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Dear Ms Stathers-Tracey

Focused visit to Tameside children's services

This letter summarises the findings of the focused visit to Tameside Metropolitan Borough Council children's services on 27 and 28 April 2022. Her Majesty's Inspectors for this visit were Mandy Nightingale and Jo Warburton.

Inspectors looked at the local authority's arrangements for the 'front door'.

This visit was carried out in line with the inspection of local authority children's services (ILACS) framework.

Headline findings

During the previous focused visit, in May 2021, council leaders agreed to provide immediate additional investment to address a lack of capacity across several parts of the service which was causing delay for children in having risks identified and their needs met. However, this has not been implemented at pace.

Since that time, the local authority has continued to experience capacity issues across all levels of the service, and the response to some children at immediate risk of harm has deteriorated. Too many children experience delay in having their needs for help and protection promptly assessed and met. There is a systemic delay in the convening of strategy discussions, which means that risk for most children is not promptly considered in a multi-agency forum, leaving children in circumstances of unassessed risk for too long.

The local authority's self-assessment of the front door does not demonstrate sufficient insight into the areas requiring improvement and the service improvement plan is not focused on the right areas to improve outcomes for children. The pace of change has only very recently increased following the appointment of a new director

of children's services (DCS) 10 weeks ago. Many of the changes made are too recent to demonstrate sustainable impact.

Areas for priority action

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

What needs to improve in this area of social work practice?

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

Main findings

At the previous focused visit, in May 2021, political and corporate leaders agreed an increased level of financial support to address capacity issues in the workforce. However, this has not been implemented at pace. An additional social work team was not established until 10 months later. This is now contributing to some early improvements. However, at the time of this visit, the impact on improving children's lives is not evident. Within the last 10 weeks, the new DCS has secured additional funding to increase capacity in the leadership team, and recruitment was progressing at the time of the visit.

The new DCS has very recently made some positive changes to support improvements in social work practice, staff morale and partnership working. Improvements include the move of the multi-agency safeguarding hub (MASH) to new premises, which has enabled the co-location of early help and MASH, the development of neighbourhood teams and the reintroduction of duty and assessment teams. Early help assessments that are completed by partner agencies have increased and schools are supported to work more closely with social workers.

Tameside has continued to experience high rates of COVID-19 infections. Staff continued to mostly work from home until the week before this focused visit. The DCS reported that staff sickness and absence levels have not, however, increased due to COVID-19. Through a refreshed recruitment and retention strategy, the local authority has already seen an increase in the number of experienced social workers

returning to work for Tameside. While this has had a small impact on social work caseloads, too many social workers have high numbers of children on their caseloads, and this leads to delay in timely interventions in children's lives.

Despite these recent changes, political, corporate and operational leaders do not know their services and the impact for children well enough. A recently refreshed self-assessment of the front door services demonstrates what has changed in this area of service and the main challenges. However, before this visit, leaders were not fully aware of the extent and impact of repeated contacts about children, the systemic delay in convening multi-agency strategy meetings and in allocating a social worker to assess risks and needs in a timely way.

Before this visit, the new DCS had identified that the current improvement plan is not fit for purpose and does not sufficiently address the practice improvements needed to improve children's lived experiences or hold individuals to account for their role in bringing about these changes. She has commissioned an independent review across services to better inform ongoing service planning.

When children are at risk of significant harm, there is a systemic delay in the process for convening strategy meetings. For too many children, the risk of harm is not being considered quickly enough to agree actions and put in place safety plans to reduce risk. Greater Manchester police are not always available to attend strategy meetings promptly and this delays the date of these meetings, adding to the risk that children experience. When multi-agency child protection strategy meetings are held, they are attended by the relevant professionals involved in the child's life. They share relevant information, assess risk and identify appropriate actions to reduce risk, to safeguard the child.

Too many children experience unnecessary delay in having their needs assessed and met. In most of the cases that inspectors reviewed, children were not allocated a social worker from the duty and assessment team in a timely way. Children are not always being seen by social workers promptly and this is potentially placing them at risk of ongoing harm.

