

Tameside Borough Council

Inspection of services for children in need of help and protection, children looked after and care leavers

and

Review of the effectiveness of the Local Safeguarding Children Board¹

Inspection date: 26 September 2016 to 20 October 2016

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Children's services in Tameside are inadequate		
1. Children who need help and protection		Inadequate
2. Children looked after and achieving permanence		Requires improvement
	2.1 Adoption performance	Good
	2.2 Experiences and progress of care leavers	Requires improvement
3. Leadership, management and governance		Inadequate

¹ Ofsted produces this report under its power to combine reports in accordance with section 152 of the Education and Inspections Act 2006. This report includes the report of the inspection of local authority functions carried out under section 136 of the Education and Inspections Act 2006 and the report of the review of the Local Safeguarding Children Board carried out under the Local Safeguarding Children Boards (Review) Regulations 2013.

Executive summary

Failure by the local authority to ensure sufficient capacity to meet increased levels of demand in almost all areas of the service is a primary contributory factor to the poor practice seen in this inspection. This failure has led to a workforce that is not suitably experienced, high staff turnover, and some practice that does not intervene to protect and support children when needed. As a result, there are serious and widespread failings in the help and protection that children in Tameside receive. These failings, along with services for children looked after that require improvement, represent a deterioration in the quality of service provided to children and young people since the local authority was last inspected in March 2012.

Senior leaders' actions to address high staff turnover and increased demand for services have been ineffective due to poor analysis of need to inform planning. A failure to maintain appropriate arrangements for the oversight of domestic abuse notifications from July 2016 onwards meant that an even larger number of children were experiencing unacceptable delay before their circumstances were considered by a suitably qualified and experienced social worker. While senior leaders took swift action when inspectors raised concerns, they had not detected the extent of the issues through their own quality assurance activity, which was insufficiently rigorous. This had left the local authority not knowing whether these children were safe.

For some children, poor application of thresholds resulted in: multiple repeat contacts to children's social care, children receiving services at the wrong level of need, allegations of abuse that were not investigated in accordance with statutory guidance and children at risk of child sexual exploitation receiving services that were not informed by appropriate assessments of need. As a result, the risk to these children was not adequately identified, responded to or reduced, and some remained at risk of significant harm for too long before effective action was taken. Senior leaders' initial responses to concerns raised by inspectors in individual cases did not demonstrate an understanding of the detrimental impact on children of poor practice and thresholds for intervention that are too high.

Social workers' caseloads are high, in most teams, and the work is frequently complex. This means that social workers often do not have sufficient time to understand fully and respond to children's circumstances. Turnover of staff results in some children having to tell their story repeatedly and others not having their voice heard, hindering progress in their care planning. Deficits in social work practice are not always addressed, due to ineffective management oversight in many parts of the service. For children needing help and protection, most assessments do not sufficiently address risk, resulting in poor decision making and care plans that lack focus on ensuring progress for children. When children go missing from home or care, information from return interviews is not used well to reduce risk.

Overall, performance management information is not used effectively. Inaccurate data in some parts of the service limits managers' and senior leaders' understanding of what is happening for children. Insufficient benchmarking and shortfalls in quality

assurance activity have meant that senior leaders and elected members were not fully aware of the deficits identified in this inspection, leading them to have an overly optimistic view of the services for children.

Some children receive effective early help from specialist teams within the local authority. The quality is inconsistent and, across the wider partnership, the use of the common assessment framework to prevent escalation of need is too limited. The local authority plans to introduce changes to monitor and improve standards.

Some children looked after experience good-quality assessment and effective care planning, resulting in improved outcomes, but this is not consistent for all children. Assessments are not routinely updated to take account of a child's current situation and ongoing risks. Not all children have effective permanence plans and many do not receive the support they need to improve their emotional health and well-being. The corporate parenting strategy and pledge to children who are looked after require urgently updating. The children in care council, despite good work, needs support to increase its membership and influence.

Good-quality, stable placements and strong support from the virtual school mean that many children looked after make progress in their educational attainment and attendance. Independent reviewing officers ensure that most children participate in their reviews and challenge other professionals when practice needs to improve, although this is not always effective. When children remain in their birth families, they do so informed by good-quality assessments of family members.

A specialist service for care leavers established in February 2016 is beginning to ensure some care leavers move into appropriate accommodation. However, too many care leavers do not have a pathway plan that addresses their current housing needs, and those spoken to by inspectors were unsure of their entitlements. A few care leavers aged 18 and over are placed in bed and breakfast accommodation for short periods. This is unacceptable, even in an emergency.

Services to children in need of adoption are good. This is because timely, effective work in the adoption team compensates for the previous poor experiences of children through the provision of well-planned adoptive placements and extensive ongoing adoption support. Children in private fostering arrangements have their needs responded to well. Children with disabilities receive a good-quality service from a specialist multi-agency integrated team. Senior leaders have appropriately identified some other areas of improvement. These include arrangements for the external support of newly qualified staff and reintroduction of services for children on the edge of care. However, these changes are new or are planned, and have not yet resulted in practice improvements or better outcomes for children.

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The local authority

Information about this local authority area²

Previous Ofsted inspections

- The local authority operates four children's homes. Two were judged good or outstanding at their most recent Ofsted inspection.
- The last inspection of the local authority's safeguarding arrangements was in March 2012. The local authority was judged to be adequate.
- The previous inspection of the local authority's services for children looked after was in March 2012. The local authority was judged to be good.

Local leadership

- The director of children's services (DCS) has been in post since May 2013.
- The DCS is also the executive director for people, which includes responsibility for adult services, stronger communities and education.
- The chair of the Local Safeguarding Children Board (LSCB) has been in post since January 2015. The LSCB is not shared with any other local authority.

Children living in this area

- Approximately 48,985 children and young people under the age of 18 years live in Tameside. This is 22.1% of the total population in the area.
- Approximately 23.1% of the local authority's children are living in poverty.
- The proportion of children entitled to free school meals:
 - in primary schools is 19.5% (the national average is 15.2%)
 - in secondary schools is 18.9% (the national average is 14.1%).
- Children and young people from minority ethnic groups account for 14.7% of all children living in the area, compared with 21.5% in the country as a whole.
- The largest minority ethnic groups of children and young people in the area are Asian/Asian British and mixed backgrounds.
- The proportion of children and young people with English as an additional language:
 - in primary schools is 14.2% (the national average is 20.1%)
 - in secondary schools is 12% (the national average is 15.7%).

² The local authority was given the opportunity to review this section of the report and has updated it with local unvalidated data, when this was available.

Child protection in this area

- At 30 June 2016, 1,379 children had been identified through assessment as being formally in need of a specialist children's service. This is a reduction from 1,485 at 31 March 2015.
- At 30 June 2016, 261 children and young people were the subject of a child protection plan. This is an increase from 212 at 31 March 2015.
- At 30 June 2016, three children lived in a privately arranged fostering placement.
- Since the last inspection, five serious incident notifications have been submitted to Ofsted and four serious case reviews have been completed or were ongoing at the time of the inspection.

Children looked after in this area

- At 30 June 2016, 437 are being looked after by the local authority (a rate of 89.2 per 10,000 children). This is an increase from 415 (a rate of 86 per 10,000) at 31 March 2015.
 - Of this number, 142 (or 32.49%) live outside the local authority area
 - 50 live in residential children's homes. Of these 50, 26 live outside the authority area
 - One lives in a residential special school,³ and is outside the authority area
 - 306 live with foster families, of whom 84 (27.4%) live outside the authority area
 - 36 live with parents. Seven of these 36 live outside the authority area One child is an unaccompanied asylum-seeking child.
- In the period April 2015 to March 2016:
 - There have been 16 adoptions
 - Ten children became subject of special guardianship orders
 - 122 children ceased to be looked after, of whom 6.55% subsequently returned to be looked after
 - 12 children and young people ceased to be looked after and moved on to independent living
 - 19 children and young people ceased to be looked after and are now living in houses in multiple occupation.

³ These are residential special schools that look after children for 295 days or fewer per year.

Recommendations

1. Ensure that all areas of service have sufficient staff of a suitable level of qualification and experience for the role that they are required to undertake and that their workloads are manageable.
2. 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.
3. Ensure that social work assessments include an effective consideration of history and parenting capacity that informs thorough analysis of risk and ensures that assessments are updated regularly to reflect children's changing needs and circumstances.
4. 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 a child's involvement with the local authority, including contacts within the public service hub.
5. Improve the quality of performance management reporting to senior leaders and elected members, so that they have sufficient information to benchmark improvement against clear, good practice standards.
6. Ensure that all staff receive high-quality supervision and managerial oversight at a frequency that reflects their skills and levels of experience and agree levels of external support for newly qualified staff on the assessed and supported year in employment programme.
7. Ensure that children's views and wishes are consistently gathered, recorded on files and used to inform planning.
8. Work with partners to ensure coordinated early help for a wider group of children through increased use of early help assessment and plans via the common assessment framework, and implement an effective quality assurance framework to monitor and improve the quality of work done in early help.
9. Ensure that children looked after are provided with timely services to make certain that their emotional health and well-being are promoted.
10. Ensure that when children go missing from home or care, the information gathered at return home interviews is used to inform planning effectively and reduce future risk.
11. Ensure that all care leavers have an up-to-date and good-quality pathway plan that reflects their current needs and circumstances, and that they have full information about their entitlements to support them into adult life.

