Inspection of Tameside local authority children's services

Inspection dates: 4 to 15 December 2023

Lead inspector: Andy Waugh, His Majesty's Inspector

Judgement	**Grade**
The impact of leaders on social work practice with children and families	Inadequate
The experiences and progress of children who need help and protection	Inadequate
The experiences and progress of children in care	Inadequate
The experiences and progress of care leavers	Requires improvement to be good
Overall effectiveness	Inadequate

There has been ineffective senior leadership in Tameside since the last inspection in 2019, which has resulted in too many children not receiving effective services that meet their needs.

Not all shortfalls identified during the last inspection in 2019, or the focused visit in June 2022, have been addressed. Senior leaders have not had a clear line of sight on practice and, as a result, the quality of social work practice has deteriorated for those children in need of help and protection and children in care.

A new leadership team has been appointed following the commissioning of a peer review in August 2023. Since that time, swift and decisive action is being taken in some parts of the service, to improve management oversight and raise the quality of social work practice. It is too soon to see the impact of these changes for children and to know whether they will lead to sustained improvements.

There are serious failures that leave children being harmed or at risk of harm. While staff turnover has decreased, caseloads in some areas of the service have increased and there is an over-reliance on newly qualified and agency staff. Children who need help and protection are not always identified at the earliest opportunity. There is

insufficient analysis of children's individual experiences to inform critical decisions, including in the multi-agency safeguarding hub (MASH) and through assessments. The quality of assessments is not good enough. Social workers' analysis of concerns does not consistently identify the risks and needs of children and, therefore, children are not receiving the right interventions at the right time. Too many children experience drift and delay, including due to changes in social worker, weak planning that is overly adult-focused, and a lack of robust management oversight and direction. As a result, some children experience ongoing harm, and live in neglectful situations for too long, without timely authoritative action being taken. Too many children experience delay in securing permanence and are not living in the right placement to meet their needs.

There are some discreet areas of the service, such as for children at risk of exploitation, where children receive interventions that support them effectively and keep them safer.

What needs to improve?

- The council's oversight, accountability and governance of leadership of children's services.
- The multi-agency recognition and response to risk, including referrals, strategy meetings, when children go missing from home or care, arising risks for children in care and care leavers, and when allegations are made against professionals.
- The consistency in applying thresholds and interventions for children.
- The quality of assessments to identify children's needs and risks to support decision-making around next steps.
- The quality of plans for children in need of help and protection, children in care and care leavers to enable them to receive the support they need.
- The regularity and effectiveness of management oversight and challenge.
- The timeliness of children achieving permanence.
- The response to 16- and 17-year-old children who are homeless.
- The sufficiency of placements to meet the needs of children.
- The timeliness and quality of the induction, training and review of foster carer agreements.
- The work with care leavers to help them understand their rights and entitlements, their health histories and their understanding of the local offer.

- The engagement and participation of children and young people in their assessments, planning and service delivery.
- The recruitment and retention of staff and support for newly qualified social workers.

The experiences and progress of children who need help and protection: inadequate

1. The MASH is not always effective in identifying children who need help and protection. Although history is routinely gathered as part of the screening of concerns, this is not used well enough to understand risk to inform next steps. As a result, some children are left at risk of further harm without purposeful action being taken to protect them. Police do not always refer children quickly, including when they require a protective response. Delays are further compounded due to insufficient social worker capacity impacting on the timeliness and conclusion of screening. This means that some children do not receive the help and protection they need at the earliest opportunity.

2. Senior leaders have recently recognised significant weaknesses in the MASH through a commissioned diagnostic assessment. This has resulted in swift action being taken to restructure the service and increase management capacity, but there is still more to do to ensure that children and young people receive an effective initial response.

3. There are inconsistencies for some children in the application of thresholds, and recognition of risk, meaning that some children are left in situations of harm for too long. The quality of strategy meetings and subsequent enquiries is inconsistent and not always timely. Professionals at some strategy meetings do not sufficiently analyse risk to inform decisions, and actions often lack specificity about how the enquiry should progress. Stronger meeting discussions and enquiries use children's history effectively to understand cumulative harm in order to inform next steps, including safety planning.

