Report into Children's Services in Middlesbrough following inspection

Report for the Secretary of State for Education

Peter Dwyer CBE: Commissioner for Children's Services

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1. Introduction: The Role of the Commissioner

The Secretary of State in February 2020 appointed Peter Dwyer CBE as Commissioner for Children's Services in Middlesbrough. He was asked:

1. To issue any necessary instructions to the local authority for the purpose of securing immediate improvement in the authority's delivery of children's social care; to identify ongoing improvement requirements; and to recommend any additional support required to deliver those improvements.

2. To bring together evidence to assess the council's capacity and capability to improve itself, in a reasonable timeframe, and recommend whether or not this evidence is sufficiently strong to suggest that long-term sustainable improvement to children's social care can be achieved should operational service control continue to remain with the council.

3. To advise on relevant alternative delivery and governance arrangements for children's social care, outside of the operational control of the local authority, taking account of local circumstances and the views of the council and key partners.

In addition to the above standard remit the Commissioner was also asked

4. To make an early assessment of Middlesbrough's capacity and capability in relation to the "No Wrong Door" project as part of the national "Strengthening Families" programme.

The Commissioner was asked to report back to the Secretary of State by at latest the 28 May 2020.

This report has been produced a few weeks in advance of that deadline. This acknowledges the impact of COVID on improvement activity and the work of the Commissioner. The recommendations contained create opportunities for ongoing engagement over a longer time frame.

2. Executive Summary and Main Recommendations

2.1 The challenges faced in delivering high quality services to an area with the scale of social and economic challenges as those seen in Middlesbrough, should not be underestimated. The world faced by many children and young people in this area is extremely daunting and should necessitate the highest quality of support and intervention on a partnership basis. It is now clear that over many years that has not been the case. Such omissions should not be viewed as the responsibility of any one individual but are the product of deficiencies across the wider system.

2.2 The LA should be commended for the way both political leaders and senior officers have responded to the very challenging Ofsted feedback. There is no apparent defensiveness at the most senior levels of the organisation with a full acceptance of responsibility and a recognition of the need for change. A new senior leadership team is in place within children's services which carries significant relevant experience and enhanced credibility. The new Executive Member for Childrens services, is also the Deputy Mayor and brings considerable passion and informed energy to the agenda. A raft of improvement activity is underway and an immediate assurance plan evidences impact in addressing some of the most concerning issues. The improvement activity is well structured within both an initial assurance plan and developing wider improvement plan, overseen by an Improvement Board. The Board is independently chaired with strong partnership engagement. A stronger, whole council approach is evident and relationships have been enhanced between corporate and departmental staff. Within the directorate consistent messages are now being better communicated and staff talk optimistically about the calm clear focus on improvement displayed by new leaders. A culture of high support but also higher levels of challenge is both described but evident within the organisation. Additional resourcing has been made available to enhance leadership and strategic and organisational capacity. This is not an organisation however, operating with typically high numbers of agency workers or exceptionally high caseloads. The LA has many existing skilled knowledgeable staff within the organisation and partner organisations are demonstrating greater levels of capacity and appetite for the delivery of collective improvement.

2.3 At the same time, the organisation has been seeking to deliver improvement at pace during the unparalleled challenges posed by COVID 19. In my assessment, they have responded to COVID 19 impressively. Such challenges may have helpfully reinforced elements of necessary culture change but they must also have impacted upon the speed of delivery of required improvement. However, despite this, there is sufficient confidence in the changes being made to indicate that ***this is not an LA where we should move quickly to consider alternative delivery mechanisms*.** There is no evidence of a currently dysfunctional political or corporate environment that would support the case for "freeing" the children's leadership from local control. Current senior leadership of children's services have the

confidence of the workforce, are credible and are proven in the delivery of improvement in LAs facing similar challenges.

2.4 The Commissioner was also in relation to Middlesbrough asked to make an "early assessment of Middlesbrough's capacity and capability in relation to the No Wrong Door project as part of the Strengthening Families programme". That assessment included as an Annex to this report concludes that the project should be retained within the wider programme because of its real potential to both operationally deliver and also contribute to key improvement priorities in Middlesbrough.

2.5 The Commissioner is recommended to continue during May-November 2020 to engage with the LA on an approximately 2/3 day per month basis to monitor and further support progress on behalf of the DfE. During this period progress in particular needs to be further progressed in these key areas:

- Strategic and Operational Improvement Boards need to develop and mature demonstrating strong independent chairing overseeing delivery, on a true partnership basis, of a detailed improvement plan. These bodies are relatively new and operating models are well described but not tested. Work to enhance system leadership and further embed culture change must be prioritised;
- The Improvement Plan has much to commend it but it is in the crucial phase of development and once finally approved by the partnership, more detailed evidence of how operational delivery of the programme of improvement is needed;
- Whilst progress in strengthening member oversight and challenge is underway, evidence needs to grow and enhance as to how political support/challenge particularly through corporate parenting and scrutiny functions will be effectively delivered;
- The new leadership team within childrens services has made strong progress. Some of the team are however on interim contracts and care is needed to ensure constancy of purpose is not lost as a consequence;
- A more joined up corporate LA needs to also ensure that all levers and opportunities are taken to enhance the children and young people's agenda. The significant economic and regeneration ambitions for Middlesbrough should also for example be judged on their impact in transforming communities and subsequently supporting improved outcomes for the youngest citizens;
- The greater clarity around practice expectations and social work delivery models has understandably not yet produced much more than specific or anecdotal evidence of impact on practice and thereby impact on children and young people;
- The new investment and approach to Quality Assurance and Performance is welcomed but needs to be sustained overtime to avoid repeating historic weaknesses in consistently embedding change across the organisation;

- The front door arrangements are crucial and specific challenges posed by Ofsted need urgent addressing. The operating model for doing so is changing and the coming period is key to understanding how those challenges are addressed in new delivery arrangements;
- The LA must prioritise work on its sufficiency and permanency strategies enhancing decision making and capacity to enable only the right children to be in care and that when in care they remain local. Within that context we will be keen to see any early impact of the NWD programme in supporting reductions in the care population and local placement stability;
- Caseload levels must be carefully monitored and reduced particularly in the assessment teams. This will be a particular challenge if increases in child protection plans and children in care post inspection are to be effectively responded to. It will also require continual review to assure that required resources are made available to deliver.

The Commissioner is asked to present a further report to the Minister in November 2020, updating his recommendations based on his engagement during the intervening period and a further review at that 6 month stage and then again at 12 months (May 2021).

In addition, the independent Chair of the Improvement Board is asked to produce update reports to the Minister summarising progress in delivery against the Improvement Plan.

3. The Local Authority area: Middlesbrough

3.1 Middlesbrough is a large post-industrial town situated on the south bank of the River Tees a few miles from the North York Moors National Park in North Yorkshire. The local council, a unitary authority, is Middlesbrough Borough Council. Middlesbrough's current population was estimated in 2016 to be 140,398. Middlesbrough is the smallest and second most densely-populated local authority area in the north east. Since a period of unparalleled growth in the 19th century, which transformed Middlesbrough into a major coal port and centre for ironworks, the town has been known for its ensuing steelworks, chemical plants, shipbuilding and offshore fabrication yards. The main economic driver, once dominated by these industries, has changed during the last fifty years. Since the demise of much of the heavy industry in the area, newer technologies have since begun to emerge e.g. in the digital sector/renewable energy. Middlesbrough also remains a stronghold for engineering based manufacturing. The town benefits from a strong further education sector presence with Middlesbrough College and Teeside University based locally.

3.2 Significant changes in the demographics of Middlesbrough since the 2001 Census highlight an increasingly diverse and ageing population in the town. 20.58% of Middlesbrough's resident population are aged 0 to 15 years. This is higher than the England rate of 19.05% and the north east rate of 17.74%. Based on 2011 census data 88.18% of Middlesbrough's resident population were classed as white (with various sub-groups) this was lower than the north east rate of 93.63% but higher than the England rate of 79.75%. Middlesbrough is the second most ethnically diverse local authority in the north east, behind Newcastle upon Tyne.

3.3 The Government's most recent (2015) Index of Multiple Deprivation rated Middlesbrough the 6th most deprived local authority area in England. Of the twenty Middlesbrough wards, six at that time had improved their ranking and fourteen had deteriorated.

3.4 Middlesbrough's council is led by a directly elected mayor with Andy Preston being elected in May 2019. The unitary council established in 1996 had always through to those May elections, been Labour controlled. The elections saw a major swing to independent members who now form the executive of the council. The Chief Executive is Tony Parkinson who has a long history within the LA being appointed into current role initially on an interim basis and then permanently in July 2017. The current Director of Children's Services is Sue Butcher who joined the LA in November 2019.

4. Methodology: The Commissioner has been engaged in the following activity:

4.1 A series of structured individual interviews with key senior officers and political leaders within the LA and across key partner organisations.

4.2 Meetings with the Chief Officer of Resources and Finance team, Legal and the Performance and Commissioning team. Additionally, meetings with key HR personnel and those leading staff recruitment and retention activity took place.

4.3 The Commissioner benefitted from meetings with senior representatives of Ofsted and with the Trade Unions which represent most childrens services staff in the LA.

4.4 A wider staff consultation exercise was created which received a level of detailed individual submissions from front line staff and managers.

4.5 I also attended and participated in two meetings of the Improvement Board (one on a virtual basis) and had separate individual discussions with the lead officer developing the draft Improvement Plan.

4.6 Focus Groups with some front line staff and with first line and middle managers on generic or a topic basis have been held. A wide range of reports and existing analysis has been made available.

4.7 I visited and observed the operational working of the front door (MACH) and a copy of my summary report is attached as an Annex.

