well-being needs. However, some children do not have up-to-date care plans that support their progress or that lead to timely permanence planning. Some children live in short-term placements for too long and, for many who are entitled to support as care leavers, pathway planning is not effective in ensuring that clear, coordinated and timely plans are developed for their future.

What needs to improve

- The quality of assessments to effectively analyse risks and parents' capacity to meet children's needs.
- Care planning with clear outcomes that measure and evaluate progress for children.
- Effective assessments of the needs of disabled children that lead to well-coordinated planning to meet their needs.
- The quality of evidence gathering during child protection investigations.
- The timeliness and effectiveness of pathway plans that lead to provision of effective support into independence.
- The internal audit of practice to provide effective analysis of the impact on children.
- Management oversight and practice leadership at all levels in the organisation to ensure that consistent, and good quality, social work practice is in place.

The experiences and progress of children who need help and protection: requires improvement to be good

1. Children do not always get a good service because of inconsistency in the quality of the assessment of their needs and care planning. Children in need of immediate protection receive a timely response from professionals that helps to keep them safe. The subsequent intervention is not consistently good, with some children's situations not improving quickly enough.

2. Children and families are provided with a wide range of early help support that they can access when needed. Co-location of early help staff within the multi-agency safeguarding hub (MASH) enables effective joint working to take place and this provides children and families with a timely response from the right service. Children have their needs assessed and progress tracked well in order to ensure that the early help they receive is effective. When early help support is not meeting children's needs, their cases are stepped up appropriately into the social work service and allocated for assessment.

3. Stepping cases up from early help does not result in an effective assessment of need for all children. Assessments do not identify children's needs, or accurately evaluate their parents' capacity to meet their needs. This results in some children being moved between support from early help and social work teams several times without their situations improving.

4. Children who are at risk of harm are referred to the MASH by partner agencies, and they get an effective response from appropriately qualified and experienced staff. Social workers and managers ensure that concerns are well recorded and reviewed, and that appropriate decisions are made to refer children for support. Where appropriate, social workers gather relevant information from partner agencies in the MASH to inform this decision-making.

5. When children are at risk of immediate harm, multi-agency strategy meetings are convened quickly to share information about families, evaluate risk and plan investigations. Meetings are well attended and effective, resulting in clear plans of action to protect children and undertake investigations.

6. Once started, too many child protection investigations end without professionals gathering and evaluating all the information or giving thorough consideration about whether an initial child protection conference (ICPC) is required. During this inspection, a small number of children's cases were seen that had been stepped down as children in need, when the children should have had their needs considered at an ICPC. The local authority responded quickly to appropriately reconsider the needs of these children.

7. Children all have an assessment of their needs completed in a timely way. Despite some stronger examples from some individual social workers, most

assessments are not good. Many assessments do not include an effective evaluation to inform decision-making for children. Although historical information is gathered, it is not always well used to inform analysis of risk or evaluate parents' capacity to meet children's needs. Assessments are often very descriptive, and the response to issues of identity and diversity is weak, particularly when children are from minority ethnic backgrounds.

8. Children are seen alone by social workers, who listen to them and record their wishes and feelings. For some children, this work is more detailed and social workers undertake direct work with them to really understand what their life is like. For many others, this does not happen and there is limited understanding of children's experiences to inform assessment and planning. Gaps in case recording also make it difficult to understand a child's journey or the rational for decisions that are made about their lives.

9. Managers review social workers' written work, and record this on children's files, but their oversight does not always challenge poor practice or the lack of progress for some children. Supervision records are not consistently clear, with many not setting timescales for actions to be completed or not following up when work is not undertaken as planned.

10. When children require ongoing support, this is coordinated via multi-agency child in need or child protection plans that are regularly reviewed. Although some children receive support that makes a positive difference, there are others whose plans do not provide an effective means of ensuring that social work makes a real impact and improves their lives. Many plans do not provide clear targets or timescales, and some are not updated to reflect changes in circumstances. Progress is difficult to measure, and many do not make it clear what action should be taken. Some children do not make progress and their situations do not improve.

11. When risks for children on child protection plans do not reduce, appropriate decisions are taken to consider whether the threshold is met for legal action. For some children, this decision-making is effective, but for others, it does not lead to them being helped quickly enough. For these children, the lack of effective and focused planning leads to delay and they remain living in situations of neglect for too long. In addition, there is insufficient focus on contingency planning and this results in further delay in securing good outcomes for children.

