

31 January 2022

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Dear Sue

### **Monitoring visit to Middlesbrough children's services**

This letter summarises the findings of the monitoring visit to Middlesbrough children's services on 14 and 15 December 2021. This was the second monitoring visit since the local authority was judged inadequate in January 2020. Her Majesty's Inspectors were Neil Penswick and Russel Breyer.

### **Areas covered by the visit**

Inspectors reviewed the progress made in the following areas of concern identified at the last inspection:

- Children in need.
- Children subject to a child protection plan.
- Children subject to a letter before proceedings and the quality and impact of pre-proceedings intervention.

The visit was carried out in line with the inspection of local authority children's services (ILACS) framework. This visit was carried out remotely at the request of the local authority. The lead inspector and the director of children's services agreed arrangements to deliver this visit effectively while working within national and local guidelines for responding to COVID-19. Inspectors used video calls for discussions with local authority staff and managers.

### **Headline findings**

Senior managers know their service well and have a realistic understanding of their progress since the 2020 Ofsted inspection. Improvements in auditing give them accurate information on what they still need to do. Social work capacity has increased and there has been a strong focus on improving compliance with national guidance. Senior managers are now working to further improve the quality of social work practice. Currently, the progress of children in need and those subject to a child

protection plan remains variable, as the quality of planning is weak and there is insufficient focus on the lived experience of children. Case management oversight is not sufficiently robust to ensure that issues are addressed. Senior managers are aware of these issues and have plans in place to address them.

## **Findings and evaluation of progress**

The Director of Children's Services and senior managers know their services well. They had prepared a detailed self-evaluation focused on the areas subject to this monitoring visit and prior to inspectors' on-site activity. This accurately described the improvements they had made in their services and the areas that needed further development.

The Ofsted inspection report published in January 2020 identified that all aspects of children's services were inadequate. Since then, senior managers have focused successfully on improving the capacity of their staff in respect of their services to children in need and subject to a child protection plan. This includes decreasing the size of social worker caseloads, employing more permanent qualified and experienced staff and creating smaller teams to improve management oversight. The permanent senior management team has also improved its line of sight through direct casework involvement and through participation in oversight panels, resulting in a better understanding of the quality of work and what further needs to occur to address the deficits in practice.

A particular strength is the auditing process which provides a wide and in-depth coverage of the quality of services. The audits focus well on gaining an understanding of children's day-to-day experiences and make judgements on how effective social work and management oversight have been on addressing children's needs. Work is ongoing to enhance front-line managers' and independent reviewing officers' skills as auditors. There is a robust moderation process which enables senior managers to review the audits and identify actions that need to be completed.

Over the past 18 months, senior managers have successfully focused on improving compliance and ensuring that essential activities are occurring. This includes ensuring that children are allocated to social workers who have the time and professional space to work with them. The frequency of visits for children in need and child protection purposes has improved. Social work supervision takes place regularly, but is not yet leading to good enough reflection or challenge. The frequency of multi-agency planning groups, and the timeliness of initial and review child protection conferences, have also improved.

Senior managers are working to a detailed improvement plan for all of their services. This includes appropriately focusing on improving the quality of social work practice through increased training and learning opportunities. Individual learning for workers and managers is identified, and wider themes are addressed. The local authority's own audits show an improving performance in the quality of practice. However, 20%

of social work practice continues to be judged in the audits as inadequate due to poor-quality practice which is not sufficiently addressing the concerns and progressing casework

During this visit, inspectors saw no child at immediate risk of harm or in need of urgent action. This is a significant improvement since the last Ofsted inspection. However, too many children continue to experience delays in progressing their plans. Key weaknesses are that plans, and planning, are not focused and lack timescales relevant to the child. There is insufficient focus on the lived experience of children, and social work tools are not being fully utilised to understand patterns of behaviours and cumulative risk. For some children, this results in them remaining for too long in situations either where their needs are not being met or where longer-term concerns are not sufficiently addressed.

Despite the work that has been done to improve one-to-one supervision, in the main these essential meetings are not sufficiently driving improvements including reviewing all the issues, identifying actions, and making sure that these are happening. Recording of management decision-making is too limited to enable an understanding of why actions are taken.

Senior managers have been working on improving the monitoring and oversight of pre-proceedings work. While positive steps have been taken, including appointing an officer to oversee this work and further developing a tool to track children in the process, management oversight does not always lead to the identification of what needs to change and ensure that this happens.

For some children, child protection thresholds have not been consistently implemented. While inspectors found improvements in the immediate response to child protection concerns, some families find themselves subject to statutory child protection planning when it is not needed. There is evidence of a risk-averse culture. For example, some families who need support but work well with the social workers and other agencies are nevertheless subject to child protection planning. Inspectors also identified a small number of families where safety plans were in place when a child's case was closed to children's social care. In these cases, other support packages would be more appropriate.

As senior managers identified, inspectors did see some examples of good social work focused on improving outcomes. For these children, there was good effective working relationships with the parents, good observations, meaningful direct work and well-focused planning and management oversight. The improvement work by Middlesbrough Council has also resulted in a stronger practice when there are immediate safeguarding issues, and in the support for children in need where there are serious concerns and they are on the edge of coming into care.

All of the social workers that met inspectors on this visit knew their children and families well, and have an enthusiasm and passion for working with them and

improving their lives. They spoke positively about the support provided by senior staff, their managers and peers during the COVID-19 lockdowns. They also reported how children's services have been improving and how they are better supported to do their work.

I am copying this letter to the Department for Education.

Yours sincerely

Neil Penswick  
**Her Majesty's Inspector**