12. Ensure that support to the children in care council enables effective representation of the views of children of all ages and those placed at a distance from the local authority. This should include work to ensure that the pledge to children looked after and care leavers is refreshed and communicated effectively to all children and young people.
13. Ensure that the use of bed and breakfast accommodation for care leavers aged 18 to 25 ceases.
14. Review and update the corporate parenting strategy to give clarity to the work of the board and ensure that this is shared across the partnership, so that external scrutiny can support improvement in services for children looked after.

Summary for children and young people

- Services for children in Tameside have become worse since Ofsted last inspected it. Social workers try very hard to help children, but they are given too many children to support to do the job well. This means that children do not always receive the right help as quickly as they should, and sometimes their problems grow more serious before they receive the services that they need.
- Although there are some good services to help families that are experiencing domestic abuse, the police do not always tell social workers about children living with domestic abuse soon enough and workers take too long before they offer children a service.
- Social workers, who have lots of children to support, do not always have enough time to get to know children and their families well. Children often have too many changes of worker. These changes make it difficult for children to tell social workers about the important things that have happened to them. This makes it difficult for social workers to make good plans to help them.
- Managers do not always make sure that social workers have the advice and support that they need to do a good job. Sometimes, they do not realise quickly enough when they need to do more to help the children.
- Children often wait too long to get help to improve their emotional health. Sometimes they do not receive help at all. Leaders in the council know this and they are working hard with health services to make things better.
- Children looked after do not receive enough help to understand their life story. Most children who are looked after live close to their family and friends. They live with good carers who know and take care of them well, and are helped to do well in school.
- Most care leavers live in good housing where they feel safe, but sometimes older care leavers, when they do not have a place to go, are placed in temporary bed and breakfast accommodation. This is not suitable, even in an emergency.
- The children in care council does a good job, but it needs more members. The council needs to do more to make sure that all children know their rights and get a chance to have their say.
- Children who are adopted and their families get good help to sort out any problems quickly.

<p>The experiences and progress of children who need help and protection</p>	<p>Inadequate</p>
<p>Summary</p> <p>Serious and widespread failings in services to children in need of help and protection in Tameside mean that they are inadequate. Children do not receive timely help, due to the inappropriate application of thresholds, leaving some children at risk of significant harm for too long before effective action is taken to help them. Too many children who need a social work assessment are referred multiple times by partner agencies before they receive a service. A lack of capacity in the multi-agency public service hub and in some social work teams means that most children experience drift and delay because requests for services are not screened, responded to or allocated for assessment in a timely way, including children assessed by police as at medium risk of domestic abuse.</p> <p>A failure to investigate allegations of abuse consistently in accordance with statutory guidance results in some children not being seen or spoken to, or assessments not completed to evaluate risk. Risk not being adequately assessed or responded to at the right threshold level limits the positive impact of the support services that are provided to children at risk of sexual exploitation. Assessments that do not effectively consider history, parental capacity or analyse risk lead to care plans that are insufficiently focused on the key issues and that do not robustly monitor progress or evaluate change. When children go missing from home, the information from return home interviews is not used well to inform plans to reduce risk.</p> <p>High caseloads and turnover of staff prevent regular direct work with children and hinder the development of a meaningful relationship between social workers and families, leading to further drift and delay.</p> <p>A specialist, integrated service for children with disabilities, with stable staffing and management, delivers better quality assessments and care planning for this group of children. Effective assessment and support from a named worker for a small number of children living in private fostering arrangements ensure that their needs are met. Young people who present as homeless receive appropriate services, including consideration of becoming children looked after.</p> <p>A wide range of early help services and specialist early help teams provide effective support to some families and prevent further escalation of need. However, positive impact is limited by insufficient use of the common assessment framework (CAF) across the wider partnership and by the inconsistent quality of assessments and reviews of many plans. The local authority has responded to this gap by establishing two CAF adviser posts to advise and promote CAF with partners, in addition to developing a quality assurance function.</p>	

Inspection findings

15. In Tameside, the application of thresholds and management of risk for children in need of help and protection are inadequate. Children do not receive the appropriate level of support to meet their needs, and experience drift and delay at all stages of their journey, with some children being left for too long at continued risk of significant harm. (Recommendation)
16. The lack of sufficient capacity and effective management oversight within the public service hub lead to drift and delay for children, many of whom are referred to children's social care multiple times before they receive a service. When risk to children is identified at the point of referral or they make allegations of abuse, this does not always result in effective assessment of risk.
17. During the inspection, HMI referred 15 children to the local authority because of concerns about thresholds being applied correctly. As a result, the local authority took action for 12 children that included reopening cases, undertaking visits, undertaking assessments, holding child protection conferences, arranging multi-agency meetings and, in one case, planning to hold a multi-agency learning review.
18. Children referred for services experience serious and widespread delay in decision making about service provision. The multi-agency public service hub lacks sufficient suitably experienced social work and management capacity to deal with the volume of work. At the point of inspection, there were over 350 children recorded as contacts to the hub who were waiting for a decision. In addition, over 150 children who were the subject of medium risk domestic abuse notifications from the police were also waiting for screening and risk assessment. Delays for children ranged from weeks up to two months, with many having no assessment of risk or need. This is in addition to the delay in the police sending notifications to the hub, and examples were seen of incidents taking place several weeks prior to notifications being processed. (Recommendation)
19. When brought to the attention of the local authority, an immediate review was conducted which found that, while no children waiting for a decision were at risk of immediate harm, a number required referral for social work assessment. Action taken by the local authority during the inspection, with the provision of additional resources, reduced the volume of children waiting for a service but did not resolve it.
20. Children who meet the threshold for social work intervention are not responded to early enough and, as a result, experience delay and some children experience further harm. While local authority data suggests that the number and rate of re-referrals in Tameside has decreased over the past year

(at 15%, it is lower than comparators at 21% and England 24%), an analysis of Annexe A data provided for inspection shows that the number of repeat contacts is high. In the three months prior to the inspection, 2,527 children were the subject of a contact to the public service hub. Of these, 365 children had two contacts within three months, 88 children had three contacts within three months and 28 children had four contacts within three months. The local authority had not analysed this data or identified the issues that led to repeat contacts to the service, instead assuming that this was the result of inappropriate requests for information rather than a service. In all cases sampled by inspectors, repeat contacts were requests for services to help children, not requests for information.

21. The local authority does not consistently adhere to child protection procedures or meet statutory requirements when responding to children making allegations of abuse. Examples seen included no direct contact at all made with children or young people, visits to children but no assessment completed and an assessment completed but no strategy meeting or section 47 investigation. This results in inconsistent and poor-quality assessment of risk, and leaves some children at risk of further harm. (Recommendation)
22. When section 47 enquiries are undertaken, the majority are informed by multi-agency strategy meetings. Decisions made at this stage are proportionate, leading to appropriate action to protect children, although the records of the discussion remain variable in quality.
23. There is no formal arrangement to ensure that the out-of-hours service has timely access to legal advice or support from senior managers, when required. Despite this, when children need social work support outside normal office hours, competent and experienced workers work closely in partnership with the police and ensure that children are safeguarded. Because of a recent review, the local authority plans changes which, it anticipates, will strengthen arrangements.
24. The majority of assessments of need are not effective, with many lacking sufficient detail, not addressing previous issues of neglect or domestic abuse and with insufficient consideration of history or evaluation of risk. There is also evidence of unchallenged self-reporting of parents being a determining factor in the outcome of an assessment, rather than the independent analytical inquiry of social workers. This means that, for many children, there is not a full understanding of their circumstances and risks remain inadequately assessed. (Recommendation)
25. The support to children with multiple and complex disabilities is stronger. Children are well supported and their needs recognised through the work of the integrated service for children with additional needs. Children in this team receive a high-quality service that is sensitive to individual needs. Assessments are multi-agency and plans include efforts to gather children's views and

wishes and meet them. There is evidence of planned multi-agency responses and positive joint work with safeguarding teams.