12. Disabled children do not receive a thorough assessment of their needs or care planning that leads to their needs being met. Until three months ago, a combination of a lack of strategic leadership, poor management oversight and inexperienced staff led to many disabled children experiencing poor social work practice in this service. Prior to this inspection, the weaknesses in practice had been identified by the current DCS, who has ensured that additional support and interim management is now in place to improve the

quality of practice. This has not had an impact for all children, with some still requiring re-assessment of their needs so that appropriate services are provided. Although no cases were seen during inspection where disabled children had been left at immediate risk, some children are still experiencing delay in getting the right support, particularly when living in situations of neglect. For some older children who are approaching their eighteenth birthdays, late planning for transition to adults' services and care leaver support is causing them and their families anxiety and uncertainty.

13. Prior to inspection, young people aged 16 and 17 who present as homeless were also identified as not getting the right response from the local authority. Since November 2018, young people who present to housing or social care get their needs assessed and are provided with appropriate support, including accommodation. They are supported as children in need, or as children in care, depending on their level of vulnerability and their wishes and feelings. However, before November 2018 assessment of their needs did not always take place, which resulted in some young people being homeless and 'sofa-surfing' for prolonged periods of time without provision of the right help and support.

14. Other vulnerable children experience a more positive and proactive response. Children who go missing from home or care are reported to the police, and, when located, they are seen by social workers to gather information about their episode of going missing. Return home interviews are recorded, although often too briefly, and information is not always incorporated into children's care plans to inform future action. When children are at risk of sexual exploitation, they receive good support from specialist workers in the Phoenix team. For many children, this work is effective at reducing risk. However, for some children, the work of the Phoenix team is not integrated into wider planning for them and is less effective. The local authority has appropriate plans in place to widen the remit of the team to develop a more effective response to children at risk of criminal exploitation, who are currently under-identified in the local authority.

15. Other vulnerable groups, such as children and young people at risk of forced marriage and honour-based violence, are responded to well in Oldham. Children at risk are responded to effectively, with the support of a specialist team, based in Oldham, that works across Greater Manchester to respond to honour-based violence, including forced marriage, and female genital mutilation. Over the past 12 months, 33 children in Oldham have been supported by the team, and this work has included the team obtaining 22 forced-marriage protection orders. In addition, the local authority has a strong and established response to children at risk of radicalisation. Children at risk are identified by professionals and referred for effective intervention and support. A comprehensive package of awareness-raising across schools and colleges is routinely delivered. The council has recently piloted a local

authority-led response to safeguarding this group of children. This was successful and there are plans to implement this across the northwest.

The experience and progress of children in care and care leavers: requires improvement to be good

16. Children in care and care leavers do not experience consistently good social work practice. While many children live in stable placements and make good progress, some experience delay in coming into care, others do not move to permanent placements soon enough, and some care leavers do not have good-quality planning and support to help them achieve to their highest potential.

17. The response to children on the edge of care is not always effective and is sometimes based on unrealistic assessments of the level of risk. Children are sometimes left in neglectful situations for too long and some come into care out of office hours or in emergencies. The rationale for decisions for children to come into care are not well recorded. This would make it difficult for a child reading their own record to understand what has happened to them or why.

18. Children in care do not all have their needs re-assessed when circumstances change. Although social workers prepare reports regularly for reviews, these are often descriptive, and do not all include an updated analysis of need to inform care planning. Care plans do not include contingency planning to prevent delay for children should the primary plan not be successful.

19. Many children do not have their care plans updated often enough. For some children who are living in settled placements that meet their needs, this does not have a significant impact. However, for others with more complex or changing situations, the lack of an updated care plan prevents a clear and shared understanding of what they need in order to help and support them to make progress.

20. Children in care have their situations regularly reviewed by independent reviewing officers (IROs). IROs see children as part of the review process and monitor their progress in between review meetings. However, the impact of their work is not always clear: when children are not receiving a good service, IROs do not always challenge this effectively. Often their challenge or intervention is about compliance with activity rather than quality of practice or outcomes for the child. Reports from reviews are very child-centred and are written in a way that children and young people can understand. However, they do not adequately record areas of action needed to progress the plan.

21. Children are seen, and their views are recorded, but they do not all routinely have the chance to develop a meaningful relationship with their social

workers due to too many changes in workers in many teams. The changes already built in because of the service structure have been exacerbated by some staff turnover, some sickness, and some additional changes in structure that have taken place over the last three to six months as part of service improvement. Most children in care do not have life-story work undertaken to help them understand their past.