4. Most assessments are not effective at identifying all children's needs and risks. While history is recorded, there is insufficient analysis of the child's experiences in the context of current concerns, or an over-optimism of, or over-reliance on, parental self-reporting. Parental capacity to change is not routinely considered. Direct work with children to inform the assessment is limited, meaning that the impact of parental and environmental risk factors, and children's experiences, is missed. Some assessments overly focus on the presenting issue, so become incident-focused and do not consider children's holistic needs. As a result, children do not receive the support they need at the earliest opportunity and, in some instances, children's cases are being prematurely closed without children receiving the support they need.

5. The quality and impact of social work practice with children and their families are inconsistent. Too many children experience drift and delay in having their

needs met, due to different factors. These include too many changes of social worker, weak planning that is too adult-focused and a lack of focus on progressing the plan. There is insufficient partner and management challenge. Available resources are not consistently utilised, such as the family group conferencing. This does not support the building of resilience in the family to keep children safer.

6. Some children are not protected well enough even when they are subject to child protection planning. When children's circumstances do not improve or they deteriorate, timely assertive action is not always taken to address risks, leaving children in harmful situations for too long. For some children, decisions to end child protection plans are overly optimistic and not always informed by up-to-date assessments to understand parental capacity to sustain change, particularly with children who experience neglect. As a result, some children are then exposed to further harm and experience repeated episodes of child protection planning.

7. For some children who are subject to the pre-proceedings stage of the Public Law Outline, ineffective management grip, changes in social worker and delays in specialist assessments have contributed to drift in securing early permanence. Senior leaders have recently strengthened their grip on pre-proceedings through improved tracking and the implementation of multi-agency legal gateway meetings, which are providing uniformity in decision-making and a sharper focus on children's progress. Recently, more timely assessments are supporting earlier decision-making about children's permanence.

8. Many children and families benefit from a strong early help offer. Early help assessments are mostly comprehensive and collaborative, informed by a broad range of partner information and the voice of children through direct work. Workers understand children's needs and the impact of support through regular reviews. Children are seen regularly, and at a frequency that is responsive to changes in circumstances. Plans are appropriately targeted and, as a result, some children's experiences improve.

9. The quality of support for disabled children is too inconsistent. Some social workers lack confidence in using alternative communication tools, hindering their ability to fully understand children's experiences.

10. The complex safeguarding team provides an effective, strong response to children at risk of exploitation. Work is underpinned by comprehensive assessments with detailed analysis of triggers and patterns to understand children's experiences, needs and risks. Multi-agency support and safety planning are effective. Children build strong, meaningful relationships with their workers, who carry out direct work that is helping to keep children safer.

11. When children go missing from home or care, the response to children identified at lower risk is mostly weak. There is insufficient disruption activity, intervention or priority given to reducing the risks. For children who are

assessed to be high risk, work is effective in understanding why children go missing and appropriate support is provided. Staff vacancies in the missing-from-home team are affecting the quality of return home interviews. The local authority has robust approaches to track children and young people missing education.

12. There are effective systems and processes in place for how the emergency duty team (EDT) meets the needs of children. Workers respond to concerns effectively, and children and families are visited to understand risks and needs. Children's records are consistently updated, enabling social workers to follow up actions without delay. Effective handover meetings are held to share issues that may arise at weekends, and, in addition, there is overlap at the end of each day for communication with an EDT worker, if necessary.

13. The response to allegations of harm against professionals is not strong enough. There are delays in progressing some allegations, leaving some children in situations of unassessed risk. However, more recently, systems have been refined to better determine levels of risk and additional capacity secured to support the designated officer. Further work is needed to ensure that children's histories are used consistently to inform decision-making about next steps.

14. Not all children aged 16 to 17 years old who present as homeless are having their needs fully assessed and met. Joint assessments between children's social care and housing are not consistently taking place, meaning that children's needs are not clearly understood. Children are not consistently informed of their right to enter care.

The experiences and progress of children in care: inadequate

15. For a significant number of children, there is widespread drift and delay in achieving permanence. For these children, decisions to come into care are too late and they are left in situations of harm for too long. For some children where their care plan is one of long-term fostering, there are significant delays in placements being ratified as permanent, which is not providing them with the stability and security that they require.