26. Consideration of children's diversity needs is inconsistent. While, for some children, there is evidence of sensitive consideration of their sexuality or impact of their disability, for other children issues of diversity in relation to the impact of parental mental health are absent, and for many White British children there is no acknowledgement or exploration of their diversity needs.
27. Children's views and wishes are not consistently gathered or recorded on files. For most children, there is evidence of social workers making efforts to engage with them through regular visits, although the frequency is often limited due to high caseloads. The use of direct work tools to aid communication with children or inform planning is not consistent. For some children, even when their views are known and documented, these are not used to influence plans. (Recommendation)
28. At the point of inspection, 263 children were subject to child protection plans, which represents a substantial increase of 51 children since March 2015. Children at risk of neglect remain the largest group (52%), with increasing numbers of children at risk because of emotional abuse (37%). The majority of children's plans are not of good quality, and they are narrowly focused on the presenting issues rather than fully addressing all the needs of children. Progress is often limited, with actions not achieved, and work continues without re-assessment or analysis of change. This results in delay for children, particularly for those at risk from neglect, with some children remaining on a child protection plan for too long before progressing into pre-proceedings or becoming looked after.
29. Regular core groups attended by a range of appropriate professionals monitor the progress of children subject to child protection plans. The poor quality of assessments and subsequent plans for children result in core groups offering support to families but not being sufficiently focused on evaluating progress or reducing risk. Child protection reviews are timely, and are attended by relevant agencies and family. Chairs of child protection conferences identify and challenge delay for some children that result in plans being progressed for consideration of legal action.
30. Child protection conference and reviews do not include adequate participation or attendance of children and young people. The current system in place to gather children's views is not well used, and not enough children have access to advocates to support participation. Local authority data since April 2016 shows that, of 167 children aged over 11 years, only 31 provided their views and only 13 attended their child protection conference supported by an advocate. The local authority has recognised this and recommissioned its advocacy service. The new provider started in August 2016, so the impact was limited at the time of the inspection.

31. Early help services in Tameside offer different levels of support and a good range of services for children and families that are delivered via seven children's centres and four family intervention teams located in the areas of most need in the borough. A range of evidence-based interventions designed to offer time-limited support for families is an attempt to manage demand. Despite this, there remains a waiting list for some services, resulting in many children not getting the benefit of this support early enough.
32. The common assessment framework (CAF) is not well embedded outside of these early help teams. CAFs completed by other lead professionals are not recorded or monitored in terms of numbers, quality or outcomes, therefore local authority managers and the wider partnership do not know how effective CAF is in supporting families and preventing escalation of their needs. There were 238 CAFs completed in the six months prior to inspection, with the vast majority of these completed by local authority early help staff who are based in children's centre or family intervention teams. (Recommendation)
33. The quality of early help assessments is not consistently good, because of insufficient consideration of the impact of parenting capacity on children, in addition to strengths and needs not being identified for every child or family. The vast majority of assessments reflected views of children, but contained no information or analysis regarding their diversity needs, including children from minority ethnic backgrounds. Progress of intervention is not adequately analysed or understood, because effective reviews do not take place for the majority of plans.
34. When children have returned after being missing from home, they are visited by the police. The police undertake 'safe and well' checks, and ensure notification of the episode to the local authority and directly to the commissioned provider to undertake return home interviews. The local authority does not have accurate data about the completion of return home interviews. Inspectors found that most return home interviews are available on children's files, but the information gathered does not inform plans to reduce risk or address the underlying factors that led to the 'missing' episode. A regular meeting to monitor closely the response to children who go missing in each two-week period, which also includes those missing from education, ensures that the short-term response is monitored.
35. The local authority has not had an overview of all those who go missing that is informed by reliable or effective data and, as a result, the wider picture and longer-term response is not clear. A recently recommissioned service to undertake return interviews is reported to be improving timeliness and the numbers of interviews completed, and the local authority anticipates that this will in future provide more effective performance information to inform its understanding of those children who go missing.
36. Tameside's established specialist team (Phoenix) responds to cases of child sexual exploitation, providing a range of education and awareness-raising and

direct work with young people, in addition to pursuing criminal investigations. As a result, professionals recognise child sexual exploitation, respond and make referrals to Phoenix to ensure that young people receive support. However, confusion about the role of the specialist team, combined with a lack of understanding and application of thresholds, results in many children not having an assessment of their needs and risks by the safeguarding social work team. The response is often not at the right level of need and the risk is not effectively reduced, despite provision of support services. All cases when young people were referred back to the local authority, due to concerns that the risks they were experiencing due to sexual exploitation were not being reduced, resulted in an escalation of service.

37. A named officer for children missing from education ensures that the local authority holds up-to-date and accurate information on these children. At the time of the inspection, there were 97 open cases of children missing from education. Clear guidance and procedures are in place that support staff well in carrying out their duties. Staff are persistent and determined in their efforts to identify the whereabouts of children missing education and evidence their efforts to identify, track and work with these children and those families that choose to provide elective home education. Evidence of effective multi-agency working and liaison results in the increasing identification of those missing education.
38. Staff work effectively to engage families that choose to educate their children at home, visiting the majority of children to assess the suitability of the education that they are receiving. In one case, sampled staff had successfully brokered work experience and support from CAMHS to improve the child's self-esteem and had successfully developed the child's career aspirations.
39. A multi-agency risk assessment conference (MARAC) ensures that the response to families affected by high-risk domestic abuse is coordinated. The social care representative updates the panel and children's case records, ensuring that information is appropriately shared. A good range of services to support children and families affected by domestic abuse is available, provided by a commissioned specialist service. However, social work with children at risk from domestic abuse demonstrates the same weaknesses in social work practice as in other areas of service. Poor quality assessments, inadequate analysis of risk and poor application of thresholds limit the impact of the support services with children experiencing drift and delay before their situation improves. This reduces the effectiveness of otherwise good information sharing within MARAC.
40. Effective assessments conducted by a dedicated housing social worker in conjunction with a housing officer ensure appropriate services to young people aged 16 and 17 presenting as homelessness, in most cases. Outcomes and offers of accommodation consider young people's needs and vulnerabilities with many young people placed as children looked after when appropriate.

41. Numbers of children privately fostered remain low despite a wide range of awareness raising activity, extensive training and the production of an updated leaflet during 2016. A dedicated worker for private fostering and improved referral pathways ensures that the response to children when identified is timely, with statutory checks undertaken, appropriate assessments completed and subsequent visits undertaken in line with requirements.
42. The competent and experienced designated officer is effective in ensuring that the authority fulfils its duties in relation to allegations of abuse, mistreatment or poor practice by adults who work with children. In addition to managing allegations and ensuring investigations are undertaken, good support and consultation, training, advice and guidance are given to professionals where required.
43. While not a priority 'Prevent' area, the local authority's and partner agencies' responses to the prevention of radicalisation in all its forms are thorough, proportionate and well informed by local intelligence, national guidance and local best practice. A well-established Channel panel considers support for young people who may be at risk of radicalisation. Agencies such as schools report greater confidence in identifying young people vulnerable to extremism because of a wide range of good-quality training and awareness-raising events coordinated by the Local Safeguarding Children Board.

<p>The experiences and progress of children looked after and achieving permanence</p>	<p>Requires improvement</p>
<p>Summary</p> <p>When children in Tameside are looked after, most of them live close to their communities in stable, good-quality placements with foster carers who know them well. Most attend good schools, where support from the virtual school helps to improve their attendance and attainment. The difference in attainment between some children looked after and their peers is diminishing.</p> <p>The quality of assessment and planning to support children is not consistently good. While the work done for applications in court is stronger and in most cases timely, for other children looked after the fact that the assessments and chronologies are not routinely updated means that their changing circumstances and risks are not re-evaluated. Children’s care plans are not always specific enough about the things that need to happen, including arrangements for contact. Children do not have timely access to a sufficient amount and range of services to support their emotional well-being.</p> <p>Children’s reviews mostly take place on time, and good support ensures that the majority of children participate in their review. While most children have stability in their lives, not all children have a plan for permanence recorded by their second review, resulting in delay in finalising decisions about their future. Efforts to complete return home interviews for children looked after result in some information gathering, but do not always sufficiently inform further care planning. When children looked after are at risk of sexual exploitation, they receive appropriate services to help to reduce risk.</p> <p>Social workers’ caseloads are too high. This means that although they visit children in line with statutory guidelines, they do not have time to visit more frequently if needed or spend time with children to undertake direct work sessions, including life-story work.</p> <p>Adoption is considered in an appropriate and timely manner for all children who may benefit. Parallel planning and fostering to adopt are effective, and comprehensive assessments of children and adopters enable suitable matching.</p> <p>Social workers and personal advisers have more regular contact with most care leavers than they did previously, and support for those with complex disabilities is a strength. The range of housing options is improving, but some young people over 18 years live in bed and breakfast accommodation for short periods. This is unacceptable. Too many young people do not have a written, up-to-date pathway plan that details the support that they will receive, and those care leavers spoken to by inspectors were unsure of their entitlements.</p>	

