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Dear James,

Monitoring visit of Tameside Borough Council children's services

This letter summarises the findings of the monitoring visit undertaken on 10 and 11 January 2018. The visit was the fourth monitoring visit since the local authority was judged inadequate in December 2016. The inspectors were Paula Thomson-Jones HMI, Shabana Abasi HMI and Majella Tallack, Ofsted inspector.

There is still considerable work to do to improve the quality of practice delivered to children in need of help and protection. The local authority has taken action to address the previously slow pace of improvement, with some early signs of success. However, these changes have not yet had a sufficient impact on the service that children receive.

Areas covered by the visit

This visit examined the work done with children in need of help and protection, with a focus on arrangements in the safeguarding duty teams. The inspection made specific recommendations for improvements to be made in the service provided for children in need of help and protection. This monitoring visit focused on four of these:

- Ensure that all areas of service have staff with a suitable level of qualification and experience for the role that they are required to undertake and that their workloads are manageable.
- Ensure that action taken by social workers is compliant with statutory guidance and that the application of thresholds in casework with children and families is appropriate.
- Ensure that the quality assurance of work by senior and middle managers routinely considers the quality of managerial decision making and the application of thresholds at all stages of the child's involvement with the local authority, including contacts within the public service hub.

- Ensure that staff receive high-quality supervision and managerial oversight at a frequency that reflects their skills and levels of experience.

The visit considered different types of evidence, including electronic case records, supervision files and notes, observation, and discussion with social workers, managers and senior leaders.

Overview

The local authority has recognised the need to increase the pace of improvement. A decision to separate the roles and responsibilities of the director of children's services (DCS) and the director of adult services (DAS) in September 2017 led to the creation of a new dedicated DCS post. An experienced interim DCS was appointed in October 2017.

Since their appointment, the DCS has led work to re-evaluate the current position and accelerate improvement. The local authority now has an accurate self-assessment. It demonstrates a good understanding of the scale of change required in systems, culture and practice. Recent reports on audit work accurately reflect the quality of practice. The revised improvement plan shows more focus on improving outcomes for children. There has been an increase in the number of social work posts. Although this work has created a greater potential for improvement, the impact of this is not yet evident in the quality of social work practice.

During this visit, inspectors saw some improvement in areas of compliance. As on previous monitoring visits, inspectors saw a few examples of good practice, but these were exceptions, and were the result of work done by individual practitioners rather than any systemic improvement. There was evidence of some improvement in management oversight of casework, and managers demonstrated a greater understanding of the practice improvements required.

Findings and evaluation of progress

Referrals for children progress in a timely way. Records evidence management oversight and a rationale for decision-making. However, the quality of information gathered in order to inform these decisions is often poor. While most cases seen had information from schools, there was often an absence of information from other key agencies, such as health services and the police. This means that children's and parents' needs are not fully understood.

Children at risk of harm are identified and immediate action is taken to keep them safe. Strategy discussions take place, and are recorded on children's files. This is an improvement compared to work seen during the inspection. However, the discussions held are usually between social care and the police, and few of them involve other agencies. In addition, agencies do not routinely contribute by sharing information, which leads to ineffective evaluation of risk. The majority of cases seen during this visit demonstrated a lack of information from health services and the

police. This means that decisions about the levels of risk to children are being made without the benefit of full and accurate information.

Decisions to undertake child protection investigations are now recorded and action is taken to keep children safe. The quality of this work is hampered by poor analysis and planning, which sometimes prevent investigations from being carried out effectively. In some cases seen, social workers or the police undertook single-agency action before strategy discussions had taken place. In others, police representatives reported that capacity issues prevented them from being able to undertake joint investigations. In the vast majority of cases seen, information about the health needs of families was not obtained during the period of investigation, leading to incomplete evaluation of the presenting risks.

Assessments are completed in a timely way for all children, but there has not been a consistent improvement in the quality of practice. A small number of examples seen were thorough and well written, and contained good analysis that led to effective planning. However, the vast majority of assessments seen by inspectors only focused on the single presenting issue, and had significant gaps in their evaluation of history. As a result, the analysis of risk and the analysis of parenting capacity continues to be weak. This leads to decision-making and planning that are based on an incomplete evaluation of risks and needs. Children do not have all of their needs identified, and are not always receiving the right help.

The lack of effective information gathering at all stages of a child's journey means that the local authority cannot be sure that thresholds for decision-making are applied consistently or appropriately. As a result, children may not be getting the right support at the right time.

Child in need and child protection plans are now in place for most children, and regular reviews are taking place. Written plans are not child focused enough, and do not have clear outcomes, actions and timescales. As a result, it is difficult for parents and professionals to understand what change is required or how progress is measured.

Case recording does not reflect the work that is undertaken in order to help children. It is difficult to understand their experiences from the written records. This is a more significant deficit for those children who experience changes of social worker. Weak case recording makes it hard for new workers to understand what is needed, and to provide a consistent service for the families. In a small number of cases, social workers had compiled good chronologies, but in most cases these were lacking, and were not used as tools for supporting the understanding of children's experiences.

All children's cases reviewed during the visit showed some improvement in children being seen and spoken to as part of casework. Children are spoken to, and what they say is often recorded, but the value of this varies, depending on the quality of the work undertaken. In a small number of stronger cases, workers had undertaken direct work, had understood and evaluated wishes and feelings, and had used this to

inform the plans and their work with the families. However, in the majority of work seen, effective direct work was not undertaken, and assessments and plans were not sufficiently child focused.

Children's records seen during this visit showed improvement in the managers' oversight of casework. There is regular case discussion recorded on the majority of children's files, showing that managers check compliance with statutory requirements. Records do not yet evidence reflective discussion or analysis. There is still not enough challenge from managers regarding the quality of practice. Supervision records show some improvement in the frequency and quality of supervision, but there remains further work to do in order to ensure that this is consistent for all staff.

Managers and social workers demonstrate commitment to, and enthusiasm for, their work, and feel more optimistic about progress because of recent developments. Workers welcome the visibility of new senior leaders, and are positive about the new improvement plan. They feel it offers clearer direction and an increased focus on children.

Although caseloads remain high in some teams, all have been reduced since the last monitoring visit. This means that workloads that are more manageable for many social workers. The permanent workforce is stabilising, with little movement, which is an improvement from previous monitoring visits. However, there continues to be a reliance on high numbers of agency staff in some teams. The high level of turnover of agency staff continues to present a risk to practice improvement.

The work undertaken to support and develop newly qualified social workers is starting to be more effective. A consultant social worker is ensuring that there are good levels of support and supervision. Workers in their first year of practice who were seen on this visit had protected caseloads, and were receiving support to enable them to learn and develop.

Work has started with partner agencies to ensure that their contribution to safeguarding practice results in children receiving a good-quality service. Some progress has been made, and there are increased health and police resources at the safeguarding hub.

The weaknesses in practice identified by inspectors during this visit are known to the local authority. Since the last monitoring visit in September 2017, the local authority has produced two thematic audit reports that accurately evaluate practice. This included a thematic audit of child protection work, where the findings were similar to those of the inspectors on this monitoring visit. This means that the improvement plan is now based on a more accurate understanding of the work required. This provides a sound basis to learn from and for future practice improvement.

The local authority's self-assessment also includes an accurate understanding of the wider work needed to support improvement. This includes improvements in the

recruitment and retention of social workers, and strengthening the senior leadership team. An experienced interim assistant executive director is now in post, and an additional head of service post has been established to provide greater capacity.

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

Yours sincerely

Paula Thomson-Jones
Her Majesty's Inspector