16. There is a lack of a coordinated response and effective oversight from managers and independent reviewing officers (IROs), and, for some children, this contributes to them remaining in care for longer than is necessary. For some children, IROs raise concerns about the progression of plans through the escalation process, but this has limited impact on improving outcomes for children, as concerns are not responded to effectively by managers.

17. Care planning for children is not always timely or informed by an up-to-date assessment of children's needs. Although meetings are held regularly, plans made at reviews are not consistently ambitious for children and do not have a clear focus on securing permanence. For many children where a special

guardianship order is the identified plan, the local authority waits too long for these plans to progress.

18. Children do not always live with carers in line with their assessed needs due to a lack of sufficient placements. For some children, this means that they live out of the authority's boundary, in children's homes or supported accommodation.

19. Too many children who are placed at home under 'placement with parents' regulations experience drift and delay. For some, this has been for many years, and they have been subject to unnecessary statutory intervention for too long. Leaders are taking action to address these delays through the implementation of a dedicated team to safely discharge orders, but it is too soon to see the impact for children.

20. A small number of children live in unregistered children's homes. Senior leaders have increased their oversight of these children and seek to place them in registered accommodation as soon as possible. However, too many children have lived in these unsuitable arrangements for too long and care planning does not consistently progress plans for children to live in homes that fully meet their needs.

21. When children are placed in the care of kinship carers, they have their needs met well and make good progress. Assessments of potential carers are carried out promptly and support effective care planning.

22. Social workers are committed to understanding the perspective of the child and their experience by regularly meeting with them. Some children have had many changes of social worker, which impacts on the quality of relationships with children.

23. Social workers recognise the importance of supporting children to live with their brothers and sisters when possible. Careful consideration is given to supporting children to have positive family time with significant family members and people in their lives who are important to them.

24. Unaccompanied asylum-seeking children are supported by social workers who are sensitive to their cultural needs and experiences. The quality of plans for these children is inconsistent. Plans are not always informed by up-to-date assessments, so children's current needs are not fully understood.

25. Social workers in the integrated service for children with additional needs understand the needs of children well. A dedicated transitions social worker is improving transition planning for children preparing for adulthood.

26. Some children are not supported to understand their family identity and experiences as life-story work is not completed for all children who are in long-term care. Direct work takes place with most children, but the impact of this is not always clear. For many children, this means that their voice does not influence their plan.

27. The Children in Care Council (CiCC) is underdeveloped and does not enable children to participate in the development of services effectively or support them to make decisions through the corporate parenting board. When inspectors met with a group of children in care, there was limited awareness of the function of the CiCC. Children also told inspectors that they did not know how they could make a complaint if they were unhappy with the support being offered.

28. When safeguarding concerns arise for children in care who live with their parents, the response to managing risk is not robust. Some children do not consistently receive an appropriate safeguarding response and are left in circumstances of unassessed risk.

29. Most children in care have their physical health needs met well. Some children experience significant delay in accessing child and adolescent mental health services. The local authority has mitigated this delay for some children, through the commissioning of a specialist service, and this has been successful in progressing assessments and accessing services.

30. Some children in care do not attend school or achieve as well as they should. Most children are supported through regular reviews of personal education plans, and their education attendance and attainment are a key focus. The virtual school is working collaboratively with education establishments to implement more systematic and rigorous systems to support the needs of children in care more effectively.

31. There are serious weaknesses in the recruitment, support and assessment of foster carers. Foster carer numbers are reducing, and this is having a negative impact on the availability of suitable placements for children. Foster carer agreements are not being used by the service. This means that carers cannot be clear of expectations or held to account regarding the quality of care they provide for children, which is contrary to regulation. The quality of induction and training for foster carers and supervising social workers does not consistently prepare and support them in their roles. Foster carers report recent improvements in training and the supervision offered. However, progress in implementing learning has been affected by a high turnover of staff in the fostering service.

32. The local authority has effective links with the regional adoption agency (Adoption Now), enabling effective recruitment, assessment and support to adopters. When adoption is recommended for a child, the plan is promptly progressed, ensuring permanence at the earliest opportunity. For some children, the successful use of fostering for adoption arrangements enables children to develop earlier attachments and permanence. Agency decision-making relating to adoption is child-centred, thorough and well considered.