Inspection findings

44. Some children live in situations of neglect for too long before becoming looked after, as a result of drift and delay in securing services for children in need of help and protection. When children are not at immediate risk, there is an insufficient range of effective services to support them to stay with their families. The rise in the number of children looked after mirrors the general increase in the region, with 445 children looked after at the point of inspection, an increase of 30 children since March 2015. A number of projects designed to support children remaining with their families, such as family group meetings, are being re-established. However, this work has been progressed too slowly and children are not yet benefiting from these services.
45. While children's safeguarding needs that result in them becoming looked after are responded to well, ongoing and emerging factors detrimental to children's well-being, such as the risk of placement breakdown, are not as well considered. Some children at risk of self-harm and other behavioural problems experience delay in accessing bespoke therapeutic work, which is limited in range and availability. (Recommendation)
46. Improved tracking and monitoring of cases within the Public Law Outline (PLO) are helping to identify potential delay and take action more quickly. Some cases in PLO do not have a clear plan about what needs to happen and, although inspectors saw some examples of good multi-agency packages of work making a difference for children, this is not happening in every case. Letters issued to parents prior to proceedings clearly explain the local authority's expectations of them. Additional meetings held with parents and their solicitor further clarify concerns and agree timescales for change. Parents spoken to by inspectors said that they understood the processes. Viability assessments of different family members, undertaken concurrently in the majority of cases, avoid further delay for children.
47. A proactive legal department ensures that consistently good-quality assessments and evidence are produced for court proceedings. The Children and Family Court Advisory Service (Cafcass) and the court are confident in the quality of work produced by Tameside and report that timeliness of proceedings has improved significantly, now taking an average of 27 weeks to complete, which is in line with performance in the region.
48. When children looked after need access to more specialist services, the assessments are updated, thorough and well written. For some children looked after who are not the subject of care proceedings or in need of specialist services, the assessments are significantly out of date, some by several years, and as a result the impact of current situations and important changes for children are not evaluated to inform their care planning. Chronologies are of poor quality and do not inform plans or capture the most important events in children's lives. (Recommendation)

49. Care plans require improvement. Most care planning documents reflect children's current circumstances but do not consistently provide sufficient analysis of children's needs, and some lack clear, measurable goals and timescales. Plans do not always specify clear arrangements for contact between children and their families, and rely on carers to promote contact without support from the local authority. For some children, this has resulted in them not being able to see their brothers and sisters as often as they would like. (Recommendation)
50. Diversity and identity needs arising from disability and ethnicity are responded to in a sensitive way. Assessments of need for children with disabilities thoroughly explore the relevant issues, and there are good arrangements in place for children making the transition to adult social care. Consideration of wider diversity needs such as faith, gender and sexual orientation is not as effective, especially for White British children.
51. Good efforts made to complete return interviews for children in care who go missing do not always result in effective use of this information to inform care planning. The response to children who go missing from care in each two-week period is monitored as part of the regular 'missing meeting', but local authority data does not yet provide an accurate overview of patterns or trends. When children are at risk of sexual exploitation, the response is more robust and, for the majority of children looked after, risk from sexual exploitation is recognised and addressed. A screening tool used to identify the specific issues and level of risk for individual children informs access to an effective range of help and support from a specialist team.
52. Visits to children are in line with statutory requirements and social workers are seeing children alone, when appropriate. However, the views of children are not always explicit in decision-making processes and advocacy is not routinely available to help children to express their wishes. (Recommendation)
53. The timeliness and quality of children looked after reviews is inconsistent, with only 88% of children's reviews currently taking place on time. The independent reviewing officer footprint is evident on many children's files, with individual challenges recorded, including the use of the escalation policy, but it is not clear what learning or changes to practice occur as a result of the issues raised. The majority of children participate in their review in some way, using an impressive range of creative activities including artwork and games.
54. Social workers routinely consider ways to support children to remain in their birth families through placement with extended family members and connected persons. Viability assessments are thorough and clearly focused on the needs of children. When there is consideration given to placing children back with their parents, the work is not as strong. Assessments of parental capacity are not always robust and, for a very small number of children, situations deteriorate following their placement.

55. Most children looked after (70%) live with foster carers and have the opportunity to enjoy family life. Brothers and sisters are placed together in the vast majority of cases, when a plan is made for them to do so. The majority of children (67%) continue to live in Tameside, which makes it easier to maintain contact with family and friends in the community. The percentage of children looked after that is placed at more than 20 miles from home is low, at 6%, better than comparators, at 12%, and the England level, at 14%.
56. Most children live in stable placements. The number of children who had experienced three placements or more was 10% in 2014–15. This performance is in line with national and comparator levels, and means that children do not experience too many unnecessary moves. Tameside’s directorate report shows that, for 2015–16, the percentage of children experiencing three or more placements was 8.7%, which is an improvement in performance on the previous year. The 2014–15 published data for the percentage of children looked after in the same placement for at least two years is 72% in Tameside, which is higher than comparators at 68%, and provides many children with the opportunity to build long-lasting relationships with their carers. Completion of life-story work is not routine for children in long-term foster placements, which means that children have gaps in information about their histories.
57. Permanence plans for children who are not going to be adopted are not always recorded at the second care planning review meeting, creating delay for some children, who wait too long before decisions are made about routes to permanence. At the point of inspection, only 8% of children ceased to be looked after because they became the subject of a special guardianship order. This is a small increase from 7% in 2014–15, but still lower than both comparators (15%) and England average (11%). (Recommendation)
58. The local authority has taken action to improve the suitability and sufficiency of placements by introducing during 2016 a ‘payment for skills’ scheme for foster carers. Despite consultation and meetings that have taken place, some foster carers told inspectors that they do not fully understand the changes implemented in July and are concerned about future arrangements. The wide range of training available for carers is difficult for some carers to access, due to oversubscription. Foster carers feel supported by their supervising social workers, but felt that staff turnover impacted on the relationships with children’s social workers, who were also sometimes hard to contact and did not always have the time to come to know children well.
59. The virtual school maintains an oversight of the educational progress of children looked after. Most of these children attend schools that are judged good or better by Ofsted. Regular meetings with partners and good information exchange ensure the identification of deteriorating performance and the plans that are put in place to address concerns. The monitoring of children’s attendance has also improved and, in most cases, attendance at school is good, with the virtual school working effectively to keep children in school. In a context of rising permanent exclusions in Tameside, there have

been no permanent exclusions of children looked after in the past 12 months. The use of fixed-term exclusions is also decreasing.

60. Social workers have detailed knowledge of the small number (14) of children who attend alternative provision, and work hard with partners such as the pupil referral service and schools to put in place individual packages of support and education to engage them.
61. At key stage 1, those children looked after who took tests in 2015 achieved less well in reading and mathematics than in writing. At key stage 2, attainment is often in line with or better than children looked after nationally. At key stage 4, nearly a third of children looked after obtained five GCSEs or more including English and mathematics in 2015. The difference in attainment between children looked after and their peers is diminishing in Tameside, and some children looked after make good progress from their starting points. Inspectors saw good examples of the pupil premium being used well to support the attendance and progress of children looked after. This includes providing additional staff to support behaviour improvement and to provide counselling for children.
62. Not all children looked after have an up-to-date personal education plan (PEP), with both quality and timeliness requiring improvement. The completion rate of PEPs has improved since 2014, but remains too low, with over a quarter of children without a current PEP at the point of the inspection (28%). Plans have sufficient detail to help to review children's progress and plan their next steps, but for some children it is hard to determine the progress that they are making.
63. The promotion of the health of children looked after varies, and it is not consistently good. The local authority has recognised this and worked with health partners to improve performance. However, the proportion of children having dental checks, at 74.8%, is comparable to previous years and requires improvement. The local authority reports that the performance in respect of the number of children having timely health assessments in the past 12 months has improved, but is not yet good. Some 77.5% of children under five, 89% of children aged five to 15 and 85.9% of children over the age of 16 have their health assessments completed within the timescales.
64. A community paediatrician completes all initial health assessments, while other health professionals carry out reviews, with the quality overseen by the named nurse for children looked after children. There are reciprocal arrangements for Tameside children placed in other areas in Greater Manchester to ensure that their health assessments and reviews take place on time. Despite this, according to information provided by the local authority, the timeliness of initial health assessments is poor. In quarter one of 2016–17, 75% of children did not have an initial health assessment within the expected timescales.

