

6 July 2017

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Dear Steph

Monitoring visit of Tameside Borough Council children's services

This letter summarises the findings of the monitoring visit undertaken on 8 and 9 June 2017. The visit was the second monitoring visit since the local authority was judged inadequate in December 2016. The inspectors were Paula Thomson-Jones HMI and Lolly Rascagneres Ofsted inspector.

The local authority has made only limited progress in the period since the last monitoring visit.

Areas covered by the visit

During the course of this visit, inspectors reviewed the progress made in the area of help and protection, with a particular focus on assessment work in the safeguarding duty teams. The visit considered a range of evidence, including electronic case records, supervision files and notes, observation and discussion with social workers, team managers and senior managers. The inspection made a specific recommendation for improvements required in social work assessment. This monitoring visit focused on this, in addition to reviewing progress against the four recommendations considered at the last monitoring visit.

- Ensure that social work assessments include an effective consideration of history and parenting capacity that informs a thorough analysis of risk and ensures that assessments are updated regularly to reflect children's changing needs and circumstances.
- 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 is appropriate in casework with children and families.
- 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 in 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.

Overview

A continued increase in demand for services, compounded by the instability of the workforce and high caseloads, continues to impact on the quality of the service that children and families receive. Despite improvements in the scrutiny of data to understand performance, compliance with statutory requirements remains a challenge. There is a lack of consistent improvement in several key areas, including visits to children who are subject to child protection plans. The recent implementation of a quality assurance framework has resulted in better-quality audit work, but this is not having an impact on the quality of practice. The quality of social work assessment has not improved, resulting in ineffective decision making and planning continuing for many children.

Evaluation of progress

Despite securing funding to establish additional posts in the safeguarding duty teams, the actual number of social workers has not increased, and caseloads for most staff remain too high. There continues to be a significant challenge in recruiting and retaining social workers and team managers. Agency staff hold the vast majority of posts and turnover has increased, and 28 social workers have left since January 2017. This has resulted in many children and families experiencing a further change in their social worker during the period of their assessment, and this has caused a delay in service provision, for some. The local authority believes that it understands the reasons for this turnover and is continuing to take steps to improve recruitment, but teams remain vulnerable to instability because of the large numbers of agency staff. The high turnover has resulted in whole caseloads of children, who each need an assessment, being reallocated to new workers who have joined the service. The local authority acknowledges that, because of this volatility of the staffing position, it needs to improve the systems that are currently in place to ensure that it is safely managing the transfer of work.

Improvement in the scrutiny of performance data has enabled the local authority to have a much clearer understanding of service provision. Clear reporting structures via senior managers and leaders have resulted in an improved identification of areas

of concern and, as a result, the local authority demonstrates a better understanding of many areas of performance.

Despite this scrutiny, a consistent improvement of compliance with key requirements, such as the visits to children and the multi-agency reviews taking place at the right time, has not been achieved. Although there were periods of improvement earlier in the year, the timeliness of visits to children looked after and subject to child protection plans has recently declined. The timeliness of key meetings, such as to convene initial child protection conferences, and reviews for looked after children also significantly deteriorated during April.

The local authority has implemented a revised quality assurance framework that includes senior and political leaders' involvement in governance visits to frontline services and, more recently, a programme of regular case auditing. The eight governance visits undertaken since January have increased leaders' understanding of the challenges faced by frontline staff, and some of the issues identified have resulted in action such as increased business support to teams and the provision of appropriate equipment to support mobile working.

The recent audit programme established in April demonstrates improvement in the quality of case reviews, with a greater focus on the quality of practice and learning rather than just measuring compliance. However, the audits do not always result in clear actions to improve practice, and there is currently no effective system in place to monitor the actions required or ensure that the learning is effective in improving the experiences of children. As a result, some audits identify the work required effectively, yet this does not result in an improvement in the quality of work with children.

The quality of assessment has not improved. The vast majority of assessments do not include an effective consideration of history and parenting capacity that informs a thorough analysis of risk. There has been very little effective work to improve practice, and staff are not clear about how they should use historical information to inform their analysis of adults' capacity to parent or to make change. There is no consistent or effective approach to the analysis of risk and, as a result, decision making is not robust. This means that many children seen during this visit are not receiving services at the appropriate level of need, and some children experience repeated assessments within short periods.

Management oversight is not effective in improving practice. Decisions are often unclear and lack an explanation, even when they appear to disagree with social work recommendations. There is a lack of challenge of poor practice and a lack of consistency between teams across the service. As a result, management oversight is not improving the quality of service that children receive.

Although staff reported feeling well supported, formal supervision is not taking place as regularly as it should and the quality has not improved, with brief records, a lack of follow up on actions and little opportunity for reflection.

While there has been considerable effort and activity to try to improve the service that children receive, the improvement plan has not been translated into a coherent strategy, a well-coordinated service or team planning that is understood by all staff and managers. This, exacerbated by the high staff turnover, means that a lack of understanding remains about the key priorities and practice improvement that are required.

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