4.8 I have interviewed 3 other Directors of Children Services whose LAs are working closely with or providing current improvement support and an interview of the Chair of Regional ADCS group to understand the sector led improvement approach in Yorkshire and Humber and Middlesbrough's engagement in that offer. The latter facilitated the appointment of the Chair of the Regional Group as also Chair of the Middlesbrough Improvement Board. I have also sought and benefitted from the views of Local Government Association representatives.

4.9 I have undertaken specific discussions both with groups of Middlesbrough and with North Yorkshire staff to understand the development of "No Wrong Door" in Middlesbrough. A report summarising these discussions can be found as an Annex to this report.

4.10 Attendance at key political meetings, children and young people's scrutiny committee/corporate parenting committee has not been possible due to COVID 19 and I say more on the impact of coronavirus on improvement activity and the work of the commissioner later in this report.

Initially based in the main accommodation of children's services staff created informal opportunities for the Commissioner to engage and observe the organisational atmosphere first hand. All I met engaged in the work of the Commissioner with considerable enthusiasm.

I am grateful for the time people have given to engage and their detailed written submissions have all assisted my work greatly. I have sought to insert direct messages from staff to help convey and strengthen key points made in this report. The engagement of the Commissioner coincided with the national coronavirus pandemic. The impact of the pandemic on both the improvement work of the LA and Commissioner activity is described in the body of the report. I am particular grateful given these circumstances for the flexibility of all and the excellent administrative support I have received from officers of the LA.

5. The Challenges facing the delivery of Children and Young People's services in Middlesbrough as described by Ofsted:

5.1 November 2019 Ofsted Inspection (published Jan 2020): Outcome: inadequate on all 4 judgement areas. The full report is accessible at https://files.ofsted.gov.uk/v1/file/50143726

Ofsted concluded in their report that "Since the last inspection in 2015, the quality of children's services in Middlesbrough has deteriorated and services are now inadequate. There are serious and widespread failures that leave children in harmful situations for too long. Risks to children and young people, including those who are being exploited, are not appropriately recognised, and insufficient action is taken to help and protect children. Leaders had recognised that significant improvements still need to be made, but had not fully identified the extent of the inadequacy at the point of inspection.

Ofsted went on to say that "Children experiencing longstanding neglect come into care too late, and decisions for them to do so are made in response to a crisis. Senior leaders have recognised that there are serious delays in achieving permanence for most children in care. However, the action taken by the service to address this has not shown an impact on reducing delays for children. Management oversight in this regard is not sufficiently robust. Insufficient attention is given to ensuring timely care planning, particularly for very young children. This creates instability for children and hinders them in forming secure attachments".

Within the list of improvements specifically sought by Ofsted were the following selected areas:

- The understanding by partner agencies of threshold decisions for social work support and the quality of referrals.
- The quality and screening of referrals so that history is well understood, and appropriate information is sought to inform decision-making.
- The quality of social work assessments and plans and the extent to which they reflect the child's history and risks to children.
- The response to children who go missing from home, care and education.
- The response to children with specific vulnerabilities, including children aged 16 to 17 years who present as homeless, disabled children and children held overnight in police custody.
- The oversight and monitoring of and response to allegations against professionals working with children.
- The timeliness and effectiveness of pre-proceedings and care proceedings work, including the quality of contingency planning.
- The availability of sufficient, suitable local homes to meet the needs of children in care and care leavers.
- The quality and timeliness of permanence planning, including the appropriate use of early permanence.

- The provision of life-story work for all children in care.
- The access to emotional and mental health support for children in care and care leavers.
- The educational outcomes for children in care and the proportion of care leavers who are engaged in employment, education or training.
- The effectiveness of management direction and challenge by leaders and managers at all levels, including the effectiveness of oversight from independent reviewing officers.
- The effectiveness of strategic partnerships to work together to improve outcomes and protect children.

5.2 December 2015 Ofsted Inspection: Overall assessment by Ofsted at that point was that children's services in Middlesbrough "required improvement to be good" but the LA achieved "Good" ratings for Adoption performance and the experience of Care Leavers.

At that stage Ofsted described how "Children and young people in Middlesbrough are kept safe by the work of the local authority. When children are at immediate risk of significant harm, social workers respond quickly and effectively. However, due to insufficient management oversight of work in frontline teams and the failure of some professionals in other agencies to fully engage with the early help offer, some children and young people have experienced delays in receiving services. Despite the authority's need to identify savings, significant additional funding has been identified to further develop the early help offer. Assessments are generally good but because they are not always supported by chronologies of children's history or reviewed in timescales that match children's circumstances, the individual needs of some children are not identified as quickly as they could be. The local authority has been successful at retaining and recruiting staff. The workforce is relatively stable. There are manageable caseloads. Corporate parenting is a strength in Middlesbrough, with a clear commitment from the council to children and young people."

However they did indicate that:

- Performance management does not sufficiently help to improve practice.. A lack of audits in the last few months limits the local authority's understanding of the quality of frontline practice.
- Strategic partnership working is under-developed. The existing multi-agency bodies do not provide a strong enough focus for agreeing how agencies plan to meet the safeguarding and social care needs of Middlesbrough's children..
- Further improvement in children's outcomes is hindered because most care plans lack detail, clear actions or timescales.

5.3 March 2017 - SEND Inspection: This joint inspection determined that a "Written Statement of Action" was required because of significant areas of weakness in the local area's practice. The summary described how:

"The disability and special educational needs reforms have not been implemented effectively in Middlesbrough. There are significant weaknesses in the strategic leadership and governance of the reforms and, since 2014, local area leaders have done too little to improve outcomes for children and young people who have special educational needs and/or disabilities"

The summary went on to describe how in their assessment "strategic planning is weak and leaders do not have a secure starting point for jointly commissioning services across education, health and social care."

5.4 August 2018 - Ofsted Focused Visit: Inspectors looked at the local authority's arrangements for the 'front door', and concluded that "there have been considerable weaknesses in the quality of frontline practice with children and families in this part of the service" Whilst "immediate child protection issues are responded to well. ..the response to lower levels of risk is too variable. The authority has not been able to secure the full commitment of partner agencies and far too many low-level children's cases are being inappropriately sent to statutory children's services to resolve matters. This has resulted in unnecessary repeat contacts and delays before children receive the support that they need. High and increasing levels of demand and a lack of sufficient staff have resulted in piecemeal decision making, with insufficient information, poor recording and a lack of consistent management oversight.

5.5 April 2019 - Ofsted Focused Visit: Inspectors recognised that Middlesbrough local authority children's services are "actively addressing shortfalls in the provision of services to children and young people through a comprehensive programme of improvement. Their self-assessment accurately reflects where they are in their improvement journey and what more they need to do to improve quality and consistency of practice. There has been substantial investment and support from the council, peers and partners to improve services for children in Middlesbrough".

In response to 5.4 above, Ofsted found that "the local authority has taken decisive action, including restructuring services and increasing capacity in frontline social work teams. During this visit, no cases were seen where risk was unassessed or not being managed at the right level. Social workers and managers were positive about the changes and the benefits to their work. Strengthened performance management and management oversight are ensuring improved compliance, for example work being completed within the timescales of the child". However on this visit they continued to find that:

- the quality of social work practice is inconsistent

- assessments do not have a sufficiently strong focus on the analysis of risk and what this means for children.
- the quality of social work practice is not sufficiently consistent
- plans do not sufficiently focus on children's individual needs, and
- the child's voice is not clear within assessments and planning.

5.6 July 2019 - SEND revisited: Inspectors here were of the opinion that the local area "has made sufficient progress to improve each of the serious weaknesses identified at the initial inspection. There is now greater collective ambition for children and young people who have SEND. Crucially, local area leaders have secured the strong support of frontline staff who share their commitment to improving the outcomes achieved by this group of children and young people".

They describe greater confidence that "The local area's strategic plan provides a strong starting point for sustaining improvement in Middlesbrough's SEND arrangements. The partnership's vision and strategy are clear and ambitious". Plans for each 'workstream' are detailed and local area leaders are checking whether the actions in these plans are on track".

5.7 July 2019 - Ofsted Whistleblowing complaint: In July 2019 a whistleblowing concern was raised by local staff with Ofsted about practice standards in Middlesbrough. The concerns included allegations that statutory visits were not being undertaken and young people in care were in inappropriate accommodation. It also suggested that the concerns had been raised with senior leaders but without any subsequent action. As usual the concern was forwarded to the LA for a response and the Chief Executive commissioned an ex DCS to promptly and independently investigate. Whilst this investigation found many of the specific concerns to be unfounded with no evidence of unsafe practice, it did comment tellingly on leadership and cultural challenges which were seen to be impacting upon the rate and potential for further improvement. The investigation found that "staff were warm and welcoming, proud to belong to Middlesbrough Children's Services and wanting to do their very best for the vulnerable children and families they work with" but that:

"There is significant work to do to ensure everyone see the bigger picture and how it fits together and their contribution to it. They also need (and want) to see senior managers and other leaders talking and acting as a team"

"Some middle leaders are overly focused on their interpretation of team priorities at the expense of having a whole system perspective and being able to support and challenge others to play their part in securing and sustaining improvements".

In summary, it would appear that this is not a LA where performance has been persistently inadequate or an LA which has not responded positively to previously challenging inspection outcomes. Even this most critical recent inspection did also recognise within the LA areas of

more effective practice and evidence that where families are engaged childrens circumstances do improve. However, some repeated concerns about for example the quality of practice, the consistent quality of assessment and planning, the consistent application of thresholds, the quality of partnership working and the quality of management oversight are clearly recognisable over a significant period of time. They should be seen as not reflection of a temporary lapse in performance but something of a far more established nature. The involvement of a Commissioner was triggered by the identification of “systemic” failure in the 2019 Ofsted report, but one could also make an argument that some challenges identified have been “persistent”. Ofsted also highlight thematic issues around risk including minimising risk to teenagers which must be addressed as part of the future improvement journey of the LA.