65. Many children looked after with additional needs associated with their emotional health and well-being do not receive effective or timely support. Strengths and difficulties assessments are routinely completed and scored before review by a community paediatric nurse who will consider making a referral to child and adolescent mental health service (CAMHS). Children often wait too long for a service, and the support for children with lower-level emotional health needs is not well developed or coordinated. (Recommendation)
66. The recent appointment of a dedicated psychologist for children looked after has had a positive impact on the timeliness of triage referrals to CAMHS and a stronger offer of consultation to social workers. The commissioning of individually tailored packages of therapeutic services happens for a very small number of children with specific needs, and there is effective use of the adoption support fund to provide therapeutic work for adopted children.
67. Despite the efforts of a longstanding and dedicated chair, the children in care council has not been provided with sufficient support by the local authority to develop and expand its membership to ensure wide representation from all children looked after. The limited membership prevents the council from informing and influencing effectively the work done with children looked after. Children are not clear of policies that affect them and do not know about the local authority pledge to the children in their care. (Recommendation)

<p>The graded judgement for adoption performance is that it is good</p>

68. The involvement of the adoption team, from the first legal planning meeting, and the early allocation of an adoption worker enable parallel planning and speed up the overall adoption process. Children and their social workers benefit from a skilled, knowledgeable, stable and experienced adoption team with a passion for permanence.
69. The number of children successfully adopted in the 12 months prior to the inspection (17% of all children leaving care) is in line with the national average. Targeting the traditionally more difficult to place children is achieving success. Older children aged five- to nine-years-old make up 28% of this group, and brother and sister groups represent 42% of all children placed for adoption in 2015–16. Although fluctuating, the number of children leaving care via adoption from minority ethnic groups or with complex disabilities remains low. Recent success in recruiting more adopters for children from these groups should increase the number of children who can be offered adoption as an alternative to long-term care.
70. Timescales for achieving adoption continue to improve. The 2012–15 adoption scorecard shows that it took on average 529 days between a child in Tameside becoming looked after and being placed with their adoptive family. Although

not yet meeting the national threshold of 487 days, this is better than the England average (593 days). The latest published data for 2014–15 shows a further drop in the days taken, to 499, and the most recent data seen at the inspection shows this trend continuing. The increase in the number of children who wait less than 16 months between entering care and moving to their adoptive family demonstrates the extent of the improvement in the past 12 months. Of the 37 children placed for adoption within the past 12 months, 73% were placed within 16 months.

71. Good use is made of parallel planning and the increasing availability of 'foster to adopt' placements. The inspection looked at the data for 54 children at various stages of their adoption journey. On average, the decision that a child should be adopted took longer than usual, but with good timescales being achieved once the decision had been made and the adoption team involved.
72. The adoption team undertakes all assessments of children and prospective adopters. All those seen as part of the inspection were of good quality, including reflection on the identity, faith and ethnic background of those assessed. Prospective adopters' assessments all give a clear understanding of an individual's or couple's readiness to adopt. Child permanence reports seen gave a real sense of the child. They reflect the social workers' knowledge of the child, painting a picture for any prospective adopter of their needs, history and personality. The vast majority of child permanence reports are regularly updated. This is important, especially for very young children, who change quickly over a short period.
73. The vast majority of case records and files seen by the adoption team were of good quality. However, the current electronic recording system does not fully support the work of the adoption team, for example with the storage of prospective adopters' records and the production of the management data required to meet the adoption standards and regulations. To compensate for this, the team keeps additional manual paper files and records data on spreadsheets. This creates additional work and introduces a greater risk of human error.
74. The current well-focused adoption recruitment strategy meets the needs of children awaiting placement. Adopters spoke highly of the timely, well-planned induction that they had received, which leads to adopters who are well prepared and understand the challenges that they may face when adopting. There have been 27 prospective adopters approved in the past 12 months, with almost all assessments completed within the required timescales. Once approved, the wait for a child to be placed is short, with most adopters (63%) having a child placed with them within six months.
75. Adoption disruptions are rare, with just one disruption in the past 12 months, which involved Tameside adopters being matched with a child from another local authority some considerable distance away. While not identifying

significant gaps in Tameside practice, the learning from a disruption review is being used positively to support learning and improvement.

76. The adoption panel meets regularly and considers with care the cases presented, appropriately checking and challenging to ensure that the recommendations to the agency decision maker are well thought through. The minutes of the panel reflect the richness of the debate. However, a number of panel minutes signed off by the panel chair and the agency decision maker contain inaccuracies regarding the roles of the panel members. The authority is reviewing all the panel minutes produced over this period and reissuing any that are inaccurate. (Recommendation)
77. Children age two and over who could benefit are offered direct work in preparation for adoption. Child appreciation days ensure that prospective adopters really understand the child's journey so far. The effort made to include all those with knowledge of the child enhances this work. Preparation and support are offered to birth brothers and sisters and parents of children being placed for adoption.
78. At the start of this inspection, some children had experienced a delay of three to four months in the production of their final life-story book, due to staff absence in the adoption team. Action has been taken to resolve this issue, with an agreement in place to have an additional resource to tackle the delay quickly. Later-life letters prepared for the children's file by the adoption social worker are well-balanced, giving a detailed account of the child's life and family history up to the time of adoption.
79. Well-planned packages of adoption support, informed by comprehensive assessments of need, provide a service to a wide range of individuals who have experienced adoption. Assessments and therapeutic inputs are commissioned, following successful applications to the adoption support fund. There have been applications for 31 children since December 2015. In addition, individual support sessions and direct work have been delivered to 65 families by staff employed by Tameside.
80. Experienced support staff actively help adopted adults to understand their histories as part of adult birth record counselling. A voluntary group, run with the support of the adoption team by Tameside adopters, supports 104 families with advice and the opportunity to share. The group also provides feedback about services and ensures that adopters are engaged in the development of policy and the regional adoption agency plans. The adoption team remains in contact with as many families as possible, and 161 families are annually invited to two events, both of which have good attendance. Adopted children aged four to 18 have their own club, 'Club Awesome', which meets monthly.

The graded judgement about the experience and progress of care leavers is that it requires improvement

81. Since February 2016, a re-established leaving care service has made improvements to the previously poor-quality service provided for care leavers. Staff are working hard to form positive relationships with the young people who are on their caseloads. Some young people have well-established involvement with workers, and the support provided now means that basic housing and health provision are available for care leavers, in addition to good support to enable them to further their career aspirations. For other young people, support has recently become more consistent now that the service is fully staffed. Young people who receive regular help from staff are positive about the help and support that they receive. The caseloads of personal advisers are too high, and this means that it is hard for them to develop meaningful relationships with all young people.
82. The local authority is in touch with most young people leaving care. At the time of the inspection, the proportion of 19- to 20- and 21-year-olds with whom the local authority was not in touch was 9%, equating to 12 young people. Inspectors saw that personal advisers are making all reasonable efforts to contact these young people to good effect. These include unannounced visits to known addresses, contact by text and telephone, and via family members and known friends. Young people who had recent contact after a period of not being in touch were positive about and welcomed the support that they are now receiving.
83. Not enough (35%) care leavers have an up-to-date pathway plan that reflects their current needs. When young people do not have an up-to-date plan, the impact is mitigated to an extent, because the support offered reflects current needs and circumstances. However, not all young people spoken to by inspectors were sufficiently clear about the level of support that they could expect, including financial support. In a minority of cases, poorer pathway plans rely too much on young people to complete tasks themselves, without identified support from staff. The team is working to address this deficiency.
84. The children with disabilities team works successfully with care leavers with disabilities. Effective arrangements are in place that offer good support for young people's transition to adult services. Pathway planning for this group is timely and covers young people's wide-ranging needs, including their health, education and accommodation. The independence of young people is promoted and a strong partnership with the local leisure services provider supports the education and employment aspirations of young people effectively. Of the last 15 young people to take part in the supported internship programme, 13 have secured paid employment.
85. The local authority has been successful in extending the range of accommodation options open to young people leaving care, and the range of

housing options available to young people is improving. The proportion of young people staying put with their foster carers when they turn 18 years old has increased and, in 2015–16, 85% stayed. The number of supported lodgings available has increased from four to 13 over the past year, and most young people who use these placements achieve successful outcomes as a result.