22. The views of children in care are increasingly sought and there is evidence of this having a positive impact on service delivery. Young people spoken to during inspection provided many examples of how their feedback and ideas had resulted in action by the local authority. This includes the development of a children's champions scheme across the council to raise the profile of corporate-parenting responsibilities, giving the children in care council the same status as the youth parliament in the borough, and getting agreement from the council to make care leavers exempt from prescription charges. Over the last six months, participation of children and young people has really developed and is an emerging strength in the service.

23. Children have their health needs met well, including the provision of support with their emotional health and well-being. Specialist provision for children in care within the child and adolescent mental health service is ensuring that children receive timely support.

24. Stronger leadership of the virtual school over the last 12 months has supported improved educational provision for many children in care. Pupils, and the schools they attend, have benefited from a strong focus on educational attainment and progress. The virtual school effectively tracks the progress that pupils make from their starting points and this allows for more accurate assessments of pupils' progress, which continues to improve.

25. All children have a personal education plan (PEP) that is subject to quality assurance by the virtual school team. Work is ongoing to improve the effectiveness and standards of these documents. The head of the virtual school manages the use of pupil premium well through the PEPs. Funding is only released once effective targets to improve educational outcomes are identified by the school. Schools put the pupil premium plus funding to good effect for additional classroom support, extra tuition and for a wide range of enrichment opportunities and pastoral support.

26. Most children live in appropriate and stable placements that meet their needs. Foster carers are well trained and supported and receive good levels of ongoing supervision and development from a strong fostering service. Most children and young people live close to their community and they are well supported to maintain good contact with their birth families.

27. Children who need permanence away from their families and cannot stay in their short-term placements do not always move to permanent homes soon

enough. A lack of effective planning with clear targets and timescales results in some children staying too long in short-term fostering placements. However, when children can achieve permanence through special guardianship orders (SGOs) with extended family members, this is progressed well. The offer of financial and practical support to carers has led to a significant increase in children leaving care through SGOs over the last 12 months.

28. Children are identified for adoption at an early stage and are assigned a specialist worker from the adoption team to support timely adoption planning. Good-quality child permanence reports include a thorough analysis of their experiences and needs. Although adoption timeliness is improving overall once placement orders are made, a limited choice of adopters and some workload issues in the team lead to some delay in identifying potential adopters, even for very young children. However, once identified, matching processes are detailed and effective, and result in good placements for children. Children are provided with child-centred life-story work and are well supported through detailed adoption support plans in their adoptive placements.

29. Care leavers now get a service from staff who know them well and who provide sensitive support. This is because previous structural and systemic failings, which gave care leavers a poor service, have recently been improved. Over the last three months, work has taken place to reduce caseloads and to create a team that specialises in working with care leavers. There have been significant challenges in producing accurate performance data for the care leavers' service, with reports historically containing significant gaps and some information still having to be manually collated.

30. There are some good documents in place to support the communication of health information and entitlements to young people, and in a format that they appreciate. However, there have not been systems in place to monitor whether young people receive these services. Prompted by questions from inspectors, the local authority accessed information from health colleagues which indicates that, in the past six months, of the 22 young people who should have attended their final health assessment, 17 attended and 15 were provided with the local authority health passport. Despite the development of a comprehensive 'Passport to Independent Living' document for care leavers in partnership with the children in care council, inspectors did not see examples of this being well used during this inspection, with some young people lacking effective support to ensure that they have a successful transition to independence.

31. Some young people have pathway plans that are not good quality or reviewed frequently enough when circumstances change. They lack ambition and do not always contain clear targets to improve outcomes. Practice over

the last three months has improved, with workers being able to spend more time with young people.

32. The rate of care leavers living in staying-put arrangements with their foster carers has increased but remains lower than statistical neighbours and the England average. Many 16- to 18-year-olds live in semi-independent accommodation, with most being provided with sufficient support from the accommodation providers. Some care leavers are making positive progress. Young people living in more settled placements are better supported to achieve their potential and are attending college, university or they are in work. Others continue to be vulnerable, with repeat periods of crisis. While young people get good and immediate support, they do not benefit from proactive long-term planning to address and resolve their issues. Of the 193 care leavers aged 17–21 years old at the point of inspection, just over half are in employment, education or training.

33. Some previous gaps in provision for care leavers have been addressed by a range of additional practical and emotional support provided via the youth service. This is highly valued by young people, who gave inspectors good examples of how the staff are available for them, how they are responsive and how they make a difference to their lives, for example by being available to them at weekends, over Christmas and during other holiday periods.