The experiences and progress of care leavers: requires improvement to be good

33. Most personal advisers build positive working relationships with their care-experienced young people, although the impact and quality of these relationships are variable. Some young people have experienced too many changes in personal adviser and, consequently, there is an inconsistency in the quality of care, support and guidance they have received.

34. Most personal advisers visit young people regularly. For a very small number of young people, there have been significant gaps in their visiting patterns. In these circumstances, any changing needs and arising risks are not fully understood or explored and some care-experienced young people are left in vulnerable circumstances.

35. Care-experienced young people aged over 21 years continue to receive support from their personal advisers should they still have a need for this, and they want the support to continue.

36. Efforts to engage and work with vulnerable care-experienced young people who are parents are mostly robust and persistent. For those who are in custody, there are regular attempts to keep in touch with them, to ensure that their basic and wider needs continue to be met.

37. Most unaccompanied asylum-seeking children who become care-experienced receive a good level of support relating to their emotional health and immigration status. Careful consideration is given to ensuring that they can access local amenities to support their cultural and identity needs.

38. For some disabled care-experienced young people, personal advisers are unable to demonstrate an understanding of their needs and they do not visit these young people regularly. Vulnerable young people told inspectors that personal advisers used their involvement with adult services as an excuse not to help them, and that this affected the level of trust and confidence they had in them.

39. The levels of co-production with care-experienced young people are underdeveloped. There is a clear corporate desire to strengthen participation and the corporate parenting function for care-experienced young people. Corporate parents understand that there is more work to do in this area.

40. Some care-experienced young people told inspectors that they were not aware of their rights and entitlements and had not received any training around budgeting, finances, claiming benefits or cooking. Some care-experienced young people told inspectors that they know how to make complaints, but some young people felt that they were not listened to, and that the escalation process was not effective.

41. Most care-experienced young people have their physical and emotional health needs met. A commissioned dental scheme enables care-experienced young people to access dentists across the borough. However, young people told inspectors that they did not understand their full health history, nor did they have access to it. Some personal advisers are unaware of the need for care-experienced young people to have health passports.

42. Most young people are made aware of the local offer by their personal advisers. However, not all young people fully understand it or know what they are entitled to. Care leavers told inspectors that they did not have confidence that the local offer would be delivered. A small number of young people at university told inspectors that they had been served with eviction notices because of their rent being paid late. The local offer was last updated in 2019. While the local authority acknowledges that it is currently being reviewed and will be co-produced with young people, it is too early to see the full impact of this. There is more work to do to ensure that the local offer is fully understood by all corporate parents.

43. The response to risk for vulnerable care leavers is inconsistent. While personal advisers are mindful of issues of domestic abuse and criminal exploitation and the risks associated with poor mental health for most vulnerable care-experienced young people, for a small number of care-experienced young people these concerns are not routinely recorded or managed. They are left in situations of potential risk.

44. Most care-experienced young people are well supported to pursue education, employment and training opportunities. Leaders recognise the need to provide more consistent support to care-experienced young people in re-engaging them in education and employment opportunities. More recently, leaders have introduced a wider range of engagement strategies to support care-experienced young people to return to education, employment and training, with a small amount of early success.

45. Planning for young people to leave care is not always effective or timely. For some, their plans are limited in content, only briefly capturing their views, and are not specific in the identification of risk. Plans do not routinely include the input of other agencies or consider the impact of the intervention for young people. Contingency planning is not always considered for young people. Some care-experienced young people told inspectors that they did not know what was in their pathway plans and that they had not seen them.

46. Care-experienced young people told inspectors that the accommodation they live in is safe and supports their needs. Some told inspectors that they did not feel prepared to move into semi-independent living at 18 years.

The impact of leaders on social work practice with children and families: inadequate

47. At the last inspection, in May 2019, the local authority was judged to be 'requires improvement to be good'. At the focused visit in June 2022, services at the 'front door' were found to have deteriorated, resulting in areas for priority action. These included improving the council's understanding of the quality of practice and ensuring that children have access to timely interventions to assess and reduce risk to them. Despite ongoing significant council financial support, there has been considerable instability across the senior leadership team and the service improvements needed have not been appropriately prioritised. The pace of improvement has been further impeded by the impact of COVID in Tameside, which was substantial, and the high staff turnover.