Children's needs for early help and support are identified promptly in MASH. Swift allocation to appropriately skilled and experienced early help workers means that children and families are offered a wide range of effective support. The flexibility of the early help offer means that families are well supported, including in the evenings and at weekends.

Effective use of parenting support programmes and targeted early help has supported some families to change and improve children's daily lived experiences and prevent escalation to statutory services.

Most partner agencies provide sufficiently detailed information when raising concerns for children and this supports the MASH managers to make decisions about next steps. Managers in the MASH engage with professionals when concerns are not sufficiently detailed to support decision-making. Concerns for children's welfare are promptly responded to in the MASH. Parental consent to gather and share information is appropriately sought and when necessary is overridden to permit multi-agency enquiries. The co-location of early help staff and several other professional agencies means that information is gathered quickly to support timely decisions about what happens next.

Decision-making in the MASH mostly considers the child and family's history and the impact on the child of the presenting issue. The voice of the child is captured at this early stage by the people who best know the child, and this contributes to an understanding of the child's lived experience. However, the application of threshold is not always consistently applied at the front door. For some children, decisions are not made in the child's best interests at the first stage of raising concerns and this means they experience repeated contacts over a short period of time. For children, this results in different professionals intervening in their lives and them having to repeat their stories. For some children, the decision to progress with further enquiries as a single agency does not result in risks being considered through a strategy meeting, resulting in delay in having their needs fully assessed and risks identified.

Children experiencing domestic abuse in their lives are swiftly referred to the MASH by the police. The quality of most domestic abuse referrals is sufficient to enable MASH managers to make a decision for next steps. Decision-making about what happens next is not consistent and some children's cases are closed too quickly, without a comprehensive child and family assessment to fully understand their lived experiences and the potential risk they face.

Children and family assessments are limited in their effectiveness to create an informed plan for families and professionals to work to and reduce risk for children and improve their lived experience. Assessments are not always timely. They lack a robust analysis, do not consider all information about families or do not always include relevant adults, including fathers and wider family members. Some children's assessments of need do not focus on the impact on the child and are too adult/parent-focused. For too many children, the delayed allocation of a social worker and frequent changes of social worker contribute to the weaker assessments. Children are not always able to build trusting relationships with their social worker and this impacts on their ability to share their experiences to inform what happens next.

Once allocated a social worker, most children are seen regularly. However, not all are engaged in purposeful direct work that helps to start building a trusting relationship with the social worker that will provide them with the opportunity to share their views and contribute to future decision-making.

Children who require support out of office hours receive an effective and consistent service from a stable and experienced team of social workers. Social workers in the out-of-hours service have effective relationships with a range of agencies to work together and provide immediate protection for children. Succinct and timely recording on children's records provides an up-to-date narrative of what actions have been taken to inform the day services.

Exploitation risks are promptly recognised and passed to workers in the complex safeguarding team. Comprehensive assessments result in effective multi-agency planning and clear written plans. Children are encouraged to engage in activities to reduce their levels of risk. Children benefit from purposeful and effective direct work with skilled workers and for some children this means that wider push and pull factors are better understood and risks are reduced.

When the risk of exploitation increases, timely risk management meetings, attended by the relevant agencies, make appropriate decisions to safeguard children.

Supervision for social workers in the duty and assessment teams is not always held regularly and it is not effective enough to improve children's circumstances. Records of supervision do not include reflection, review previous actions or have new actions for the social worker, although staff reported that they feel supported by managers. Staff also reported that they have very recently seen a positive change in the culture and ways of working in Tameside, with clearer expectations being provided, which is better supporting them in their work.

Ofsted will take the findings from this focused visit into account when planning the next inspection or visit.

We have notified the Department for Education of the areas for priority action. You should submit an action plan that responds to these areas within 70 working days of receiving this letter. It would be very helpful if you can share an early draft of the action plan with us within 20 working days of receiving this letter.

Yours sincerely

Mandy Nightingale
Her Majesty's Inspector