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Dear Richard

Monitoring visit of Tameside children's services

This letter summarises the findings of the monitoring visit to Tameside children's services on 27 and 28 November 2018. The visit was the seventh monitoring visit since the local authority was judged inadequate in December 2016. The inspectors were Shabana Abasi, Her Majesty's Inspector, and Majella Tallack, Ofsted Inspector.

The local authority continues to make some progress in the improvement of its services for children in need of help and protection. In most cases, identification of the children who are in need of urgent help and protection is recognised and responded to quickly through a multi-agency response. Contacts are progressed appropriately as referrals to children's social care or are re-directed to early help or universal services. Threshold decision-making about children's levels of need has improved and is now more consistent than it was during the monitoring visit on the 10 and 11 January 2018. As a result, the services received by most children are relevant to their needs. Weaknesses remain in the quality and consistency of assessments and analysis of children's needs, planning, chronologies and supervision.

Areas covered by the visit

This visit reviewed the quality of social work with children in need of help and protection, with a focus on arrangements in the 'Hub', which is the local authority's 'front door' team, and the duty teams. The specific areas of practice reviewed were:

- multi-agency information-sharing
- screening, analysis and decision-making regarding thresholds at the front door, including early help
- strategy discussions and child protection enquiries
- assessments of children's needs

- management oversight and supervision.

Inspectors considered a range of evidence, including case discussions with social workers who were undertaking referral and assessment duties, and meeting a number of partners within the safeguarding hub. They also looked at the local authority's performance management and quality assurance information, and children's case records.

Overview

Since the last monitoring visit on the 22 and 23 August 2018, the permanent director of children's services, assistant executive director and head of service for child protection and child in need have taken up their posts. This has strengthened the expertise and capacity in the senior management team. The local authority engaged well with external partners to review its work in the hub, and duty teams and held a practice week that included practice observations and case auditing. As a result, the new leadership team has gained greater insight into the quality of social work practice with children and families in Tameside and addressing actions from the review through the improvement plan.

The local authority has invested in a strengths-based model of practice, which it started rolling out in September 2018. This has been well received by social workers, who report that it benefits their practice. Inspectors saw evidence of improving practice when this new model is being used, for example in effective assessment and supervision.

Staff recruitment and retention of frontline workers and service unit managers continues to be a significant challenge for the local authority. Senior leaders recognise that workforce instability brings with it a number of vulnerabilities, including inconsistency in the quality of practice. The local authority is actively engaged in a number of relevant initiatives to support social work recruitment and staff development, but at this early stage there has been limited impact.

Findings and evaluation of progress

The Hub has an overly complex system for receiving contacts from members of the public, families and professionals who are seeking advice and support. This includes the use of multiple in-boxes for emailed contacts. Social workers also take telephone calls directly from members of the public and professionals, and this is in addition to their role in screening all contacts to recommend to managers the most appropriate referral pathway for children. Social workers explained that they find managing these competing demands challenging. The local authority recognises the vulnerability of the current system and has appropriate plans in place to launch a multi-agency safeguarding hub, with a single point of entry, in January 2019.

Professionals from a range of agencies make appropriate referrals to the Hub. The quality of information given on the majority of contacts is enough to enable

decisions to be made about next steps in providing a response to children. However, there is variability in the quality of information on the single agency referral form. The local authority is working with partners to strengthen the quality and consistency of the information they provide.

Contacts for early help are screened and appropriate services and interventions are identified in consultation with parents. Where an early help assessment is required, cases are swiftly referred to the multi-agency early help panel, for allocation to a lead practitioner. When early help screening leads to an outcome of no further action or advice and information, manager authorisation is clearly recorded prior to closure of the contact.

The use of thresholds by other agencies is improving and decisions regarding thresholds in the hub are appropriate. Managers provide thorough and effective oversight of decision-making for the majority of contacts and referrals in the hub and all recommendations for next steps are suitably reviewed by managers prior to authorisation. Despite the current competing demands on social workers' time in the hub, the screening of contacts is comprehensive and well recorded. It is informed by multi-agency information and the views of parents, and includes analysis of historical concerns and current risks.

Consent for social workers to liaise with other agencies is sought appropriately from parents and this is well recorded. When consent is appropriately overridden due to risks to children, a clear rationale for this is included in case records. This ensures that families' rights are fully considered. Letters to referrers informing them of the outcome of the referral are not consistently evident on case files.

When children need help out of hours, the emergency duty team responds to contacts effectively. The decisions and actions taken by the team are well recorded and specifically identify what further work is required by the daytime teams.

In some cases, once a referral decision has been made, visits to see children and to inform parents of strategy meetings are not well organised. The visits are not always undertaken by the same social worker, which means that some children and their families have to keep explaining their circumstances to different workers in quick succession.

The majority of children at risk of significant harm receive a prompt response. Cases are swiftly transferred to the duty teams to undertake child protection enquiries. Detailed case-allocation directions by managers generally provide social workers with clear guidance. However, in a small number of cases, identified actions lacked timescales.

In most cases, strategy meetings are well attended by the relevant partner agencies and information is shared and considered carefully. This leads to appropriate multi-agency decisions and actions that safeguard children. In some cases, the availability of the police has resulted in delays in convening strategy meetings, and, for a small number of children, this has had a negative impact on their outcomes. The local

authority has very recently prioritised this issue and is engaging with the police to address it.

Child protection enquiries are timely and thorough, and they evidence clear information-sharing and focus on risk. Written records of strategy meetings and investigations are not of a consistently good quality.

The quality of assessments of children's needs remains variable, as was found at the inspection in December 2016. A small number of assessments are now thorough, well written and contain a good level of analysis of needs, risks and parenting capacity to inform effective planning. In most assessments, though, history and risk are not rigorously analysed, and the impact on the child is not fully considered.

Children are seen by social workers who know them well and who undertake purposeful direct work with them in line with their plans. There is, however, insufficient analysis of children's views, which are not consistently informing planning and decision-making.

The majority of social workers receive regular supervision. The quality of supervision is variable. In some cases, there is evidence of detailed discussions that result in clear actions and a follow-up of previous actions. In other cases, recordings are task-orientated and not sufficiently analytical or reflective. Senior managers are appropriately seeking to address these weaknesses through the delivery of a management and leadership programme for all frontline managers, which commenced in September 2018.

Inspectors found that case audits accurately reflect the quality of social work practice for individual cases. This demonstrates that audit activity continues to be effective and provides accurate evaluation of the quality of practice in the hub and duty teams.

Senior leaders understand the challenges that they and their staff face and are realistic about their strengths and areas for development. This is based on a thorough and accurate self-evaluation of social work practice with children and their families. Social workers have gained more confidence in senior leaders' decisions because they can see for themselves the signs of progress and improvement.

I am copying this letter to the Department for Education.

Yours sincerely

Shabana Abasi
Her Majesty's Inspector