86. A bedsit scheme, developed to support care leavers who are moving on from residential or foster care, offers a further period of support to help them through their transition to adulthood. The accommodation seen by inspectors is of good quality and young people show pride in their first home. They receive a high level of effective support to help them to budget for their household expenses, find employment or training and take part in social activities. Timely work ensures that young people who are ready to live independently are in a position to bid for their own tenancy when they turn 18.
87. Most young people receive the support that they need to develop their skills to live independently through their foster carers, personal advisers and social workers. A training programme developed for foster carers can further equip young people with the skills to live independently. A small number of young people have successfully completed a series of six-week workshops to help them to budget and manage their own tenancy effectively.
88. Bed and breakfast accommodation is used in an emergency for short periods, for those aged over 18, without sufficient due consideration or action taken to mitigate the potential risk. This leaves young people highly vulnerable. The use of bed and breakfast accommodation is unacceptable under any circumstances. In cases sampled by inspectors where bed and breakfast accommodation had been used, young people were quickly found long-term housing options that were appropriate to their needs. Young people told inspectors that they felt safe where they lived.
89. Young people receive a range of support to help them to achieve their education, training and employment aspirations. Referrals to the specialist careers organisation are increasing, resulting in a greater availability of specialist support and guidance for young people. Published performance data shows that around four out of 10 care leavers do not have an education, training or employment placement, which is in line with national averages and better than comparators, yet requires improvement. Inspectors saw examples where good support, such as volunteering opportunities, increased young people's work-readiness for full-time employment.
90. The virtual school has recently begun to promote university as an option for young people by holding a promotional evening at Manchester Metropolitan University. A small number of care leavers are in higher education and a reasonable package of financial support is available to them, such as a £2,000 bursary which matches minimum recommended standards, a laptop and book allowance, and accommodation costs. Young people receive a reasonable

range of other financial support to help them to take practical steps forward, such as the leaving care grant of £2,000 to help them to equip their first home. Discretionary support is available to help young people, for example to present well at interviews, pay for travel costs and provide bridging payments in lieu of receiving benefits. Another example seen showed a discretionary payment helpfully topping up a young person's apprenticeship wage to enable them to maintain their accommodation. Despite this, not all young people are fully aware of their entitlements to financial support. (Recommendation)

91. Young people have their basic health needs met, with personal advisers and social workers offering good practical support to young people to help them to access the adult community mental health team, such as accompanying young people to their doctor and mental health appointments. Having free passes to the council's leisure centres and facilities also promotes the physical health of care leavers, and a team of care leavers was recently a runner up in the North West five-a-side care leavers' football competition.
92. The co-location of the leaving care team with the sexual health team and drugs and substance misuse workers enables easier access to specialist health advice and support for young people. The health passport, updated in April 2016 and shared with young people at their final health assessment, is still not widely understood, with many young people spoken to by inspectors stating that they had no knowledge of it.
93. There are very few incidents when care leavers have complained about aspects of the service or support that they receive. Inspectors saw some examples when staff 'go the extra mile' to resolve young people's concerns. However, young people spoken to by inspectors said that they did not know how to complain formally, should they be dissatisfied with aspects of the support.

Leadership, management and governance	Inadequate
<p>Summary</p> <p>A corporate failure to ensure a sufficient, stable, workforce that is suitably experienced to meet demand for services, including in some cases where the thresholds for intervention has been unacceptably high, has led to serious and widespread failings. These failings compromise many aspects of work with children, including the timely delivery of some otherwise good-quality services, such as in relation to domestic abuse. As a result, services for children have significantly deteriorated since the local authority was last inspected.</p> <p>High caseloads and staff turnover mean that an often inexperienced workforce does not give children the level of service or continuity that they require, and frontline managers do not always give staff the level of managerial oversight and supervision that they need to ensure a safe service. While most starkly evident within the local authority public service hub and safeguarding duty team, these issues are widespread across the service. They result in thresholds for intervention that are too high and children waiting too long to receive an acceptable response to their needs. Senior leaders were not aware of the extent of the delays until informed by inspectors.</p> <p>While the local authority has demonstrated an appropriate commitment to improving practice through workforce development opportunities and increased staffing, the action to date has been insufficient and, in some instances, has exacerbated problems. This has been due to poor risk assessment and forward planning. Delays in the arrangements to support newly qualified social workers to complete their assessed and supported year in employment mean that the support given does not yet meet acceptable standards.</p> <p>Insufficient quality assurance of work by senior managers in key areas of the service means that they have an over-optimistic view of the quality and timeliness of the help that children receive. Their initial responses to concerns raised by inspectors in individual cases did not sufficiently recognise and respond to risk.</p> <p>Reporting of performance to senior leaders and elected members has significant gaps. It lacks helpful analysis, sufficient benchmarking and measures against a standard of what 'good' should look like for children in Tameside. This does not assist them to understand fully the practice on the frontline or to communicate clear expectations to staff. The rigour of scrutiny arrangements is limited yet more by the wide remits held by the lead member and the scrutiny panel.</p> <p>While the local authority has comprehensive strategic plans to address some of the deficits seen in this inspection, these are not successfully implemented and, at the time of the inspection, had not been translated into good and safe services for all children in Tameside.</p>	

Inspection findings

94. Since the safeguarding and looked after children inspection in 2012, the services for children requiring help and protection have declined. During this period, demand for services has increased steadily and significantly. The local authority has responded to this challenge through relocation of staff and recruitment of additional agency workers. In areas of the service most under pressure, the action taken has been insufficient to ensure good, safe services for children.
95. This corporate failure to ensure sufficient capacity within almost all areas of the service is a significant underlying contributory factor to the deterioration in the quality of help that children receive. While most evident within the local authority public service hub and safeguarding duty team, these issues were seen to some extent at almost every point in the child's journey.
(Recommendation)
96. Poor application of thresholds, including a failure to investigate appropriately allegations of abuse for some children, was a recurring theme throughout this inspection. Initial responses by senior managers to inspectors' concerns raised in individual cases were insufficient in their recognition and response to risk.
(Recommendation)
97. The public service hub model demonstrates a clear commitment to innovative partnership working. However, at the start of the inspection, longstanding issues in the local authority's capacity to assess the large volume of contacts that it receives had not been resolved, meaning that senior managers and leaders could not be sure that all children had timely assessment of risk or need.
98. A corporate decision to increase capacity for the triage of contacts by transferring recently qualified early help social workers into the hub in autumn 2015 was insufficient to meet demand and was deeply flawed. Workers did not have the level of skill and experience required to undertake this role. Managerial oversight and formal supervision of this largely inexperienced team were weak, contributing to unacceptable delay and sometimes poor decision making in respect of some contacts seen by inspectors. (Recommendation)
99. From July 2016, due to a change in operating procedures, the existing delays in decision making increased substantially for children living with domestic abuse that was assessed as medium risk by police. At the start of the inspection, children were waiting for up to two months before a qualified social worker considered their circumstances. The local authority reports that this change, resulting from a vacancy within the social work management team, was not reported to the assistant executive director or executive director of children's services (DCS), although the reduced managerial capacity was known.

100. Delays in decision making were compounded by the already slow notification by the police about this group of children. This long-standing issue had not previously been the subject of challenge by senior leaders as a single agency or through the Local Safeguarding Children Board (LSCB), until highlighted by inspectors.
101. Despite previous reviews of the hub that had indicated potential problems with capacity and the impact on practice, senior leaders did not maintain sufficient oversight of the work and had not identified these issues prior to them being highlighted by inspectors. When these were raised, the local authority took swift action to review all of the children's circumstances. No children were found to be at immediate risk, although a number were identified as in need of a social work service. The local authority took immediate steps to ensure that this level of backlog of work could not arise again. By the final week of the inspection, although the time that children waited for a decision was still too long, the action taken had significantly improved the level of managerial oversight and the timeliness of decision making within the hub.
102. However, the local authority had not considered the potential impact of this improved efficiency on other areas of the service in a system that was already struggling to meet the volume of work. While a resulting increase was predictable, for example, in the numbers of children requiring a social work assessment, it had not been planned for as part of the senior leadership team's risk assessment of the response to inspectors' concerns, and the DCS had not known about it until informed by inspectors.
103. The local authority has struggled to recruit and retain sufficient permanent staff of the appropriate level of experience in most areas of the service. According to the most recent reported figures for 2014–15, at 25%, staff turnover was high. This is considerably higher than statistical neighbours (15%) and the England average (16%).
104. While showing a clear commitment to ensuring sufficient capacity, the local authority has not demonstrated clear risk assessment or forward planning. Although the local authority's response has been swift in light of concerns raised by inspectors, this backlog of work would have been preventable if effective action had been taken when capacity issues were first identified in November 2015.
105. In most teams, the caseloads are high and include complex work. Caseloads of 20 plus children are not uncommon, and some workers have caseloads of 30 or more children. The local authority has taken action in the short term in those areas of the service under the most pressure, such as the safeguarding duty team, through the recruitment of additional agency staff. However, this has not increased stability or significantly reduced the workloads.
106. High caseloads and high staff turnover mean that many children experience avoidable drift and delay, including examples seen by inspectors of a reliance

on other agencies to undertake work that should be done by children's social care. In other instances, while some children are seen within minimum timescales, this is not always at a frequency that meets their needs.