This appears an LA where leadership has made progress in some areas but where they have been unable to fundamentally address recurring difficulties over an extended time period. Such a conclusion is significant in understanding not only the nature of the challenges now faced but also the depth and quality of the response now required.

6. What may be behind the most recent Ofsted outcome in Middlesbrough:

6.1 It must be recognised that those responsible for the delivery of children's services do so within a highly challenging local context. The Index of Multiple Deprivation identified that 30% of wards in Middlesbrough are in the most deprived 1% in England with one ward being the second most deprived nationally. It is therefore no surprise to also see higher levels of children increasingly being raised in families on low incomes and within families with higher incidents of substance misuse and domestic violence.

6.2 In that context however, there have been clear omissions in delivering the consistent quality of collective political and managerial leadership required to embed and sustain improvements in children's services in Middlesbrough. It is clear from my involvement in Middlesbrough that Ofsted were correct in the overall conclusions which they reached.

6.3 Overtime, the pre May 2019 administration, in power from 1996, may have become distracted or it is suggested, somewhat complacent and the level of subsequent challenge and scrutiny of the children and young person's service became more limited. At the same time however there are also examples of good pieces of scrutiny work from that period eg Early Help.

6.4 Post May 2019 the new Mayor's cabinet was composed of independents many of whom including the new Mayor and then Executive Member for Children had only been elected to the council for the first time. The lack of confidence and experience in the work of local government and respective roles of officers and members is striking and they were without doubt ill-equipped to address any previous deficiencies in the delivery of engaged political leadership.

6.5 At an officer level a very hard working and experienced previous Executive Director of Children (DCS), did not have sufficiently credible or consistent social care leadership capacity within her then leadership team. This impacted upon the quality and effectiveness of the delivery of improvement and created descriptions of a reactive pattern of leadership being present. An engaged and certainly present DCS, acting down to fill leadership deficiencies in the system. A grasping at "Holy Grail" initiatives without sufficient attention or prioritisation and subsequent weaknesses in the embedding of improvement within a developed local practice model. Staff describe expressions of the right words/language at the most senior level of the organisation but not connected and translated to front line practice delivery. As the July 2019 earlier independent investigation described of the then Director:

"Staff welcome her outward focus, her energy and practice wisdom but are sometimes overwhelmed by the very qualities they rate and aren't confident that they are able to keep up with her 'next new thing.'"

As staff said to me: "There has been no shared vision amongst the leadership and no clear delivery plan for improvement. Policies and procedures are not clear and change so often

it's hard to keep track of what we are supposed to be following in practice. An improvement plan is never followed through to completion."

"When change becomes the norm people just ignore the latest fad knowing there is no need to get to grips with it as it will change again pretty soon."

6.6 Despite an expressed openness for support from elsewhere, regional leaders would suggest that it was difficult to engage fully in matching Middlesbrough's improvement needs with the regional improvement offer. Consistent follow through of good intentions was often, it is suggested, lacking.

6.7 Pre Ofsted 2019 an improvement board was already in place. This is positive but it did not appear to operate from a comprehensive analysis of the challenges faced. Some suggest that these challenges were known within the service but only as fragmented knowledge which never coalesced into a comprehensive holistic and honest self-assessment. Leaders appeared not to have a full understanding of the breadth and depth of the challenges faced. The LA may also have been at risk of a lack of transparency and openness in its earlier improvement work. Partner agencies were not included in earlier improvement board activity and a sense may have existed of trying to manage through Ofsted processes rather than lead wider systemic change.

6.8 It appears clear that the Children and Young People service were not viewed and did not operate with a strong corporate ethos. Within the service itself, there were further silos with a lack of a single coherent narrative – pockets of effective practice within a managerial system which lacked common joined up systems and culture. This may reflect omissions in strategic vision and quality of leadership but resulted in poor transfers/inconsistent practice and inevitably weaknesses in the service experience for children and young people. Instability in leadership has further exacerbated the sense of a lack of continuity of shared purpose across the service. Heads of Services within children's services do not appear to have always worked collaboratively consistently or collegiately.

The 2018 Annual Social Work Health check found evidence that "communication within teams was good but communication between teams is poor".

As staff said to me: "There has been no consistency in handover points and the advice and guidance has changed multiple times over the past two years"

"The different service areas such as CiN/CP, assessment, CLA, Pathways, work oppositional to each other rather than taking one service view with the child as a priority. Each service area tries to protect itself and this can get confrontational and often there is a bad atmosphere between service areas."

6.9 Historic deficiencies in joint working between corporate and directorate staff are evident and this has impacted upon the delivery of effective improvement and efficiency

programmes. It has also resulted in structures being established pragmatically to reflect that deficiency. An experienced finance lead director managing No Wrong Door (NWD) and residential care delivery outside of other resource provision probably reflected a lack of confidence in finance and programme management capabilities within mainstream social care leadership. This has more recently now been resolved with a consolidation of resources and intervention under integrated management and positive engagement of senior social care leader in the oversight of NWD.

6.10 The care population appeared out of control. Planned reductions in the use of external residential care to achieve planned £1.4M efficiencies actually led to an annual run rate of £6M overspend. Growth in the use of connected carers is recognised with a rise from 64 to 176 such placements over the past 2 years. This now accounts for 29% of all placements compared to a national average of 13%. This development needs to be better understood as it may reflect organisational culture and defensive practice. Most worrying is the growth of over 150 children into the care population between May 18 and December 19 (a 30% increase) in an LA with both existing high care rates and unit costs at some of the highest in the country. Nationally the care population increased by 4% in the year 2018/19. Of most concern is that this picture did not appear to generate or lead to the effective delivery of an adequate local collective response. The LA has lacked a detailed sufficiency strategy to deliver the local family placements and edge of care provision so clearly needed.

6.11 A lack of confidence exists that young people are on the most appropriate orders or in the most appropriate placements. A lack of confidence in core practice/interventions may have resulted in risk averse mechanistic applications for proceedings, subsequent applications for particular orders or premature engagement in Public Law Outline (PLO) processes. Appropriate advice from an historically stretched legal service, may have carried greater significance for case decision making in the absence of internal pathways and/or consistent management challenge.

6.12 The area has lacked an embedded understanding of a consistent local practice model across the organisation. New initiatives were not fully implemented before new ideas to enhance practice were then introduced. This resulted in confusion, inconsistency and a lack of depth and maturity in the development of local practice. Practice models adopted eg Signs of Safety, appeared implemented in the eyes of some, once training was completed, rather than a part of changed practice, language and culture within the whole organisation.

As staff said to me: “the vision and direction of travel has at times been somewhat confusing from the most senior leaders, we appear to have had a multitude of improvement plans, theories for improvement”

6.13 A disconnect appears to have occurred in social work teams regarding practice expectations. A drive to enhance “grip” through tick box mechanisms failed to achieve the evidence needed for Ofsted but was also undermining of the implementation of

improvements in social work practice. It was suggested to me that compliance has dominated at the price of quality and staff have as a consequence been disempowered. The existence of what was described to me as additional local "rules and burdens" eg the requirement for monthly care planning meetings, demonstrates inflexible, unrealistic and unnecessary controls to tackle albeit recognised practice deficiencies.

As staff said to me: "We need to change the language and mindset in the organisation ….compliance will be met by the quality of work that we do"

6.14 Internal performance challenges for all agencies means that work to enhance shared system leadership is underdeveloped. Agencies may historically have become more inward looking in response to performance challenges from their respective regulators. Partnership working it was suggested, has not been supported by challenges in preparing shared data/analysis across organisations who are working on differing geographic footprints. The lack of coterminosity has challenged the capacity of some leaders to consistently engage on a specific LA level and the development of joint strategy/provision across wider footprints has been inconsistent.

6.15 There is a history of the organisation on a partnership basis making really strong progress post challenging inspection experiences eg SEND. This gives some confidence for the future, but also raises fundamental questions as to why external challenge is need to provide the clarity and focus good internal challenge processes should proactively provide. The organisation and partnership historically appears to have needed external criticism and reputational damage to point it into the right direction collectively. As one partner said to me "Inspection proved a catalyst to move a lot of things on". When reviewing other Ofsted feedback received during 2019 there is also significant evidence presented which would support the need to do more of the same rather than the feedback generating more fundamental change.

6.16 Key leaders of child and adolescent mental health provision recognise that the system has historically struggled to provide the range of tiered interventions needed across the partnership. There are important gaps in local provision including no specialist CAMHS team for LAC and limited school based mental health provision. Whilst individual assessments and some interventions for those in greatest need are available, the capacity to work proactively and deliver wider preventative, training/development and consultancy roles are less developed.

6.17 The overall service has historically taken an immature approach to performance management with data being available but not consistently analysed and then used to enhance both collective understanding and subsequent improvement planning. Performance management was seen as a burden rather than core business; data analysts and professional practice managers failed to consistently work well together with any apparent clarity and respect for respective roles.

6.18 Policies and procedures for the service are underdeveloped and often in need of review and updating. They are said to lack sophistication and are potentially more to do with needing a policy/procedure rather than supporting core practice. Certainly the shared Tees threshold document is an example of a document now being reviewed which did not support consistent decision making.

6.19 The IRO service has not been successful enough in fully impacting at either an individual case level or on collective practice. The service would suggest that evidence of deficits in both were presented (although Ofsted found this to be inconsistently so) but often within a service and forums where attendance/core compliance was limited. As a consequence improvements sought were not always delivered.

