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Helen Watson
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Dear Ms Watson

Focused visit to Middlesbrough council children's services

This letter summarises the findings of a focused visit to Middlesbrough council on 7 and 8 August 2018. The inspectors were Neil Penswick, Her Majesty's Inspector, and Matthew Reed, Her Majesty's Inspector.

Inspectors looked at the local authority's arrangements for the 'front door', the service that receives contacts and referrals for the agency.

Inspectors looked at a range of evidence, including from case discussions with social workers, evaluations of children's case records and meetings with senior managers. They also looked at local authority performance management and quality assurance information, commissioned evaluations of current practice and relevant action plans.

Overview

There have been considerable weaknesses in the quality of frontline practice with children and families in this part of the service. A new director and a new chief executive have led a programme of improvement, which has begun to strengthen the support being provided for children. The local authority has provided additional investment for children's services and, in the main, detailed plans are in place to address the issues.

At the front door, immediate child protection issues are responded to well. However, 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. Front door services are not going far enough to get to the overall understanding of children's needs that is required as the basis for successful intervention in complex situations. 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.

In response to the inspectors' feedback, senior managers made immediate changes during the focused visit to significantly strengthen the staffing and management of front door services.

What needs to improve in this area of social work practice

The local authority needs to take further action to address the following areas of weakness at the front door:

- Delays in the response to contacts.
- Management oversight and decision-making.
- Relationships between the local authority and partners and the understanding of consent and application of thresholds.
- Analysis of demand and appropriate levels of staffing.
- The focus on strengthening practice, including at the front door, in the improvement plan.

Findings

- The current director of children's services started in post in August 2017. To better understand the strengths and challenges facing the authority, she immediately commissioned several reviews of key aspects of children's services. These reviews identified significant increases in the demand for services and found that there were too few social workers to deliver a satisfactory service. There were also significant gaps in the strategic planning, partnership work and performance management of services.

- In response, Middlesbrough re-established a children's trust. An improvement board was also established and is chaired by the chief executive of Middlesbrough council. There has been a significant additional financial investment in children's services; this has been used primarily to increase the number of social workers, resulting in a reduction in caseloads to ensure that staff can provide more effective support for children and their families. Performance data, challenge clinics and focused case auditing have assisted managers to better understand the quality of services.

- There are a high number of contacts and these are rapidly increasing: from 1539 in April 2018 to 1899 in July 2018. However, inspectors found that many of the contacts from partner agencies do not need to be shared with children's services. Many of these contacts are unclear as to what the concerns are and what is expected of children's services. Social workers are spending far too much time trying to understand the issues. In too many situations, where there are no safeguarding concerns, partner agencies have not sought the required consent from parents and families in order to share information with children's services.

- Data collation has improved and a real-time 'dashboard' assists social work managers in understanding workload pressures. However, inspectors found that the data lacks sophistication. For instance, although there has been an increase in 'contacts', many of these are not new contacts needing a response from the front door but information on open cases or duplicate contacts on issues already raised. The local authority does not have an accurate picture of actual demand so that it is able to resource its front door services correctly.

- There is very little contribution from partner agencies at the front door and what is there is very recent. This lack of contribution from partner agencies hampers information gathering and joint planning to provide integrated support. The local authority has set a date of April 2019 for a multi-agency safeguarding team to be in operation. This will not just need resourcing but also a demonstrable cultural change from partner agencies in taking responsibility and working together for vulnerable children and their families.

- The multi-agency Local Safeguarding Children Board threshold document for access to services is not being followed by all agencies. The way it is applied by the contact team is also getting in the way of ensuring that the right services are put in place. There is too much focus on identifying whether or not the criteria are met for a safeguarding referral rather than on gathering evidence to support sound decision-making to help improve outcomes for children and families. The experience of children and young people is not at the heart of decision-making.

- Inspectors found that the quality of the response from the front door was too variable. Children's cases involving high risk of harm and obvious child protection issues are identified quickly and actioned promptly. However, in other cases, where there are less obvious or less serious concerns, social workers do not always identify the evident needs or action them in a timely manner. This results in repeated contacts, and in delays for children and their families having their needs met. Management oversight is not always evident in these cases.

- Senior managers took robust action on being made aware of the weaknesses that inspectors were finding during this focused visit. They immediately increased the number of social workers at the front door and strengthened management oversight to ensure that all cases were being reviewed prior to closure. They are further reviewing what actions they need to take in relation to the children and

families whose cases had been closed recently, with their needs potentially not fully identified.

- Two new assessment teams were introduced in July 2018. This was to improve the quality and timeliness of responses. One of these is a team of local authority social workers, the other an experienced team commissioned from an external agency. Inspectors found assessments undertaken by these teams to be of a reasonable quality and, if needed, they result in services being offered.

- Staff initiate child protection enquiries appropriately. Strategy meetings are well attended by all agencies and they evaluate risk well. Professionals agreed appropriate actions, although they do not identify timescales for completion. The rationale for the next steps is always clear. Where there are disability needs, these are well considered. Children are always seen, and their views sought, to ensure that their needs are integral to decision-making.

- In April 2018, and as part of the improvement work, the local authority reviewed all cases of children subject to a child protection plan for over 15 months. They found that many cases had not always been progressed appropriately. Seventy-seven children were removed from a child protection plan and instead offered child in need services. The local authority initiated court proceedings for or accommodated 31 other children. Inspectors sampled these children's cases and found that decision-making was mostly appropriate and supported by unanimous agreement from the professionals involved, who knew the families well.

- Inspectors looked at the recording of decisions to bring a child protection plan to an end. The minutes of review child protection conferences are inconsistent. While a small minority of minutes are clear and demonstrate a robust focus on risks, most do not clearly identify the reasons why children are subject to a plan, the progress made against the plan and what now needs to occur. The local authority acknowledges weaknesses in the consideration of risk and how this is being recorded. Since July, key decision-makers have been trained and a new risk assessment model is to be introduced in order to improve this aspect of practice. This was too recent for inspectors to see an impact.

- Inspectors also looked at a small number of children who had come into care recently and found that all these children should have been in care.

- Staff are positive about working for Middlesbrough council. Supervision is happening, and is focused on compliance and ensuring that tasks are completed. Staff have welcomed this scrutiny. They recognise that service improvement is much needed.

- Other regional local authorities are starting to support Middlesbrough council in improving the quality of social work practice. A highly regarded model of risk assessment is about to be introduced and all staff are due to be trained to use this approach.

- The improvement plan has identified the breadth of issues that need to be addressed in Middlesbrough. Working together, senior managers and politicians have delivered some of those changes and have plans in place and timescales for future work. However, as evident in this focused visit, the improvement plan does not always sufficiently focus on the improvements necessary to strengthen frontline practice and on improving children's experiences and their outcomes.

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

Yours sincerely

Neil Penswick
Her Majesty's Inspector