Ofsted Inspection of Tameside Children's Service – May 2019

Operational	Strategic
• Children in Care – consistency of practice. • Views of children to better inform assessments and actions. • Child protection conferences / IROs - oversight and challenge. • Removing any delays in delivering timely permanence for children in care. • Information recorded and passed between the Early Help Hub and MASH – decisions being made and possible gaps/risks. • Quality and appropriate referrals from partner agencies. • Strategy discussions – speedier distribution of note and actions with all partners involved. To build consensus and ownership of the agreed actions and expectations for delivery. • Timeliness of applications to court in order to secure welfare. Lack of detail and clarity in the letters to parents and what is expected of them. • A need to align EHCP plans with that of CIN and CPP. • The impact of supervisions in supporting the progressions of plans for children. • Strengthened life-story work undertaken in long-term foster care. • Addressing mental health needs of young people at risk of exploitation or going missing. Specifically for Social Workers involved in Healthy Young Minds. Not as strongly address as it is by the duty and safeguarding teams. • Around half of initial health assessments take too long. • Care plans and review meetings to identify and reference support for young people to access hobbies and interests. • Support and training for foster carers. • Leaving care and the potential for earlier allocation of personal assistants.	• Children in Care – ambition / impact. • Caseloads – knock-on effect. • Out of hours – workforce planning / contingency. • Delays – children waiting too long for initial child protection conference. Speed of assessments to match the needs of children. • Direct practice and techniques – voice of children / recording of basic personal data. • Clearer and more specific actions to address risk when reviewing CIN and child protection plans. A need for desired outcomes and timescales. • Structure of pre-proceedings work. • Arrangements in place to support children with a disability. • Permanence planning. • To achieve more sustainable relationships by reducing the 'rate of change' in social worker contact with children. • The ability of support to harness individual aspirations and educational needs. The link to achieving improved attainment outcomes. Personal Education Plans and the need to improve future connection and linkages between Children's Services and Education. Availability and access to alternative provision. • Contact centre – fit for purpose? • Managerial oversight and assurance, with regards to a small cohort of children placed in unregistered settings. • Interpretation and understanding of performance information presented to the Corporate Parenting Board. What this means for children.

Ofsted Focused Visit – May 2021 (Covid – remote visit)

What needs to improve in this area of social work practice

- Workload of social workers and personal assistants.
- Access to sufficient and suitable placements.
- Support for care leavers.
- The oversight of social work practice by all managers – to ensure there is a focus on the experiences and outcomes for children and young people.
- Senior leaders work with health partners to improve attendance at multi-agency meetings and timeliness of health assessments for children in care.

Findings

- Scrutiny by senior leaders is too focused on measuring process through performance data and overall audit grades rather than the evaluation of the experiences of children.
- The need to be more child-focused in senior leaders' approach to performance management and quality assurance.
- Although the results of audit work is collated and reported to senior leaders, these actions are often too focused on process and do not routinely have an impact for children.
- Supervision takes place regularly and provides support for social workers, but does not provide effective challenge or sufficient reflection on the quality of practice.
- When the outcome of screening is that further information-gathering is needed to inform ext steps, some children experience delay before they are provided with support from early help.
- For many strategy meetings, health colleagues are not represented, leading to gaps in some of the information available to inform decisions about the level of risk. This means that social workers and managers cannot be confident that the decisions made are appropriate.
- Changes in social worker directly impacting some children, with drift and delay in the progress of their plans.
- When children go missing, the impact of return home interviews is limited by the overly rigid use of closed questions and they do not inform future planning in a meaningful way.
- When children need to come into care, a lack of placement choice leads to some children being placed in unsuitable placements. A lack of sufficiency within the local authority's own resources, as the result of an underdeveloped fostering service, has left them over-reliant on residential provision. In addition, a small number of children with complex needs are placed in unregistered settings.
- The number of care leavers in education, training or employment remains too low and is below that of other local authorities.
- The quality of support for care leavers is significantly impacted upon by the high caseloads of the personal advisers in the leaving care team. Their basic and immediate needs are responded to, but high caseloads mean that for many, the support is overly focused on short-term problem-solving and does not demonstrate ambition to enable them to reach their full potential.

Ofsted Focused Visit – April 2022 'Front Door'

Areas for priority action

- Political and corporate leaders' understanding of the strengths and areas for improvement and for this to be underpinned by a well-informed self-assessment and improvement plan that will drive and monitor practice improvement effectively.
- Timely interventions to assess and reduce risk to children, including multi-agency strategy meetings and the allocation of a social worker to see children.

What needs to improve in this area of social work practice

- The quality and timeliness of child and family assessments to inform next steps planning.
- The effectiveness of management oversight, including the frequency and quality of supervision and the challenge of poor social work practice that causes drift and delay.
- The strategic and operational relationship with Greater Manchester police, to ensure timely engagement in child protection assessment and planning.

Findings

- Improvements include the move of the multi-agency safeguarding hub (MASH) to new premises, which has enabled the co-location of early help and MASH, the development of neighbourhood teams and the reintroduction of duty and assessment teams. Early help assessments that are completed by partner agencies have increased and schools are supported to work more closely with social workers.
- Despite recent changes, political, corporate and operational leaders do not know their services and the impact for children well enough.
- Before this visit, leaders were not fully aware of the extent and impact of repeated contacts about children, the systemic delay in convening multi-agency strategy meetings and in allocating a social worker to assess risks and needs in a timely way.
- When children are at risk of significant harm, there is a systemic delay in the process for convening strategy meetings.
- Too many children experience unnecessary delay in having their needs assessed and met. In most of the cases that inspectors reviewed, children were not allocated a social worker from the duty and assessment team in a timely way.
- The application of threshold is not always consistently applied at the front door.
- Decision-making about what happens next is not consistent and some children's cases are closed too quickly, without a comprehensive child and family assessment to fully understand their lived experiences and the potential risk they face.
- Assessments are not always timely. They lack a robust analysis, do not consider all information about families or do not always include relevant adults, including fathers and wider family members.
- Supervision for social workers in the duty and assessment teams is not always held regularly and it is not effective enough to improve children's circumstances. Records of supervision do not include reflection, review previous actions or have new actions for the social worker.