6.20 Governance of improvement programmes have lacked focus, rigour and discipline. Non-compliance appeared to have limited consequences. The culture has certainly been one of high support but apparently without consistently high levels of required professional challenge. Instead reasons have been found not to challenge often based in the difficulties faced within this deprived community. A lack of credibility in some leaders and constant leadership changes have stifled the development of quality professional relationships which facilitates higher shared expectations.

6.21 Whilst the financial resources made available by the LA for the front line childrens agenda have clearly been prioritised, the budget has not kept pace with escalating demand and growing costs. Austerity it is suggested led to a local “decimation” of support services and a movement not atypical nationally, to a model seeing operational managers assuming greater responsibilities. These models can work effectively. However service indiscipline and a lack of prioritisation led to difficulties in implementation and further tensions it is suggested, between corporate and departmental leads. At the same time sickness absence levels within children’s social care were some of the highest in the LA and ahead of national comparisons.

7. How effective or otherwise has been the response to the inspection findings?

I have used the structure of the **"enablers for improvement"** model to provide the following analysis.

7.1 **LEADERSHIP GOVERNANCE and STRATEGY: In Middlesbrough**

There has been an impressive response to the inspection outcome. All including Mayor and Chief Executive have accepted the findings and concentrated on the delivery of necessary improvement. The Mayor fronted the media response and the Chief Executive has made clear to staff that the organisation let front line staff down and not the other way around.

The local political system and new Mayor do carry considerable potential for greater strategic influence and delivery of real impact on partnerships and Middlesbrough as a place. Understandably that potential has yet to be fully realised.

Leaders are invariably highly ambitious and deeply passionate about the place, with high justifiable aspirations for economic regeneration and subsequent benefits for the whole community. This ambition has not always however been connected to or expressed in ways which enhance the children and young people agenda.

Post inspection, significant decisions have been made to fund the local improvement journey. An additional £3.3M over 2 years has been made available to enhance capacity particularly around leadership, system development, programme and performance management etc. In additional a further recurring £3.6M has been added to the core budget due to historic overspends particularly arising from placement costs.

Previous deficits in practice knowledge and wisdom at a senior level of the children's social care service appear to have been addressed. Senior appointments have been made at DCS, Director of Childrens Care, and Head of Service Transformation all whom carry significant experience/credibility in the improvement of children's social care services. Many have worked in LAs facing comparable challenges and carry with them evidence of the delivery of sustained improvement. They are on longer term contracts with the LA (minimum of one year) and very much describe themselves as permanent rather than interims and appear committed to seeing through the longer term improvement journey.

As staff said to me: "The new management in place is listening to staff and creating a new culture that staff can buy into. Staff can now feel confident that they are being listened to and that action where possible will be taken. Support plans are being actively implemented"

The new leadership have also rightly recognised the strengths and capabilities in place amongst the existing workforce. There certainly appears a strong compliment of leaders/managers within the service with considerable potential to fully contribute to necessary improvement. Unusually and probably as a result, there does not appear a

disconnect between new and existing leaders/managers on how key and necessary improvements will be delivered.

The Chief Executive is known, appears respected within the children and young people's service and has undertaken responsive visits and engagement with the front line. He is actively involved in all induction sessions describing core values and subsequent expected behaviours of the people of the organisation. The LA has worked hard overtime to develop its branding and key values which are clearly represented across the organisation. Staff recognise and support/welcome this work. He has been active in the Improvement Board chairing meetings until an independent Chair was identified.

The new DCS is said to have brought a calm and focused discipline to the organisation. She is already known, visible and respected including on a corporate footing. The organisation repeatedly expressed confidence in her individually and welcomed the clarity and confidence she brings to the role. She is said to be responsive in her communication and takes an "if you have a problem I have a problem" approach. She is said to be creating a culture where there is greater clarity about shared expectations/non-negotiables and thereby potentially reducing the inconsistencies that have been previously apparent particularly in social care.

An energy for change at pace is now evident at the most senior levels of the organisation and there is growing evidence of more joined up, engaged and productive joint working across the LA between corporate and directorate leaders.

A new Lead Member of Children's Services (not education) has been appointed. This role is to be filled by the Deputy Mayor who brings considerable energy, competence and relevant experience to the role.

The LGA have been engaged to develop a bespoke programme of support to local politicians. This will be comprehensive and includes mentoring/training of those fulfilling specific roles as well as wider member awareness training. The LGAs work could also support the Mayor in understanding how personally he can positively support and "touch the system" of improvement. The organisation is already however revisiting the Mayors 9 priorities at a work plan level to better reflect the children's agenda.

Despite the difficult political history recent budget process gained significant cross party support and the Labour Group have expressed to the Commissioner a clear desire to work constructively on delivering a political climate which supports children's services improvement.

There is also evidence of progress in the delivery of the LAs economic ambitions with implications for local people from a Mayor/cabinet and Chief Exec well connected to local voice/communities.

7.2 WORKFORCE: In Middlesbrough

There is clearly a considerable cohort of people within the organisation who care deeply about the place where they work and often live. People who have made a long term commitment to the area and to the organisation.

Whilst the overarching Workforce Strategy is said to lack depth and understandably coherence with the newly developed Improvement Plan, there appears a more engaged and connected mood across leaders at all levels of the organisation.

The social work teams are relatively small affording good potential opportunities for supervision and management oversight – the previous lack of a one service approach will have reduced opportunities for resource sharing in the interests of service continuity.

The social work teams, unusually for an LA in intervention, are not dominated by the significant use of agency workers. The workforce itself is said to be inexperienced but clearly this will change over time depending on retention capabilities. There has been good access to both Front Line and StepUp programmes and a retention scheme of remuneration is in place.

The workforce is supported in their work by relatively good infrastructure arrangements eg office accommodation/ICT/case management system etc.

Whilst there are times when this may not have been the case, it is now fully recognised that newly qualified social workers (ASYEs) have to consistently be afforded caseload protection and clear opportunities to make the most of development and training offers.

There is a recently updated career progression route for social workers closely aligned with local practice standards and the national skills and competencies framework. This is positive but one wonders whether the top of the grade may be more accurately called a senior practitioner. This could support both retention/career progression and clarify expectations. The LA has oscillated in its approach to Deputy Team Manager's roles and expectations of them – this would appear to be resolved with greater clarity around their intended practice focus.

There has been positive engagement with the National Assessment and Accreditation System (NAAS) but more is needed to embed core skills and competencies into all job description and recruitment processes. There is now a dedicated Principal Social Work role well equipped with the highly experienced Director of Practice to champion practice improvement

Social work caseloads are too high in the current assessment teams. Leaders are rightly cautious about simply adding extra social work capacity at the issue believing it may reflect other factors. Additional temporary teams have however been created to reduce duty

pressure on assessment teams to enhance throughput and thereby reduce caseloads particularly given the added challenges of COVID 19.

The respective Trade Unions have been consulted as part of the Commissioner role. They consistently describe current leadership of children's services as providing a level of effectiveness and engagement not previously experienced. Given this they express confidence that improvement will be delivered. They suggest that whilst formal liaison forums existed historically, concerns of the Trade Unions around workload, sickness levels and restructurings were not in their opinion resolved. They recognise and welcome the clearly expressed ownership of the outcome of the inspection at the most senior levels of the LA.

7.3 PARTNERSHIP: In Middlesbrough:

Strategic and Operational Improvement Boards are now in place on a partnership basis with clear membership and terms of reference. An immediate compliance plan has been in place and well monitored and a longer term Improvement Plan is in an advanced state. Work has been undertaken to locate the work of the Boards in the context of wider strategic planning activity eg Children's Trust. Clarity through experience is needed however as to how they will work effectively together. It is encouraging that an independent Chair for the Strategic Board, an experienced and credible Director of Children's Services from the region, has been identified. This should also enhance opportunities for engagement with the regional improvement support offer.

There is good representation and active engagement of headteachers on the Strategic Improvement Board. They express confidence in the LA response to COVID and the work of individual officers. They are keen to see historic inconsistencies in joint working around vulnerable learners overcome and express greater confidence in delivery against increasingly clear priorities. They share the view that there is much learning from the response to COVID that should become more mainstreamed.

Cleveland Police have faced significant historic challenges and inspection criticism. As a result a relatively new Chief Constable and an experienced seconded team from other forces have been brought together to deliver required improvements. They are keen to enhance joint practice, work closer with local communities and provide the consistency and quality of leadership which the organisation requires. In doing so they will enhance the quality of response to Ofsted and the senior officers I have met seem well equipped for the challenge.

The leadership of the health services have also been potentially distracted by organisational changes and internal performance challenges. The SEND inspection outcome was said to have a cathartic effect. As a consequence we now see dedicated childrens health commissioning capacity and a renewed commitment to seek collaborative improvement. Further examples of joint commissioning around speech and language therapy are now

available. The provider of the healthy child programme is highly credible and committed to collocated joint practice.

The current CAMHS provider is committed to supporting the development and if successful mainstreaming of No Wrong Door model to help address historic deficits. The provider also recognises new opportunities for better engagement, improved commissioning and clearer strategic oversight partly as a result of new care and commissioning models but also as a result of closer recent engagement with DCSs across the Tees valley.

It is also highly encouraging that the voice and influence team can describe examples of engaging on a partnership basis and an appetite for cultural change at senior levels of partner organisations being translated into specific activity.

Despite the challenges described earlier for partnership working there are examples of effective partnership working. The strong performing South Tees Youth Offending Service, the improvements made in response to Ofsted on the SEND agenda; and in the work of the local Children's Strategic Partnership. In 2019 the Inspectorate said "South Tees YOS delivers outstanding work with children and young people across the region. Staff are particularly strong at assessing cases; they demonstrate a clear understanding of each child or young person's life and the factors that affect their current behaviour and risks."