107. The local authority has appropriately identified stabilising the workforce as a key element in its improvement journey. Although it does not have an overarching workforce recruitment and retention strategy, it was clearly able to articulate comprehensive coherent plans which are well informed by rigorous analysis of the profile of its workers, its position in the market and sufficiency considerations. This has informed a service redesign that is ready for implementation, which the local authority expects will reduce workloads through an increased establishment of staff and providing incentives for experienced staff to progress and share their expertise. However, this remains untested and, at the point of the inspection, the volume of work means that workers are not always able to give children the level of service that they need.
108. This high volume of work compromises frontline managers and middle managers' capacity to provide workers with timely effective oversight of casework. While workers report that they feel well supported, this is not always evidenced in consistent, timely, reflective supervision or management oversight that challenges poor practice effectively.
109. Arrangements for the supervision of newly qualified workers completing their assessed and supported year in employment do not meet the local authority's own practice standards. This, combined with significant delay in their external support, means that the current cohort has not received the level of oversight required or the protected caseloads that they are entitled to. Arrangements have now been made for this group to commence external training with a local university in December 2016. (Recommendation)
110. The local authority has collaborated well with local universities and neighbouring authorities to provide high-quality training opportunities for staff, based on the professional capabilities framework, and includes managers and independent reviewing officers. This is complemented by the good range of training provided through the LSCB, including dedicated single-agency lunchtime sessions on specific topics and a council-wide leadership programme for managers, launched in summer 2016, which 37 managers in children's services have already completed. However, this positive investment in learning has yet to be reflected in improved standards in frontline practice.
111. Insufficient quality assurance of work by managers and senior managers in key areas of the service, such as the hub and safeguarding duty team, means that senior leaders have an over-optimistic view of the quality and timeliness of the service that children receive. For example, the local authority does not report on or quality assure decision making in the large number of repeat requests for service that it receives that are recorded as contacts, because it assumes that

numbers are high because they include routine information requests.
(Recommendation)

112. Middle and frontline managers routinely engage in monitoring performance within their service areas. At a team manager level, this is largely focused on compliance and on ensuring that performance management information is correctly input on the local authority's management system. This is appropriate, given the challenges that the local authority faces in ensuring that some basic practice standards are met.
113. The local authority supplements this activity with a cycle of monthly thematic audits. Learning from some of these audits has resulted in effective action planning to drive up standards in some areas, for example to reduce the numbers of children subject to child protection plans. However, in others, proposed actions have not been taken, resulting in repeat recommendations. The numbers of cases audited are not always sufficient for the local authority to form firm conclusions. At the time of the inspection, the local authority had suspended the audit cycle since August 2016, due to a staff vacancy.
114. While the local authority reports that team managers routinely audit all casework at the point of transfer and case closure, findings from this work are not collated or disseminated. This is a missed opportunity to inform and improve practice.
115. Prior to the inspection, the local authority had recognised that it cannot fully assure itself of the quality of practice in relation to children missing from home or care or those at risk of child sexual exploitation. This is due to gaps in performance management information, and it is taking action to address this.
116. Reporting of performance to senior leaders and elected members lacks helpful analysis, sufficient benchmarking and measures against a standard of what 'good' should look like for children in Tameside. This does not assist senior leaders or elected members to have a thorough understanding of practice on the frontline or to communicate to staff clear expectations of performance based on good practice standards.
117. The local authority has recently strengthened arrangements for oversight of practice by the chief executive and lead member through formalising arrangements for them to meet quarterly with the DCS, the assistant executive director and the chair of the LSCB. The chief executive has given a clear steer to streamlining and improving the quality of information brought to this meeting. However, this is too recent to measure the impact of the changes on either senior leaders' understanding of practice or improving outcomes for children.
118. The rigour of scrutiny arrangements by elected members is limited by the wide remits held by the lead member of children's services and the scrutiny panel. Scrutiny by the panel of key areas of the council's core business in relation to

children's social care, such as the public service hub, while planned, have not yet taken place. Despite these capacity challenges, the scrutiny panel has undertaken a useful audit of the council's response to children at risk of sexual exploitation that was well informed by relevant research. This has resulted in action planning to improve services, including to young people placed from out of area by other local authorities.

119. Strategic planning in relation to corporate parenting requires updating, and while the work of the corporate parenting strategic group is progressing, the lack of a current strategic plan means that opportunities for improvement through external challenge are limited. The pledge to children looked after and care leavers requires urgent refreshing and relaunching to ensure that it is effectively communicated and speaks directly to children and young people in language that is accessible to them. (Recommendation)
120. There are well-established links between the Health and Well-being Board, the LSCB and the Adult Safeguarding Board, supported by key senior leaders such as the DCS sitting on all three boards. A recent review of joint working protocols identified that some strategic priorities would benefit from further alignment. Learning from this review will be combined with a joint board development session planned for April 2017 to inform changes to the joint Health and Well-being strategy, which is due to be refreshed.
121. Current single commissioning arrangements are appropriately informed by the joint strategic needs assessment. While, overall, in common with many areas, single commissioning is largely health focused, the service has staff dedicated to children's services, ensuring that the needs of adults do not take precedence.
122. Through commissioning, the local authority is beginning to address historical decisions that have led to gaps in services, for example for children at the edge of care and family group conferencing. Commissioning, informed by good strategic planning in relation to domestic abuse, supports victims well. However, delays in responding to requests for service and assessing children's needs mean that children wait longer than necessary for a service.
123. The local authority routinely uses learning from complaints, children's and young people's participation, and peer reviews to inform its strategic planning. However, at the time of the inspection, service improvements because of this learning were still at the planning stage and had not resulted in demonstrably improved outcomes for children.

The Local Safeguarding Children Board (LSCB)

The Local Safeguarding Children Board requires improvement

Executive summary

Tameside Safeguarding Children Board (TSCB) is not fully effective in its scrutiny and monitoring of the quality of frontline practice across the partnership, because of a lack of good-quality performance information, for instance useful data. The child sexual exploitation strategy is not informed by an integrated multi-agency data set, which if available would provide assurance of the sufficiency of the strategy.

While the board can demonstrate effective challenge in some areas, the challenge to agencies in relation to the poor application of thresholds and delays within the public service hub has not been systematic or rigorous enough to ensure that agencies provide evidence of improvement.

Governance arrangements between the board and other strategic partnerships, such as the Adult Safeguarding Partnership Board and the Health and Well-being Board, are satisfactory. There are no formal reporting arrangements to either the corporate parenting strategic group or the family justice board, which limits the board's ability to monitor the safeguarding of children who are looked after and those going through a court process.

The board has a range of appropriate sub-groups and task and finish groups that effectively discharge statutory requirements and lead work on board priorities. The domestic abuse steering group has been successful in raising awareness of the nature and impact of this type of abuse and improving support services. The recently agreed neglect strategy has led to improvements to specific training on the graded care profile. The child sexual exploitation sub-group has overseen a number of positive developments relating to raising awareness: training, victim support, enforcement and prosecution. The learning from serious case reviews and audits is responded to and disseminated across the partnership.

The TSCB annual report 2015–16 provides a comprehensive account of board activity, but lacks analysis of the quality of services for children and evidences only piecemeal involvement in their planning. Similarly, the business plan is updated regularly, but the absence of some key issues means that the effectiveness of the business plan to support improvements is diminished.

A clear commitment to involving children and young people in influencing board activity resulted in the safeguarding youth forum, established during 2015 which influenced work undertaken on online safety. At the point of inspection, the group was not active due to lack of membership, and as a result young people are not currently engaged in improving safeguarding in Tameside.

Recommendations

124. Undertake an urgent review of Tameside Safeguarding Children Board (TSCB) priorities and update its business plan to include concerns about frontline practice and service delivery at all levels of need, and ensure that an evaluation of the impact of safeguarding practice upon children's well-being and safety is undertaken and included in the board's annual report.
125. Establish a programme of sufficient multi-agency and single-agency audits to enable effective scrutiny and evaluation of the quality of frontline practice and service provided to children.
126. Ensure that the board is able to evaluate whether the application of thresholds across the partnership is effective and is resulting in timely and appropriate intervention for children.
127. Improve understanding and informed challenge of safeguarding practice in Tameside by regular critical analysis of accurate and up-to-date performance information from all partners. This is to include the development of an integrated multi-agency data set concerning children at risk of child sexual exploitation, ensuring that the prevalence is accurately captured and enabling an evaluation of the effectiveness of the current strategy.
128. Re-establish effective methods of ensuring that the views of children and young people influence the service planning needed to deliver TSCB priorities and plans.
129. Establish effective links with the corporate parenting strategic group and family justice board to ensure that the TSCB has appropriate oversight of outcomes for children looked after and those who are the subject of care proceedings.

Inspection findings – the Local Safeguarding Children Board

130. The chair has strengthened the structure of the board and built capacity to ensure that it works more efficiently and effectively. All board members and sub-group members are clear about their responsibilities and accountabilities. The business manager sits on the strategic group and the business group, as well as all sub-groups. This is with the exception of the learning and improvement group, which is attended by the board's training coordinator, and the quality assurance and performance management sub-group, which is attended by the quality assurance officer. This structure helps to avoid duplication and identify any gaps.
131. Governance arrangements between the board and the Adult Safeguarding Partnership Board and the Health and Well-being Board are appropriate, and work is planned to strengthen the existing governance arrangements. A joint development event held in April 2016 agreed to establish a shared

safeguarding strategy and revise joint protocols, but this has yet to be progressed, due to capacity issues.