48. In response to the areas for priority action identified in June 2022, senior leaders and managers formed an improvement board, developed service plans and worked to strengthen the governance of children's services, including a strengthening of the council's scrutiny function. As a result of more robust oversight at a senior leadership level, concerns about the progress of some areas for improvement started to emerge and the chief executive commissioned an independent service diagnostic assessment in August 2023. The diagnostic team very quickly identified some significant weaknesses in the front door that required an immediate protective response for some children. Since that time, the local authority has continued to review all aspects of children's services to better understand the scale of the improvements needed, aspects of which are still ongoing.

49. In August 2023, a new director of children's services (DCS), with experience of improving services for children, was appointed, along with a new experienced senior leadership team. Since her appointment, the new DCS has refreshed the improvement board and high-level improvement plan, and this is leading to the local authority prioritising the right areas for improvement. There is now a more systematic approach to improvement, with a renewed focus on being 'brilliant at the basics' to support the further implementation of the social work practice model. The delivery of this plan is in its infancy and senior leaders have not had time to implement the improvements needed or to have sufficient depth of understanding of all aspects of the service.

50. The pace and impact of the local authority's delivery plan are hindered by workforce sufficiency. The refreshed workforce strategy is still in its infancy, and it is too soon to see its longer-term impact. Staff shortages are affecting the quality and timeliness of practice in some areas of the service. Staff turnover has significantly reduced, and senior leaders are taking a measured approach to recruiting people with the right skills and abilities. Despite this, the service is heavily reliant on agency staff. Social workers report that they are well supported but some newly qualified workers are holding responsibility for children subject to child protection plans with insufficient support for their

practice from advanced practitioners. The local authority continues to convert a number of agency staff into permanent posts and targeted recruitment campaigns are ongoing.

51. There are stronger governance arrangements implemented to support and monitor the service improvements needed and ongoing financial council investment. A re-established improvement board, along with the introduction of an independent chair of the safeguarding partnership, is now providing a greater scrutiny of social work practice. However, it is too soon to see the impact of this on improving children's experiences.

52. Many of the service delivery plans are still new and have not been fully implemented but there are some signs of more recent practice starting to make a difference to children. Examples include greater partner involvement in attending strategy meetings and better information-sharing, and increased management oversight of children in pre-proceedings and of vulnerable children in unregistered children's homes. Despite the recent accelerated pace of improvement, the continued scale required to strengthen the quality of practice is significant.

53. More recently, relationships with partners have begun to be strengthened. The judiciary and Children and Family Court Advisory and Support Service (Cafcass) report how the new leadership team is now more responsive and meetings with senior leaders are regular. The implementation of escalation processes for strategy meetings is ensuring that the right professionals are now attending child protection meetings, but there is more work to do to ensure that there is a consistently timely response to children at risk of harm and to improve the multi-agency response for children who experience neglect. The action being taken to improve the response by the police, including multi-agency audits of contacts, is not having sufficient impact. The corporate parenting board continues to be underdeveloped, and plans are more recently in place to address this.

54. Leaders have recognised that the span of responsibility for some managers has been too wide, and additional management capacity has been introduced across the service. As a result, there is improving oversight at a more senior level, but this is yet to be embedded across frontline managers. Supervision is now regular but there is insufficient challenge and reflection to progress planning for children.

55. Senior leaders have taken a determined approach to better understand frontline practice, inviting external scrutiny through peer reviews, maximising partner-led improvement activity and refreshing the performance management framework. Diagnostic assessments are continuing to support a more detailed understanding of all areas for improvement.

56. The DCS has established a more robust performance framework. Managers at all levels of the service are beginning to have a better understanding of what is

expected of them and how performance is used to drive improvements in practice. A DCS-chaired performance board, along with an accountability board, is improving the line of sight into practice. It is too early to see the full impact of this.

57. Quality assurance has been strengthened through the development of a new framework and auditing tool, which is supporting senior and frontline managers to better evaluate the impact of practice on children. Most audits are completed collaboratively, with social workers identifying both strengths and deficits, providing a positive opportunity for learning and reflection. However, a performance culture is not embedded across the workforce to help workers understand themes and areas for further improvement.

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Piccadilly Gate
Store Street
Manchester
M1 2WD

T: 0300 123 1231
Textphone: 0161 618 8524
E: enquiries@ofsted.gov.uk
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