7.4 PRACTICE & SYSTEM: In Middlesbrough

The new DCS/Director of Childrens Care and Heads of Service share both credibility but also practice confidence which can if consistently implemented enhance the focus of the organisation on improving practice. Whilst leaders express confidence in their ability to deliver sustainable improvement, at the same time they express an absolute openness to work with others including other LAs/Partner in Practice LAs on the right issues. This engagement will be aligned to the Improvement Plan and driven by the LA and its partners.

Post inspection, a **Strengthening Practice programme** which embraces elements of previous models eg signs of safety is being rolled out. Significant enthusiastic attendance by practitioners at what has been helpfully branded "Clarity and Confidence" workshops has achieved very positive feedback. Anecdotal evidence of the impact of these sessions is also available. Importantly, these sessions have been jointly delivered by local senior leaders alongside external capacity/expertise. It also appears significant that these sessions have focused specifically at areas highlighted in the Ofsted report eg safety planning, Post 16 statutory responsibilities. A manager's element of that programme was planned for Spring 2020. Delivery of that training is affected by COVID 19 although coaching and online work is happening remotely. However the scale of the challenge should not be underestimated as recent audit activity focused on neglect found further evidence that:

"children in Middleborough who are living in neglectful situations are not consistently receiving the 'right intervention' at the 'right time'. Some children are stuck in a revolving

door into Social Care, in a cycle of referral and assessment but only receiving help at crisis point. More rigorous attention is required through management oversight and a focus on positive and purposeful intervention. SMART planning is key and plans need to be understood and owned by the children and their families. An area that also requires timely improvement is the fact that the child's voice and views need to be represented. It is vital to include the child's lived experience, the history of the parents and the impact that this all has for the child".

The **front door** is currently delivered through a shared joint arrangement with a neighbouring LA, Redcar and Cleveland. The service whilst directly managed by Redcar and Cleveland, is overseen by joint governance arrangements. Governance and resourcing of the provision has to date been ineffective. Attached at **Annex 1** is a summary of Commissioner feedback into current discussions on future options for that joint arrangement. In that annex I conclude that: *"The current integrated front door appears to pay the price for clear omissions in the original planning; design; resourcing and ongoing governance of the shared arrangements".* However management capacity within the service has now been enhanced and governance improved. Encouragingly recent independent audits of decision making in the MACH would suggest that some operational improvements have also been made. This is encouraging in evidencing that work on clarifying thresholds and decision making at the front door appears to be having an effect. Whatever the form of future MACH organisational arrangements, there remains more to do to maintain this progress and enhance the overall quality of front door arrangements. The Improvement Board of the 22 April heard of the decision to move to a Middlesbrough specific front door located alongside assessment teams from 1 June 2020 on an at least interim basis. Partners had been well engaged in this decision and most felt confident they could operate well within it.

The **Early Help** offer (Stronger Families) as recognised by Ofsted, has much to offer in providing targeted support to families and engaging single agency activity by others. The service works with approx. 900 cases directly with 600 supported on single agency basis. The service has changed becoming more targeted, evolving overtime and will continue to do so mainstreaming e.g. Troubled families' provision. It has a far stronger reputation as a service, undertaking evaluation of its impact and of engaging positively with the voice of the child and family. Unusually within Early Help, is a Family Partnership team with more developed expertise around Trauma Informed Practice. The work of this team has to date been focused on more complex cases which come back into early help but this may be worthy of reconsideration. A considerable amount of post inspection work has been undertaken to jointly audit early help work and a significant number (130) of cases have been moved to be in social care where additional capacity has been created to accommodate.

The ICT system used by staff is well regarded nationally and fit for purpose but the system has not to date been developed locally in a way which supports practice and system

improvement. Work is now underway under a newly formed LCS Transformation Board which directly links to practice priorities around eg kinship carers and permanency planning.

The LAs work on voice and influence has been comparatively underdeveloped but over the past 15 months appears to have made significant progress. A range of tools/groups/ resources have been developed and a strong research evidence created. Whilst training has been well received, consistent implementation of stronger participation at an individual case level has struggled because of the lack of perceived discipline and consistency of management grip within the social care leadership teams.

The LA have also recognised the importance of enhancing their approach to communication and in particular strengthening awareness and support for the campaign 'Middlesbrough Children Matter'. External expertise has been sourced to deliver this and linked sub-campaigns around Futures for Families and Raising Aspiration. They will create a Multi-agency Communications Board, chaired by the DCS which will be made up of partner decision makers on behalf of their organisations. They will work to further establish what matters to Middlesbrough children, how they can and would like to engage as partners in shaping service delivery. They will also seek to clarify how key messages about them and about services can best be developed and shared by and with them. Importantly the strategy will be built on co-research and co-design with young people and those who work with them. This approach further evidences the growing commitment to a culture of greater engagement and improved communication on a partnership basis.

The Ofsted challenge on "the quality of permanency planning" is fully accepted locally and improvements are certainly being sought strategically and at an individual case level. There appears to an acceptance that the current care population reflects that history rather than current need. The need to fully reengage with core principles of the legislation within the workforce and the wider system is recognised. At the same time, those principles eg presumption of no order must be embedded within more robust assessment, planning and enhanced capacity for interventions. A language of strengthening practice and in so doing meeting agreed compliance requirements is now more common.

Encouragingly, new reshaped Legal Gateway and Permanency Planning arrangements have been recently introduced. Agreed investments in legal capacity should also enhance capacity to engage more proactively with the service.

The more recent greater consolidation of resources and intervention including family group conference capacity, under integrated management is necessary and welcomed within the organisation. Whilst integrated the model also sees the outreach embedding of intervention capacity within each of the assessment teams. Again this has considerable potential to enhance the speed of delivery of intervention and support.

In response to the Ofsted inspection the service has created additional Personal Assistant capacity in the **Pathway/Leaving Care** team and permanent recruitment has now taken

place. In the interim, agency Personal Assistants were sourced and this has enabled reductions in caseloads of PAs from over 30, to an average of 22. The service is collocated with LAC health resources and the risk and resilience/VEMT service. The team also has a seconded dedicated CAMHS worker. All create good opportunities for effective joint development work, some examples of which can be found. The Pathway Plan is being redeveloped in consultation with young people with the aim of being shorter, more engaging and at the same time provide a sharper analysis around risk. Lower caseloads aligned with improved assessment tools and management oversight should support an improvement to the quality of practice, support and interventions provided to care leavers. It is also hoped that from September 2020 new LA arrangements for allocating appropriate accommodation and new housing options will directly enhance the availability of suitable accommodation.

Additional capacity has also now been agreed to support the assessment and re-assessment of all **children with additional needs** who are receiving short break provision. All children newly identified as needing a short break are receiving a service in line with the DFE standards, i.e. assessments are undertaken by a social worker. The additional capacity will also seek to ensure that the current back log of cases which require a social worker to complete a reassessment of their needs will be resolved. This responds positively to the Ofsted challenge. The service is now increasingly feeling part of mainstream provision with staff better placed to access relevant training and development opportunities. The service may wish at some stage to consider opportunities to integrate leadership of residential and home based short break support to enhance the flexibility of provision to children and their families.

7.5 IMPROVEMENT & INNOVATION: In Middlesbrough

The **12 week Assurance Plan** was well structured with clear milestones/ownership and progress is updated and monitored on a weekly basis including risk analysis. It was “of its time” but does provide evidence of prompt and effective action and of delivery of important compliance with some key Ofsted requirements.

The work to produce an overarching **Improvement Plan** is advanced and benefits from dedicated capacity from an independent source. It has been produced in an inclusive way which seeks ownership across the organisation and partnership. The Plan rightly in my view, seeks to ensure that practice improvement is located within a wider approach recognising that to be sustained, improvements in leadership/management and organisational culture on a partnership basis are also required.

There is a real local appetite for the **No Wrong Door (NWD) programme**. All welcome the opportunities it provides to enhance capacity and impact but also the contribution it can make to necessary changes in organisational culture and partnership working. A more detailed report on NWD is attached at **Annex 2.** I conclude in that report that NWD Middlesbrough should remain in the programme because it carries:

"the potential to both deliver and contribute to key improvement priorities in Middlesbrough. The need to enhance the range of interventions available and creatively respond to the needs of vulnerable young people in and on the edge of care is greater here than in almost any LA. Planning for delivery is very advanced with key staff appointed and some in place and significant investment has also been made in the hub building. The managed delivery model in place provides real opportunity to safely land operational delivery in a context of currently clear senior/middle and political leadership support. The service may not be landing on operational "fertile ground" but can play an important part in enhancing both the range of provision whilst also contributing to the heightened ambition for improvement on a partnership basis".

Whilst the organisation is keen to better understand workload within the social work teams, decisions have been made to enhance capacity by investing in 2 additional temporary teams in assessment and in child protection/child in need. These teams will both build capacity needed in the short term; enhance resilience through COVID 19 but also support improvement work by modelling quality assessment and intervention work.

The LA can also now evidence local initiatives around for example both contextual safeguarding and domestic violence which must build partnership confidence in the joint ability of organisations to deliver proactive innovative approaches which address local challenges. This work should and it is said will, ideally be located within refreshed strategic approaches.

An important priority for new leaders has been improving the approach to quality assurance and subsequent practice learning. This has many strands to it including significant levels of jointly undertaken review work of current cases held in Early Help and there subsequent transfer to social care; reviews of case decision making in the front door and current cases in the assessment service; the commissioning of an organisation to complete a series of audits focused on the above areas but also focused on repeat S47 investigations and child protection cases featuring neglect. All of these factors were concerns expressed in the Ofsted report. They are also working to ensure this external capacity works closely to enhance the consistency and skills of LA auditors and managers to embed improvements in the longer term.

