Ofsted
Piccadilly Gate
Store Street
Manchester
M1 2WD

T 0300 123 1231
Textphone 0161 618 8524
enquiries@ofsted.gov.uk
www.gov.uk/ofsted

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Sue Butcher
Middlesbrough
PO Box 505, 3rd Floor
Civic Centre
Middlesbrough
TS1 9FZ

Dear Ms Butcher

Monitoring visit of Middlesbrough local authority children's services

I write to summarise the findings of the monitoring visit to Middlesbrough children's services on 23 September 2020. The visit was the first monitoring visit since the local authority was judged inadequate in December 2019. The inspection was conducted by Jan Edwards and Lorna Schlechte, Her Majesty's Inspectors.

Her Majesty's Chief Inspector of Education, Children's Services and Skills is leading Ofsted's work into how England's social care system has delivered child-centred practice and care within the context of the restrictions placed on society during the COVID-19 (coronavirus) pandemic.

The methodology for this monitoring visit was in line with the inspecting local authority children's services (ILACS) framework. However, a different delivery model was used. This visit was undertaken off site, using information technology and video conferencing to facilitate child- and service-related discussions between inspectors and local authority social workers, managers and leaders. The approach was agreed in advance by the Director of Children's Services (DCS) and Ofsted to ensure an effective visit while working within national and local arrangements during the COVID-19 pandemic, and to meet the needs of the Middlesbrough workforce.

The local authority has made some progress in improving:

- the social work practice in their 'front door' service
- the immediate response to 16- and 17-year-old homeless young people
- performance monitoring, including a new quality assurance framework
- its strategic oversight of services for children and young people.

However, leaders know that there is significant work to do to improve the quality of practice for children and young people in other areas of the service, that remain not good enough.

Areas covered by the visit

During the visit, inspectors reviewed the progress made at the 'front door' of the service, with a focus on the quality and screening of referrals, the identification of and response to risk, the understanding by partner agencies of threshold decisions for social work support, and the quality of initial assessment and planning.

A range of evidence was considered, including electronic case records, case discussions with social workers, the elected member for children's services and senior leaders, and management and performance reports provided by the local authority.

Overview

Since the ILACS inspection in December 2019, there have been significant changes in both the middle and senior leadership teams, with the DCS being confirmed in post in July and the separate post of Director of Children's Care (DCC) being confirmed shortly after this visit. The DCS has demonstrated a determination and vision towards improving the quality of interventions that will make a difference to children and their families.

Following the Middlesbrough ILACS inspection in December 2019, which found significant weaknesses in the South Tees Partnership Multi-Agency Children's Hub (MACH), the Middlesbrough MACH was disaggregated, after extensive planning with all partners, from the South Tees Partnership in July 2020. This visit found substantially improved practice in the Middlesbrough MACH, especially in the quality of referrals and screening, and in decision-making and manager oversight.

This new 'front door' service, including the assessment service, has experienced exponential demand due to a necessary change in the application of thresholds for service, and a lack of throughput of children's cases. Throughput has been affected by a lack of resilience and capacity in how social work is delivered in the current structure. The increased volume of assessment activity has impacted on assessment timeliness, with three quarters of assessment activity being out of time. This means that children's needs are not always being assessed within the timescale that meets the children's level of risk and needs.

There is improved analysis of risk in children's assessments. However, children's plans are not consistently effective in outlining the plan of intervention or a contingency for when children's circumstances are not improved. Manager oversight has also improved some areas of social work practice, but this is not consistent. The supervision of social workers is not always regular or effective. Caseloads are too high and are affecting social workers' ability to provide a timely service for children and their families.

Since the inadequate judgement in the ILACS inspection in December 2019, the local authority has completed a wide range of case auditing in order to understand the

quality of practice. Practice that is inadequate or that requires improvement to be good is consistently identified through case audits. Consequently, senior leaders have a realistic understanding of the endemic weakness in social work practice, and this understanding is used to inform an appropriately focused improvement plan.

Findings and evaluation of progress

This is the first monitoring visit since the inadequate judgement in December 2019. The visit was delayed due to the COVID-19 pandemic.

At the time of inspection in December 2019, the senior leaders had not been aware of the extent of the inadequacy in the service. The new permanent senior leadership team is now providing improved stability at this level and developing a shared vision for what needs to change. Leaders acknowledge the challenges the local authority faces and has utilised the support of 'Partners in Practice' to ensure that improvement is effectively focused, and appropriately paced.

Partnership working is much improved. Safeguarding partners who are represented on the improvement board are increasingly engaged and are showing increasing ownership of their part in the improvement of children's services. Senior leaders have introduced a range of initiatives designed to improve outcomes for children. These include:

- a new quality assurance framework
- an improved performance reporting and monitoring system
- a more rigorous approach to scrutiny and challenge from the improvement board and elected members.

These strategic developments are now beginning to demonstrate an improved understanding of the quality of social work practice for children.

The local authority has also implemented a range of transformation projects, including the development of an edge of care service for children and families, a strengthening of the role of corporate parenting in the whole council, the electronic case management fit for purpose programme, and the centre for practice excellence. These transformation projects are in their infancy, and therefore it is too early to report on the difference they are making for children.

