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Dear James

Monitoring visit of Tameside Borough Council children's services

This letter summarises the findings of the monitoring visit to Tameside children's services on 22 August 2018. The visit was the sixth 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.

In too many areas of the service for children looked after, the pace of progress has been slow. The quality of social work practice, supervision and management oversight, and challenge by independent reviewing officers (IROs) still require significant improvement to ensure that practice improves and delivers good outcomes for children looked after. Inspectors found some evidence of improving performance in the timeliness of statutory requirements, such as reviews, completion of health assessments and personal education plans.

Areas covered by the visit

This visit reviewed the progress made with regards to children looked after, with a focus on:

- the quality of assessments and care plans
- the timeliness of permanence planning
- the effectiveness of management oversight and independent reviewing officer (IRO) scrutiny
- the effectiveness of corporate parenting.

The visit considered a range of evidence, including electronic case records, performance data, and discussions with workers, senior leaders, the chair of the corporate parenting board, IROs and members of the Children in Care Council (CiCC).

Overview

The local authority's updated self-assessment accurately identifies the key areas for improvement within the children looked after service. It is of significant concern that many of the areas of the service that need improvement for children looked after are the same as those highlighted in the Ofsted inspection two years ago. Progress has been slow. The local authority recognises the need to accelerate progress and improve basic practice. Plans and practice guidelines are agreed to address the improvements identified in its self-assessment and recognise the need to accelerate progress and improve basic practice.

Senior managers acknowledge that there was little progress made during 2017 to improve services for children looked after. The local authority has taken action to address the pace of improvement and has strengthened the management of the service although in the short term this has resulted in a period of instability for the service, with a team manager, practice managers and a number of social workers leaving. Changes in staffing have resulted in an increase in caseloads and a number of children experiencing a change of social worker, which has impacted on the quality of care planning for them.

The difficulty in trying to secure a stable workforce is the local authority's biggest challenge. Strategic leaders recognise this and are making every effort to recruit permanent staff with the relevant skills and experience to support children. The focus on recruitment of permanent social workers is now showing some positive results. The local authority reported 17 recent appointments and a further 15 shortlisted for interview. Despite all the local authority's efforts and incentives 41% of staff are agency workers.

Findings and evaluation of progress

The threshold for bringing children into care is appropriate. No children were seen who should not have come into care, and children were safeguarded effectively. In a small number of cases more timely action to address escalating concerns should have been taken.

Recording in case notes is timely. Case summaries are on the whole up to date and provide a pen picture of the child and a good sense of the child's journey into care. Chronologies are generated by the electronic recording system. This limits their usefulness in informing assessments and plans.

The quality of child and family assessments and plans is weak. Assessments are not routinely updated to reflect changes in a child's circumstances. This means that planning for the child is based on out-of-date information and the child's plan is not reflective of their current situation. Some care plans contain too much narrative and lack sufficient detail about the child's day-to-day life, aspirations or overall plans for permanence. Plans do not sufficiently recognise children's strengths, and overall care planning fails to focus on long-term plans for the child. Senior managers are aware of these deficits and plan to address them through the roll-out of a strengths base

model of practice. Inspectors noted that some of the plans they reviewed had clear actions and timescales.

Written care plans are not routinely shared by social workers with carers, parents and professionals. This reduces the ability of social workers, carers and professionals to hold each other to account to ensure that effective care planning is taking place and that they are working together purposefully to improve children's outcomes. Inspectors made senior managers aware of this practice and they took immediate action to respond and rectify this.

Statutory visits to children are taking place regularly, children are seen alone by their social workers, recordings of visits are thorough, and the voice of the child is evident. Social workers know the children well and are motivated to achieve positive outcomes. The average caseload at the monitoring visit was 18.5; however, some social workers reported having caseloads of 26 to 28. Senior managers are aware of the range of caseloads. Caseloads have been reducing but continue to remain too high for some social workers.

The majority of statutory reviews for children are held regularly. Children are actively encouraged to attend and participate in their reviews. However, the views of children are not always well recorded within the minutes, and therefore it is not clear how the voice of the child informs care planning. IROs fail to effectively challenge any drift or delay in children's plans, and records do not indicate how the review process is used to ask critical questions about the decisions made about children, or to consider their future needs.

Senior managers recognise the need for increased IRO oversight and challenge to address drift and delay. They have begun to address this through a revised dispute resolution and mid-review tracking process. However, it is too early to see the impact of this.

Management oversight by front-line managers lacks rigour and consistency and is not focused on driving improvements in the quality of practice. The rationale for decision-making is not always clearly recorded. Supervision for social workers is either not taking place regularly or is not being recorded. Where it is recorded it has not provided an analytical overview of the children's case, clear case direction or demonstrated reflective practice. Supervision has been a consistent area for development identified by the monthly audits. Steps are now being taken by senior managers to address the issues by providing workers with individual support and coaching, a management development programme and a supervision tracker.

Permanence planning is not robust and is not considered soon enough. Many children in foster care achieve permanence by staying in their short-term foster placements for a number of years. Although these children are in placements where they are well cared for, delays in formally matching children and foster carers mean that some children remain uncertain about their futures. Senior managers acknowledge that there are delays in permanence planning and have recently revised the arrangements for permanence, to be implemented from 1 September 2018. All children awaiting a formal match have been reviewed and additional fostering panels are scheduled from 1 September 2018.

Life story work is not being completed with all children looked after. It is unacceptable that children wait too long to understand their life experiences and decisions made about them because of the absence of life story work. There are plans to support social workers to have the skills and confidence to undertake this work. Several social workers stated that they did not have the capacity to do life story work.

Contact arrangements are well managed, reviewed and informed by the child's wishes and needs. Consequently, family relationships for children are maintained when it is appropriate and safe to do so. Brother and sister contact is well considered and promoted.

Quality assurance processes are improving. Individual and thematic case audits identify gaps in the quality of chronologies, assessments, permanency planning, management oversight and supervision. These reflect the findings of this monitoring visit. This reliable audit information accurately raises concerns about the quality of practice. Social workers are positive about the case auditing process and are able to evidence reflection and learning.

Refreshed terms of reference, and membership, and the appointment of a new chair of the corporate parenting board is evidencing a renewed drive and focus on corporate parenting. In the last six months the board has ensured that children looked after access apprenticeships and work experience opportunities within the council. CiCC has also attended the corporate parenting board, with a young person co-chairing these meetings. Work around the pledge for children in care and the care leavers charter has yet to been completed.

The CiCC is a vibrant and vocal group, which consists of children looked after and care leavers. The appointment of a participation officer in May 2018 has provided the group with renewed focus and momentum. Young people were positive about their very recent participation in the corporate parenting board. However, they also expressed a concern about the changes of social worker. They felt that their experiences were never really understood and that there were delays in things being completed. Young people had a level of scepticism about promises being delivered by the corporate parenting board based on their previous experience. They were also concerned about the upcoming changes in senior management and were anxious that these would bring more changes again. Senior leaders are aware of the impact of the impending changes at senior management level and have transition plans in place to ensure there is a smooth handover. If these are successful, the local authority may be able to expedite the pace of improvement that is needed.

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

Yours sincerely

Shabana Abasi
Her Majesty's Inspector