Most importantly the organisation has amended their approach to learning from audits and other sources of evidence/feedback. Previous tiered models of performance clinics are said to have lacked disciplined attendance and subsequent follow through. New models, see the potential for greater engagement of managers from all levels of the organisation aimed at ensuring that learning from whatever source (audit/data/IROs/complaints/voice and influence etc) is consistently understood debated and actions arising more robustly implemented. Additional audit capacity is in place in the short-term and crucially plans are in place to upskill local auditors/managers to ensure a shared understanding of good practice and high challenge is in place within the organisation.

At the same time, stronger connections have been made to ensure that this learning feeds directly into the work to enhance the focus of training and development of staff, the work of the Principal Social Worker and the development of a planned Centre for Excellence. These approaches aligned with leadership and culture changes, carry considerable potential to move to an organisation which not only knows itself comprehensively, but one which is better placed to more consistently embed actions which deliver clearly necessary improvements.

7.6 RESOURCES: In Middlesbrough

As described earlier, post inspection, significant decisions have been made to fund the improvement journey. An additional £3.3M over 2 years has been made available to enhance capacity particularly around leadership, system development, programme and performance management etc. In additional a further recurring £3.6M has been added to the core budget due to historic overspends. The latter however is not sufficient to address last year's outturn.

Pre inspection and pre NWD the LA had already agreed investments (£1M) and delivered enhancements in the availability of local placements – 2 bed units and new post 16 provision.

The approach to Commissioning and Procurement within childrens services carries with it considerable potential for improvement. Effective commissioning can it is recognised support the delivery of improvement and greater financial efficiency. Historic inconsistencies in senior leadership and challenges in agreeing clear priorities for improvement may have affected the effectiveness of joint working between specialist commissioning staff and senior leaders of childrens services. Considerable activity on a regional and sub-regional footprint create potential opportunities but require a strong local professional analysis of need for effective engagement. Examples exist where weak change programme oversight and governance impacted on effective delivery eg strong fostering campaigns without the capacity to undertake the volume of subsequent new assessments.

There are strong relationships with the voluntary and community sector and some progress has been possible in joint commissioning with the S Tees CCG and Redcar and Cleveland LA (eg speech and language therapy). This could be extended further on a wider partnership basis eg with Police and Crime Commissioner. The commissioning team has recently enhanced its capacity with a dedicated specialist children's team leader and there is far more of a sense of the team being closely integrated within children's departmental management team leadership structures. New leadership is also engaging more effectively with public health to ensure that commissioned services like the healthy child programme is delivered in an ever more integrated way. There is certainly energy, expertise and collective will within the organisation to enhance the quality of needs analysis and stimulate the redesign or procurement of services better placed to meet local requirements.

8. The Implications of COVID 19 on Improvement and the work of the Commissioner:

8.1 LA leaders had initially expressed confidence that the challenges presented by COVID 19 would not distract from the pace of their improvement work in childrens services. They were keen to see whether the challenges presented may indeed help unlock cultural changes needed within the organisation and partnership. As evidenced below and in Annex 3 there is some evidence of this being the case. However, it is increasingly now recognised that certain improvement activity will of necessity have been adversely affected by COVID 19. Training programmes have needed to be deferred, new delivery models have been unable to be launched with their originally intended focus and collaborative partnership activity has lost potential richness. In my view this is all inevitable and not as a consequence of any deficits in local ambition, energy or leadership.

8.2 In terms of the work of the Commissioner, it was possible to undertake considerable face to face fieldwork during March and before the national lockdown expectations came into force. A considerable number of interviews and group discussions have since been possible remotely and access to key documentation has been unaffected. There have been some limitations again inevitably, on the opportunities for the Commissioner to visit more frontline services to test hypotheses across the depth of the organisation. Attendance at and the holding of some key political meetings, children and young people's scrutiny committee/corporate parenting committee has not been possible.

9. The LA Response to COVID:

9.1 I attach my analysis at **Annex 3** on the LA response to COVID 19. The analysis is again structured against the enablers of improvement and completion benefitted from key questions supplied by DfE.

9.2 In summary, it demonstrates the incredible challenges presented to the delivery of core LA provision by COVID 19. Challenges amplified by the lack of comparative experience and expertise of such scenarios upon which leaders could draw. In such circumstances leaders have needed to adapt, prioritise, continually focus and refocus, work collaboratively and communicate well. In Middlesbrough, there is strong evidence that this has been in place. There is a sense that the response to COVID 19 provides evidence of leadership styles which will also be needed in the longer term to deliver sustained improvement in children and young peoples services. The response to COVID has of necessity required:

- whole council/whole department engagement which strengthens key relationships and promotes ever more collaborative delivery;
- a whole system response recognising shared explicit priorities and jointly agreeing deployment of ever more shared resources;
- flexible creative approaches to communication and engagement which better connects all levels of the organisation;

- opportunities being created to add value to service delivery through enhanced corporate/partnership working and engagement with wider region.

At the Improvement Board meeting of 22 April the Board heard of further progress on the completion of child safety plans. Across social care and EHCPs, approximately 3000 of the required total 3600 are now in place. At that same meeting, Headteachers described regular enhanced communication between social work staff and schools and a real appetite for closer joint working to support most vulnerable students post COVID 19.

It is also encouraging to see Middlesbrough respond positively to the Ofsted offer of inspectors coming to work during the pandemic in LAs. Their openness to receive inspectors into the service from the regulator demonstrates an openness/transparency and growing confidence in their improvement work. In addition and post the completion of the analysis at Annex 3, the LA have conducted an internal survey of staff on the response to COVID 19. Impressively the survey in children's services found in response to the questions:

How well do you think we have managed maintaining delivery of services during COVID 19?: 70% thought well or very well and 28% thought OK

Do you feel informed about how you should work during COVID 19?: 81% said Yes

The LA has also prioritised taking the views of young people on COVID 19 related issues. A survey launched on 3 April had by 15 April, 51 responses, included 100% feedback on young people "knowing how to keep themselves and others safe during COVID 19" and 100% having "access to smartphone tablet or laptop".

Both of these surveys are of value in themselves but also provide further positive evidence of an organisation keen to prioritise engagement with its workforce and children and young people in the face of myriad competing priorities presented to the organisation during the pandemic.

11. The Presumption: Alternative Delivery Models (ADMs)

11.1 The Commissioner is asked to specifically "advise and report to the Minister on whether an alternative delivery and governance arrangement for childrens social care, outside of the operational control of the Council is required".

11.2 The detail included in this report helps evidence the conclusion that in my assessment and at this stage, **an Alternative Delivery Model does not appear to be required in Middlesbrough**. Whilst there is still so much to do and the pace of progress on that improvement journey has been affected by COVID 19, there are also evident strengths which should be allowed to further flourish. Immediate assurance plans are in place and new political and officer leaders are instilling a new sense of shared confidence at least within the LA. There is certainly no senior organisational denial of the challenges faced and additional capacity has been released to support necessary improvement. The new

leadership team is well versed in what good practice looks like, are working well together and there is a far greater focus and cohesion between corporate and directorate resources.

11.3 There are examples of ADMs bringing enhancements to quality through expert governance and skilled challenge. This has been lacking in Middlesbrough and considerable work is needed to ensure that both political scrutiny and oversight by the Improvement Board is of a similar high standard. If the recommendations of this report are accepted the Commissioner will be keen to see and support improvements in professional oversight, scrutiny and system leadership.

12. Concluding Analysis:

12.1 The LA area covered by this LA contains some of the most disadvantaged communities in the country and the impact that disadvantage has on the wellbeing of children and young people is inevitably considerable. As consequence they need access to the highest quality of service delivery from the LA and its partners. Provision which has the capacity and quality to ensure local children and young people are increasingly safe and life chances are consistently enhanced. The Ofsted inspection of November 2019 judged the LA "inadequate" against all elements of the framework. This is the most critical assessment that can be made on service delivery, for a geographic area where excellence in delivery is particularly needed.

12.2 Encouragingly there is no challenge from any quarter to the Ofsted outcome and new political and officer leaders have embarked upon detailed improvement work at pace and with expertise. As described in the body of this report there is prioritised and sequenced improvement activity underway which is visible in increasingly developed plans and overseen by a governance structure with considerable potential. Most encouragingly the organisation is working more collegiately within the LA and the directorate but also the potential for improved partnership working is there to take. Additional resources have been agreed to supplement what is already a workforce with considerable talents and local commitment.

Given this, there are reasonable grounds to conclude that this is not an LA where alternative delivery models are needed at this stage. It is recommended that the LA and its partners are afforded the opportunity to further enhance their improvement activity to date. To be given the chance to create the conditions where over time we will increasingly see the improvements in practice which are needed.

COVID 19 has brought unparalleled challenges to the LA and wider system leaders. As demonstrated in this report there is much to commend this LA for on its response. They have evidenced their ability to lead, co-work and communicate highly effectively, collectively and at speed. COVID 19 must inevitably however have impacted upon the planned improvement activity during this period. This would be the case anywhere. Whilst

considerable activity has still been possible other work has needed to be deferred. The positive messages on the work undertaken to date and actions underway to deliver change to organisational culture and practice needs more time to collectively embed. Given this the option of maintaining Commissioner engagement over the coming period to support improvement activity is also recommended.

This role would be on an approximately 2/3 day per month basis culminating in a more extended stocktake in November 2020 and then again in May 2021. At each stage a further report to the Minister would be provided.

Annex 1: MACH arrangements Middleborough/Redcar and Cleveland: some reflections: March 2020

These comments are provided to assist current strategic discussions but are however based on limited experience gained over the past 2 weeks talking with senior leaders and visiting the service – they certainly do not equate to a full review.