Following the last inspection, there was a recognition by senior leaders that the shared South Tees Partnership MACH was underperforming and lacked robust governance arrangements. Following extensive consultation and planning, a decision was made to disaggregate from this partnership arrangement, forming the new Middlesbrough MACH. Further work is being completed to develop how contacts from the police are triaged with a new multi-agency triage planned for October 2020.

Within the newly established Middlesbrough MACH, inspectors have seen improved practice during this visit. Most screening of contacts to the service is thorough. Screening takes account of the child and their family's history, and of the multi-agency information, forming a balanced analysis of risk. Management oversight at this early stage provides direction and guidance for the social worker in how to screen the contact. Workers seek consent appropriately, and it is clearly recorded, including when consent is needed to be overridden. This facilitates a prompt response to requests for a service to safeguard children, and it minimises any potential delay. Most contacts by partner agencies are converted to a referral for a social work service. This demonstrates that there is an improved understanding of thresholds by referring agencies.

Caseloads are too high across the whole service, but particularly for newly qualified social workers, and for those in the assessment, safeguarding and care planning teams. High caseloads are having a demonstrable impact on the quality of social work practice for children, the throughput of children's cases, the timescales of work completed, management oversight, and the ability to embed learning from audits and training to social workers.

Most children and families are stepped up from early help to statutory services appropriately. While inspectors saw much improved practice from a low base in the MACH, there is a legacy of poor practice spanning several years, whereby children have been left at risk for too long and without the right service to reduce the risk or effectively meet their needs.

When children are identified as needing an immediate response, strategy meetings are held promptly, and in most cases, all safeguarding partners are represented. However, there are some examples where the police and education professionals are not represented. Strategy meetings explore risk through a scaling process, which ensures that partners are taking shared responsibility for rating the level of risk and contributing to safety planning. While the strategy meeting records show that safety planning has been completed, the records fail to state the planned actions clearly. This is a missed opportunity to ensure that partners understood their roles and the actions necessary to keep children safe.

Conversely, there has been a rigorous approach to safety planning for children during the COVID-19 pandemic. In particular, there has been a robust multi-agency shared response to those children who are living with domestic abuse at times of pandemic lockdown. All vulnerable children continued to receive face-to-face visits, and some social workers have built up an effective rapport and relationships with families during these challenging times.

The quality of some children's assessments has improved since the last inspection. However, most assessments are not completed within a timeframe which supports the child's identified needs. Risk is better understood through a recognised risk methodology, and the child's voice is heard through direct work. However, children's voices and their lived experience are not consistently seen in all casework. Children's identity and diversity needs are narrowly understood as being only of religion and

ethnicity. This is a missed opportunity for gaining a more rounded understanding of the child's world.

Often the initial plan developed from the assessment is brief. Better plans identify the area of need and provide clear timescales in which to see improvement, or a contingency plan, if improvement is not achieved. Most interventions are effectively delivered where needed by the intervention worker while social workers are progressing assessments.

Young people aged 16 to 17 years old who present as homeless are now screened effectively in order to establish their needs, risks and vulnerabilities, with appropriate progression to a referral for an assessment.

A model of quality assurance, Audit for Excellence, is starting to provide a robust practice of auditing that is linked to individual and team performance. Combined with the improved performance monitoring, there is a collective ownership of performance and prompt identification of gaps in practice. This is informing team, and wider service, improvements.

Demand created by the numbers of children open to children's social care has meant that some children's cases remain open for too long. As a result, the throughput of children's cases has been a focus of the work on the team profiles and is a priority in team plans. Leaders have also been engaged in demand forecasting to further support caseload planning, the workforce strategy and to mitigate against risks associated with an increase in demand in the context of COVID-19.

There is improved manager oversight across the teams that make up the 'front door'. However, the quality of management oversight and direction is not consistently contributing to the progression of children's plans or to rectifying a legacy of poor planning and case management. This means that some children experience delay in having their needs assessed and understood and some children have been receiving a service at the wrong threshold of need.

Supervision is not always regular for all staff. When supervision does occur, there is variable practice. Some social workers said that they receive reflective supervision that helps them to think about their practice and to progress planning for children. Other practitioners only receive brief actions and direction, which is not helping children to make swift progress. Some auditing practice is not always effective in sighting managers on all deficits in practice for follow up in supervision or in escalating gaps in service provision to senior management. This has meant that some children have not received a timely or effective service.

The recruitment and retention of social workers remains a challenge. Social workers spoken to said that morale is good. They told inspectors that they feel valued and supported, and that senior managers are visible and approachable. Training delivered under the new 'clarity and confidence' programme has brought positive changes to how social workers practise, for example in relation to children and young people who present as homeless.

In addition to the significant changes in the children's social care workforce at all levels, there has been significant change to the political landscape. There is a continuing commitment from the chief executive and lead member, both of whom are fully engaged in the improvement work.

I am copying this letter to the Department for Education.

Yours sincerely

Jan Edwards
Her Majesty's Inspector

The letter is copied to the Department for Education