The impact of leaders on social work practice with children and families: requires improvement to be good

34. Strategic leadership has not provided continuous improvement of services for children since the last inspection in 2015. The chief executive and political leaders did not have enough knowledge and understanding about the reasons behind a significant rise in demand for children's services, or the impact that this increased demand was having on the quality of social work practice.

35. Following the Ofsted inspection of SEND in October 2017, which identified significant weaknesses in service provision, the chief executive increased the leadership capacity for children's services by creating a separate role of DCS. Since their appointment in June 2018, the interim DCS has developed an accurate understanding of the quality of social work practice through the commissioning of several independent reviews of services for children. Effective and regular reporting of this work has ensured that senior and political leaders are also fully appraised of the current effectiveness of services provided to children.

36. Senior leaders have given their full support to plans for transformation of children's services proposed by the DCS. Some short-term additional capacity has already been provided to enable some teams to reduce workloads.

Further plans, to be implemented during 2019, include a re-shaping of services to increase capacity of frontline staff and leadership, provision of new accommodation for social work teams, and implementation of a social work model of practice. The council has agreed to all plans and has supported this with the provision of substantial additional funding over the next three years.

37. Senior leaders now maintain an accurate understanding of the quality of services for children through increased scrutiny of more detailed and holistic performance management information. They fully understand that, despite some initial improvements, they have ongoing challenges if they are to deliver consistent and good social work practice for all children.

38. Over the last six months, the local authority has also developed a stronger sense of corporate responsibility for children in care. Mechanisms to consult and listen to the voices of children have improved and are beginning to influence the development and provision of services. Senior leaders and managers have shared information about services and established effective and productive relationships with partners to support service development.

39. Prior to the arrival of the current DCS, accurate and detailed performance information was not readily available, and was not well used to monitor the effectiveness of services, or to target improvement. Over the last six months, the local authority has developed more accurate and effective performance management and monitoring. The DCS has started to make some progress in refining the internal quality-assurance system. This includes using regular auditing of practice to inform learning and development.

40. The focus on achieving compliance within the service has led to audits being focused on this, rather than on evaluating the quality and impact of social work practice. Because of this, audits do not accurately evaluate the experience of children. Audit activity does not always result in effective learning for the individual practitioner or in a better service for children.

41. The overall quality assurance activity, supplemented with external independent and peer review, has led to an accurate understanding of services for children. This has led to relevant action to start to improve the service that children receive. Weaknesses identified during this inspection were known and understood by senior managers, and work has begun to address them. Over the last six months, there has been an increase in the numbers of frontline staff, a reduction in the caseloads of social workers, additional support placed within some teams to help practice improvement, and an increase in quality assurance and audit activity. However, work is still in its early stages and is not leading to children receiving consistent and effective social work support and intervention. For some vulnerable groups, particularly disabled children and care leavers, the impact of poor practice has not been fully addressed.

42. Management oversight of frontline practice, including that by IROs, has improved, with most children's records now showing evidence of regular supervision and managers reviewing practice. This has resulted in improved compliance with basic standards, but managers and IROs are not ensuring that the quality of practice, particularly assessment and planning, is good. Their oversight does not ensure that change is taking place for children quickly enough.

43. Leaders have appropriately recognised that, to improve services for children, they need effective leadership across all levels of the organisation. This is not fully in place, and there remains significant work still to do to recruit and develop leaders in key roles.

44. The workforce in Oldham, many of whom have worked with the local authority for a long time, are committed to the proposed changes to improve practice. Staff talked to inspectors about feeling that the service is getting better and said that there is a sense of being on a 'journey of improvement'. Staff talked about being listened to by increasingly visible senior leaders. The planned move to new and more suitable offices is welcomed by them and is contributing to their more positive view about the future.

45. Newly qualified social workers, and those in their first year of social work, are well supported in Oldham. Reduced caseloads, additional reflective supervision and a good training offer lead to new workers feeling valued. The provision of a wide range of training for staff is starting to have an impact on improving practice.

46. Although additional capacity has resulted in reduction in caseloads for all staff, caseloads remain too high in some teams. This means that not all workers have sufficient time to spend with children and to deliver good-quality social work practice.

47. A great deal of work has been undertaken to gain a thorough understanding of the services that children receive. Some progress has been made, but this has not had an impact for all children. Some children in Oldham have had poor experiences of services and there remains a great deal of work to do before the service provided for all children is good.

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Piccadilly Gate
Store Street
Manchester
M1 2WD

T: 0300 123 1231
Textphone: 0161 618 8524
E: enquiries@ofsted.gov.uk
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