Reflections:

- The current integrated front door appears to pay the price for clear omissions in the original planning; design; resourcing and ongoing governance of the shared arrangements;
- There has and is a challenging context for the shared delivery arrangements with the service having to strive for improvement of new arrangements in the face R and C system challenges; Middleborough Ofsted inspection and now Covid 19;
- There have been omissions and instability in the management capacity of the service which has been recognized and which are now beginning to be addressed eg deputy Team Manager roles – you could suggest that these issues should have been included and addressed proactively in the original design discussions;
- The planned strategic and operational groups to jointly oversee the work of the team have previously been ineffective with cancellations and inconsistency of attendance;
- The quality of performance data and subsequent analysis relating to the service is very underdeveloped;
- The service is not doing strategy meetings a key benefit of the integrated approach;
- Police capacity appears very stretched but this now appears to be recognised;
- The service has been challenged to do more than deal with core operational processes - ambitions to undertake strategic work to improve eg referral quality or engage in issues of audit/quality of the work has not been delivered – these issues were also subsequently highlighted by Ofsted;
- There are a good wide range of partners present within the team but there are also considerable inconsistencies between the 2 LAs on what is collocated eg Middlesbrough have both a DV presence and the missing team based within the team – this could further impact on the sense of it being a shared integrated service;
- There is currently no triage system in place for DV referrals.

But I also saw:

- Good office setup and facilities
- Sound administrative processes
- Systems for RAG rating prioritization and management decision making
- Social workers actively engaging with referrers/partners and public to enhance the screening process
- Operation Encompass in place

Based on my limited involvement and reading it appears an underdeveloped and less sophisticated front door than others – but it did not appear to have unsafe processes - the lack of attention to data/audit may lessen confidence in overall quality and safety.

All appear to recognize the above description and would agree both the need and focus for significant improvement activity. Follow through on capacity building and improvement activity is needed regardless of the model going forward. Care is needed that deficiencies and improvements needed in other services should not be conflated as always the product of challenges faced within the MACH.

The debate is possibly only but significantly a debate about what are the organizational arrangements which are most likely to be effective in addressing those issues.

There appears comparable timescales for both LAs because of previous or future inspections and both appear open to use existing or new leadership expertise to apply to the task. However Middlesbrough are leading a wider programme of significant change and may feel more comfortable with a model which sees more direct management of that change rather than influencing change through even enhanced contract/governance arrangements.

The decision to collocate probably recognized the important opportunity that existed to increase service resilience on a partnership basis at the front door. Clearly resilience can also be achieved through other models of integration on a partnership basis eg assessment teams. The implications of COVID 19 must also be factored into those resilience discussions without restricting longer term strategic ambition.

Improvement is needed whichever model is applied on a short or long term basis – there is no “do nothing” option but arrangements could include:

1.Improvement of the current model with enhanced governance expectations, enhanced capacity in some areas eg police and targeted external leadership activity to enhance quality and address the challenges posed by Ofsted;

2. A collocated model which sees separate functions for Middlesbrough and Redcar and Cleveland serviced by a shared partnership collocated resource across both - in such a model discrete different provision would be within the geographic team eg DV and missing. Each team would have own TM/Deputy TM. Such an arrangement would also require targeted external leadership activity to enhance quality;

3. An early (within say month) move to a LA specific function including partner capacity. For Middlesbrough that would be within an integrated model with the assessment function. Such a model fragments partnership capacity but could enhance management oversight, consistency, pathways and communication. Again such an arrangement would also require targeted external leadership activity to enhance quality. This approach could or not be

viewed as a short term development in response to both Ofsted/Covid and a wider review of long term delivery arrangements could then be commenced.

I hope this is of some assistance to your forthcoming strategic discussions

Peter Dwyer

DfE Commissioner

Annex 2: No Wrong Door Implementation in Middlesbrough: Summary

1. Context:

The Strengthening Families, Protecting Children National Programme aims to enable more children to stay at home in stable family environments so that fewer children need to be taken into care. The programme is investing £84M over 5 years in 18 LAs including Middlesbrough that have high or rising numbers of children in care. These authorities will be supported to embed one of 3 models which carry with them an encouraging evidence base of success. Middlesbrough are working with North Yorkshire to locally implement a version of the "No Wrong Door" model, an approach which focuses on providing integrated targeted support for young people at risk of going onto care.

2. Role of the Commissioner:

On the 24 January 2020 Ofsted published a children's services inspection report based on fieldwork between 25 November and the 6 December which assessed Middleborough as being inadequate against all of the 4 categories of judgement. This necessitated the appointment of a Commissioner by the DfE. In addition to the normal Commissioner remit the Commissioner was also asked to specifically to also:

"Make an early assessment of Middlesbrough's capacity and capability in relation to the "No Wrong Door" project as part of the Strengthening Families Programme"

3. Commissioner Activity:

In addition to the usual Commissioner activity opportunity has been taken to specifically assess progress in implementing No Wrong Door (NWD) in Middleborough. This has involved dialogue with DCS and senior leaders locally; DCS and senior staff at North Yorkshire County Council, dialogue with the Innovation Unit (an independent body supporting rollout); analysis of key documentation and papers for recent Project Board.

3. Implementation of NWD in Middlesbrough:

It is clear that over a period of 12 months much progress has been made in delivering NWD locally. This progress includes:

- A Strategic Board on a partner basis is in place with clear project plan established
- Capital investment in developing a NWD hub has been made by the LA with subsequent building work completed
- Recruitment of a dedicated team for delivery is well advanced incorporating roles across partners eg life coaches/communication staff
- Whilst some key leadership roles within the hub are employed by NYCC there is an expressed commitment to see NWD becoming a mainstream approach once NYCC interaction, development and funding is complete

The work has been supported by the engagement of the Innovation Unit particularly focused on theory of change and work on organisational culture.

Whilst there has been some slippage, all is in place to see the staff team in place from April 2020 with following intense training programme, the hub opening in June 2020. Young people are currently being identified who could potentially benefit from this provision. This progress in the context if an organization which has clearly struggled by itself to focus and deliver good programme management is worth highlighting. I will say something later on how Covid 19 may and now does impact upon this.

4. Analysis:

4.1 There is evidence that this model will not prove to be successful in implementation without these and other factors being in place:

- a demonstrated surety that strategic leaders are fully signed up and committed to delivery;
- LA and partners being fully engaging and viewing implementation as part of an interrelated programme of improvement rather than a discrete initiative;
- Improvements in the quality of mainstream assessment and care planning for children and young people in the LA;
- A high quality team being in place who are collectively passionate about the model and the development of placement options which support their work;
- The right young people being carefully identified who could benefit from the model

4.2 Initial external No Wrong Door (NWD) analysis of some cases in Middlesbrough confirmed the concerns that were expressed by Ofsted. This analysis identified significant concern about weaknesses in identification and then poor intervention to overcome deficits and omissions. Anecdotally auditors describe practice as of greater concern than they had identified in their joint working experience with other LAs. At the same time all recognize that the numbers in care are ahead of statistical neighbours and when in care too many young people are living in residential care and care outside of the LA boundaries. This really is an LA where practice improvement is needed and the impact the NWD model has made elsewhere, is needed.

4.3 The lack of an up to date or coherent Sufficiency Strategy is clearly of concern but this is accepted and should feature in the new improvement plan. More positively the lack of clear strategic planning had not prevented the development of some additional investment and the establishment of some new residential provision ie a 2 bed unit and additional post 16 places. Generally and in the context of NWD this is welcomed in enhancing local placement options. Positively, the LA had also already agreed investment to reshape edge of care capacity prior to engagement in NWD. To the potential frustration of some this was then delayed to ensure new provision was fully aligned with NWD. All now agree that this has resulted in potentially richer and more effective arrangements - a 6 rather than 4 bedded

hub and a broader staff group in the hub team incorporating life coaches/communication workers – partnership skills and resources which had not been in the model originally developed internally. Through the period of joint development we have also seen the LA engage in and being trusted to introduce modifications which reflect local need eg age range.

4.4 The local leadership of NWD delivery has been organisationally unusual and reflects other challenges which the new leadership are now seeking to address. The key officer for residential care for example has not been responsible for other placement and intervention services. This role is also line managed within a portfolio led by albeit competent senior leader but with a lack of practice experience. This reflects the historic concern that existed within the LA regarding escalating placement costs but also an historic lack of confidence of effective programme and financial management within social care leadership. More recently and encouragingly we now see both the colocation of all placement and additional intervention services eg FGCs within integrated single leadership and we see greater engagement of social care leadership in joint oversight of NWD programme delivery. However, the need for continuity and consistency of middle and senior leadership is now clear if we are to overcome a considerable frustrating history of strategic briefings and preparation both politically and managerial with people no longer in role.

4.5 Given the challenges Middlesbrough faces it is of benefit that independently it is said that the "fidelity of the model is good and higher than in any other adopter LA" (Innovation Unit). What is meant by this is that the more "managed model" with key operational leaders of the hub employed by NYCC may create future transitional challenges, but over the next say 2 year period creates considerable opportunity to support the local effective embedding of the model. Hub managers in Middlesbrough clearly benefit from feeling part of a wider team of more experienced practitioners confident and experienced in delivery of the model. The engagement of NYCC in managing those running local operational delivery at a time and in in an environment where there are such competing priorities can be of real value.

4.6 Operationally embedding delivery needs to occur within a strategic climate which embraces the model and locates delivery within a changed organizational culture. I have seen and heard strong expressions of commitment and excitement from new senior leaders of the opportunities NWD affords to support the improvement work underway. Opportunities to heighten collective challenge which could enhance assessment and planning processes; to achieve models of integrated partnership working which improve partnership confidence/endeavor and enhance capacity to meet strategic priorities aimed at the care population. These commitments however, need to become embedded in strategic activity and it is encouraging to see NWD featuring prominently within an improvement plan (currently in draft format) which also describes wider leadership and cultural activity which should if delivered also enhance NWD delivery.