132. The relevant sub-groups are addressing an acknowledged problem with the sufficiency, quality and analysis of data reported to the board. This includes an overdependence upon police data with regard to children who are at risk of child sexual exploitation, or involved in 'missing' episodes or domestic abuse incidents. The board has compensated for this by asking agencies to undertake manual trawls of data, where possible, and has rearranged their meeting cycle to align with the reporting cycle. However, until the quality of performance reports and supporting analysis improves significantly, the effectiveness of the board in monitoring the quality of frontline practice is reduced. (Recommendation)
133. Some qualitative performance information is obtained through multi-agency audits, but findings are limited due to the small number of cases that are considered. The audits undertaken in 2015–16 relating to child sexual exploitation and domestic abuse reviewed only two cases each. This limits the usefulness of the findings. (Recommendation)
134. The thresholds guidance was revised in November 2015, but the board has yet to evaluate the impact of the partner agencies' application of thresholds, through either the multi-agency auditing process or the scrutiny of single-agency audits. There is no plan to evaluate the impact of the children's needs framework launched in June 2016. (Recommendation)
135. The board demonstrates some evidence of effective challenge, for example challenge to the local authority regarding the insufficiency of data relating to common assessments and the lack of an effective early help quality assurance framework. This has led to agreement to appoint two common assessment advisers who will both collect data about completed assessments and evaluate impact. The board also successfully challenged the local authority about its need for an effective joint protocol between housing and social care, to ensure appropriate assessment of homeless 16- and 17-year-olds. This led to a revised joint protocol and an improved joint assessment process. Challenge concerning lack of therapeutic support for child sexual exploitation victims has met with partial success, with an agreement of how the support will be delivered beyond March 2017 still to be resolved.
136. The challenge from the board to the partnership has not been rigorous enough in some key areas. For example, the board was aware of the concerns relating to the way that the public service hub was operating and the resulting delays in progressing contacts and referrals for some children, having received the report of the review of the hub in December 2015. The board has not subsequently analysed whether the action taken in light of the review led to improvement. The board has not called the police to account for delays in referring to the hub children whom officers had assessed as at medium risk of

domestic abuse. The chair has strengthened the challenge process from the board, but this is too recent to show impact.

137. Cafcass' lack of capacity to attend regular board meetings, combined with the current weak link with the family justice board, limits the board's ability to monitor the experiences of children involved in court processes. Similarly, better links with the corporate parenting strategy group are required to ensure that the board takes an active role in monitoring and promoting the safeguarding of children looked after. (Recommendation)
138. The TSCB annual report 2015–16 provides a comprehensive account of board activity, achievements and priorities, but lacks analysis of the quality of services for children. This will need to be addressed to ensure that the annual report is useful in providing helpful and analytical commentary on safeguarding activity in Tameside. (Recommendation)
139. Despite an established strategic plan and an annual business plan that are routinely updated by the executive business group meeting, a number of key issues and developments of concern to the board do not feature in the 2016–17 business plan. This includes the known data quality issues and their proposed resolution, longer-term therapeutic support for victims of child sexual exploitation, an evaluation of the impact of the new early help adviser posts and the work to align the three strategic boards. The plan continues to propose only to monitor the public service hub, and these omissions risk reducing the effectiveness of the board. (Recommendation)
140. The influence of the board in service planning is evident through its contribution to the planned transformation of mental health services for children and young people, securing therapeutic support for child sexual exploitation victims until March 2017, ensuring appropriate support services for families experiencing domestic abuse and improving pathways to services for young people involved in self-harm. However, the board's approach to driving service planning and monitoring improvement in Tameside lacks coherence, is insufficiently proactive and not clearly reflected in the TSCB annual report and business plan. (Recommendation)
141. A Tameside safeguarding youth forum established by the board did some useful work during 2015–16 with regard to updating the board's website and involvement in a pilot in a secondary school concerning safe social networking. Unfortunately, some young people have left the group and consequently it has not met since February 2016. A fresh recruitment process has not yet secured new membership, so young people are not currently involved in influencing improvements in safeguarding in Tameside.
142. The board has a child sexual exploitation sub-group that oversees the delivery of the strategy to counter child sexual exploitation. Evidence of services delivered include: awareness raising across communities through a recent week of action against child sexual exploitation and, in schools, through the

roll out of 'Real love rocks' and 'Love or lies' resources; training for partners, taxi drivers and managers of licensed establishments; and enforcement, disruption activity and prosecution. The lack of accurate performance information in relation to child sexual exploitation hampers the board's ability to analyse its prevalence and prevents full understanding of the impact of the work completed. The serious and significant case review sub-group has commissioned a review of the child sexual exploitation system, but this will not take place until later in 2016. This means that the recommendations of the peer review undertaken in March 2016 have not yet been agreed or implemented.

143. The domestic abuse steering group appropriately reports to both safeguarding boards. The group has worked effectively to ensure that a range of appropriate support is available to victims, perpetrators, young people and children living with domestic abuse. This includes the pilot of domestic abuse awareness tools in 13 schools and the implementation of operation 'Encompass'. The multi-agency training programme delivers awareness-raising training and training on the whole-family approach to domestic abuse.
144. The neglect strategy is informed by research findings and learning from serious case reviews. The strategy is located within the Greater Manchester neglect strategy and identifies the key indicators to measure impact. The multi-agency training programme has been adjusted to reflect the requirements of the strategy and training on the graded care profile, and delivery commenced in the summer of 2016. This is too recent to evidence impact.
145. As part of the learning from a serious case review relating to the death of a young person, the board has contributed to the establishment of the Children and Young People's Emotional Well-being and Mental Health five-year (2015–20) transformation plan. This proposes a new approach across Tameside and Glossop that aims to strengthen referral pathways and deliver a clear offer to meet the emotional well-being and mental health needs of children and young people. As part of the programme's workforce development work stream, the board's task and finish group concerned with self-harm and suicide has progressed an appropriate mental health training ladder delivered through the multi-agency training programme.
146. The child death overview panel (CDOP), shared with Stockport and Trafford, is chaired independently with effective communication supported by a shared CDOP manager based in Tameside. The annual report 2015–16 provides clear information concerning notifications received and closed down, and the themes and issues that have emerged. The predominant findings relate to the deaths of children under the age of one year due to prematurity, low birth weight and mothers smoking during pregnancy. These issues are addressed by public health actions and, in Tameside, this has led to improved planning by maternity services with pregnant women and in a midwife post dedicated to support pregnant women to cease smoking.

147. The serious and significant case review sub-group is an active group that has managed effectively a considerable number of serious case reviews and multi-agency case reviews, relative to the size of the local authority. The national panel has endorsed all of its decisions regarding the initiation of serious case reviews. The panel has effectively ensured implementation of action plans by the relevant agencies and has progressed dissemination of the findings through the learning and improvement sub-group.
148. Tameside contributes to the Greater Manchester safeguarding policy and procedure group. Revisions of threshold guidance in 2015 and the children's needs framework in June 2016, combined with revision of referral pathways for self-harm, female genital mutilation, forced marriage and children at risk of radicalisation, have ensured that procedures are up to date.
149. A strong section 11 audit process incorporates the voice of the child and ensures that partner agencies produce evidence of their compliance. Scrutiny by members of the quality assurance and performance management sub-group assures the validity of evidence before signing off the agency's section 11 response. Multi-agency audits concerned with strategy meetings and pre-birth assessment are planned for 2016–17. The establishment of a schedule of single-agency audits provides a more systematic approach to evaluating the quality of both frontline practice learning and service delivery.
150. The TSCB has an appropriate learning and improvement framework, a training strategy and a well-regarded multi-agency training programme. Training reflects policies and procedures, and their updates and learning from serious case reviews, multi-agency case reviews and audits, and has a focus on skill development as well as knowledge. Additionally, learning is communicated through widely circulated seven-minute briefings that are discussed in team meetings, six-weekly safeguarding update events and e-learning opportunities. The training coordinator has recently recruited 13 more professionals to the training pool, and the learning and improvement sub-group has developed a new process to secure a better return on the impact on practice questionnaires.

Information about this inspection

Inspectors have looked closely at the experiences of children and young people who have needed or still need help and/or protection. This also includes children and young people who are looked after, and young people who are leaving care and starting their lives as young adults.

Inspectors considered the quality of work and the difference adults make to the lives of children, young people and families. They read case files, watched how professional staff work with families and each other and discussed the effectiveness of help and care given to children and young people. Wherever possible, they talked to children, young people and their families. In addition, the inspectors have tried to understand what the local authority knows about how well it is performing, how well it is doing and what difference it is making for the people who it is trying to help, protect and look after.

The inspection of the local authority was carried out under section 136 of the Education and Inspections Act 2006.

The review of the Local Safeguarding Children Board was carried out under section 15A of the Children Act 2004.

Ofsted produces this report of the inspection of local authority functions and the review of the local safeguarding children board under its power to combine reports in accordance with section 152 of the Education and Inspections Act 2006.

The inspection team consisted of seven of Her Majesty's Inspectors (HMI) from Ofsted and one additional inspector.

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