4.7 The Ofsted inspection was highly critical of the quality of assessment and case planning within the LA. When originally bidding for Innovation funding NWD had been challenged as to the benefits of an assessment function located within the hub rather than in fieldwork teams. The current model was approved based on confidence on the quality of the mainstream assessment and planning function but clearly that confidence does not exist regarding Middlesbrough. All in my discussions are very mindful of this. Work has been prioritized to enhance wider assessments and planning but this will certainly take time to impact on practice. In the interim, options potentially exist to support that improvement through the approach and challenge taken by NWD.

4.8 I have also reflected as to whether a decision on NWD implementation preempts the outcome of the wider Commissioner review. In my assessment the reviews can be treated separately – the decision on the future funding and delivery of NWD can be dealt with earlier to reduce any risk of inertia. The delivery of NWD is also possible in any future organizational context – in any LA or alternative delivery model.

5. Coronavirus: the current pandemic is unsurprisingly affecting delivery of the NWD model locally. Planned management training/induction arrangements of the new staff team are now proving impossible to safely deliver. This could impact on the potential initial focus of the team and could adversely impact upon related wider work streams to enhance assessment and care planning activity.

6. Conclusion and Recommendations:

The NWD model has the potential to both deliver and contribute to key improvement priorities in Middlesbrough. The need to enhance the range of interventions available and creatively respond to the needs of vulnerable young people in and on the edge of care is greater here than in almost any LA. Planning for delivery is very advanced with key staff appointed and some in place and significant investment has also been made in the hub building. The managed delivery model in place provides real opportunity to safely land operational delivery in a context of currently clear senior/middle and political leadership support. The service may not be landing on operational “fertile ground” but can play an important part in enhancing both the range of provision whilst also contributing to the heightened ambition for improvement on a partnership basis. Importantly the new Improvement Plan rightly provides a strategic coherence previously lacking and firmly locates the role of NWD in that improvement journey. A Head of Service from another part of the department described NWD as “a very important part of our recovery journey” for the difference it can also make in practice and culturally.

As a consequence of the above, I would therefore support the continued funding of the programme to develop NWD in Middlesbrough. In doing so I would also suggest that care is particularly taken to ensure:

- The strategic and operational partnership boards must engage senior leaders across social care and retain their focus post implementation with all partners;
- The integration of the resources function under integrated leadership which includes NWD and other interventions must be implemented and sustained;
- A model is needed which ensures that the identification of the right young people for engagement for the service and that the quality of overarching assessment and care planning is prioritized must be in place – this model must be cross directorate;
- The NWD programme must be embedded in the forthcoming wider improvement plan of the LA and the future sufficiency strategy of the LA;
- A sophisticated communication strategy is required to ensure that the implementation of NWD locally is known understood and benefits from wider engagement and support;
- Clarity is provided of how the new team will operate in the context of Covid 19: clarity both from those leading local delivery but also from the DfE as to whether what is proposed is consistent with grant conditions etc

Peter Dwyer

DfE Commissioner

Annex 3: COVID 19 Response: Middlesbrough

Strategy Leadership and Governance:

- The DCS and leadership team carry with them considerable collective leadership credibility with a good balance of new and LA experienced staff.
- The response to Covid 19 must be viewed in the context of the dedicated capacity in place which oversees business continuity and risk management generally within the LA. The LA has clear business continuity plans in place in which critical areas of service are clearly identified.
- A comprehensive structure of gold silver and bronze command meetings are in place with appropriate representation. A similar structure of partnership meetings are also in place. There is a real intensity to the frequency of and attendance at all forums. A risk and action log is in place for each set of meetings.
- A detailed exercise has been undertaken to project forward to potential reductions in available staffing – reductions in phases of 80-100%; 50-80% and below 50% with clarity provided of children's services priorities under each scenario. The priorities agreed appear sound. The plan provides clarity surrounding redeployment of staff from less essential service areas to core statutory and safeguarding responsibilities.
- The LA has also undertaken analysis of which groups and individual young people need to be prioritised and this is subject to ongoing review. It is not a simplistic description of core statutory responsibilities but a more meaningful focus on risk regardless of statutory status. Within this S47 assessments are prioritised.
- There are a comprehensive range of communication activity in place. Daily Chief Exec video staff briefings/ staff newsletters/daily school communication/Director Vlogs and daily meetings (bronze) of all key managers are used to disseminate key messages. Feedback and response are welcomed through all. Creative methods for communicating with families regarding eg contact have been developed
- This feels very much collective leadership endeavour. Strong corporate engagement and strong departmental leadership activity engaging all managers. The Chief Executive is highly visible and engaged in leading this work.
- The LA and its staff have worked to try to maintain core decision making processes but through the use of technology. Initial and review child protection conferences are still taking place but done remotely with pre-discussion of conference chair with families and video links for them to join the meeting.

Workforce

- The LA is tracking staff absence through self-isolation or COVID 19 on a daily basis. Initially there was approx. 10% of the approx. 600 workforce absent but this has reduced over time as staff return from self-isolation.
- As described earlier projections of higher staff absences have been made with resulting redeployment of capacity to agreed priority activity. At the same time the

organisation has enhanced resilience through the introduction of additional social work capacity in the form of externally commissioned teams (2). Planned to support improvement activity within the service this capacity also creates necessary resilience for the impact of coronavirus.

- In addition new staffing funded via Strengthening Families national programme (No Wrong Door) were coming into post and this enhances on partnership basis capacity for additional support to young people on the edge of care.
- Interestingly the service would currently be faced with staff absences through Easter leave much of which is now not being taken. This adds to overall capacity within the service.
- Recognition of vulnerability of particular services with specialist skills has seen a recognition and plans to operate more closely with adult services/health to proactive plan service challenges eg bereavement/counselling.
- The technology already available to staff is of a good standard and this has enable effective working from home to be achievable. In addition resources have been released to enhance smartphone technology within foster homes and thereby facilitate contact arrangements with birth families.

Resources:

- Work to ensure young people on free school meals continued to get support during school holiday period predates the national activity and is in place. Voucher system is in place. The LA is being said to be looked to for strategic direction by the school community and the partnership with schools is being enhanced as a consequence.
- All houses in the borough have been leafleted and helpline numbers for support/assistance is available. Hardship food parcels have been delivered (600 plus) with string volunteer network in place)
- The LA has received £5.2M national funding to support their response. This is supporting but not restricting local ambitions to support local families. A decision for example in advance of the national funding to change timing of council tax payments was already agreed.
- Gold command has overseen prioritising and allocating PPE. Equipment has been available although some challenges on face masks. The use of PPE is somewhat limited eg young people in custody/children with complex disabilities etc

Practice and Systems:

- A Guidance document for social workers undertaking home visits is in place.
- There is an expectation that all allocated cases will have a child safety plan in place and at the time of writing (early April) of the approx. 2500 requiring such plans 984 have been completed. There is a clear expectation of progress against the remainder over the next week. Similarly safety plans for children on EHCP being completed and of the approx. 1000 needed 80% are in place and again will be resolved in next week. Training has been provided on completing quality plans and auditing activity has already occurred on 20% with remedial action where necessary. The LA was

criticised for the scope/quality of its safety plans by Ofsted and a new template has been further amended to pick up specific reference to COVID 19.

- A combination of face to face meetings with children and young people and contact technologically is being undertaken. There is still a firm requirement to complete statutory responsibilities. It appears very much business as usual as possible in MACH and in the assessment teams Care leavers are having a minimum of weekly phone calls and arrangements for electronic access to allowances is now in place. The DCS has met specifically with the care leavers group to discuss the implications of COVID
- The LA has worked jointly with CAMHS provider to identify and develop a shared list of children of most concern requiring joint targeted support.
- Care planning and legal proceedings are taking place albeit being done virtually through the use of technology.
- The court have accepted that current challenges impact upon expected contact arrangements. Families have not been having face to face contact over recent weeks although capacity/technology is now available to enable remote face to face contact through IFAs residential and foster homes. This mirrors the regional arrangement.
- There have been no issues relating specifically to support to UASC
- The LA has invested in additional capacity around QA and this is being used flexible eg to audit safety plans. The supervision arrangements are unchanged albeit often completed remotely.

Partnerships:

- As described earlier the leaders of children's services are working closely and well within strongly established corporate planning and risk management activity. That activity is also being undertaken within a partnership planning context.
- Interestingly the service is working differently but has core capacity in place and is not being faced with any deluge of new work arising from the pandemic. The numbers of missing children for example has been lower than the norm during the period of the restrictions on movement.
- Impressively the LA is also thinking about recovery plan activity and recognising the services may be faced with additional challenges from young people eg loss of grandparents/ absence of good transitional arrangements to primary/secondary education/impact of greater levels of domestic violence etc
- As described earlier schools are working together and being encouraged and responding positively to the challenge of support to the most vulnerable pupils during this period

Provision:

- All commissioned services have been approached and where appropriate have been supported in all producing business continuity plans. An example was provided of LA staff going flexibly to work in private provider who were struggling with capacity to meet the needs of a Middlesbrough young person.

- At the time of writing there are no young people self-isolating within the LA residential care
- Whilst the Gleneagles short break provision has needed to be closed down this was understood by families who were already conscious of the risks of their vulnerable young person going elsewhere from their family home. There is capacity for a single placement each evening but this has not been taken up. Staffing available can be used to enhance outreach respite where agreed but again many families of profoundly disabled children are self-isolating
- There has been no significant movement of children in the care population as a consequence of COVID 19
- Foster carers have had same communication and advice as staff. There is ongoing support from link workers to respond to some understandable anxieties. Turnover in foster placement is actually said to be down in comparison to normal weeks.

Peter Dwyer

DfE Commissioner

10 April 2019