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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 13 and 14 July 2022. This was the fourth monitoring visit since the local authority was judged inadequate in January 2020. There has also been a focused assurance visit in July 2021. Her Majesty's inspectors for this visit were Louise Hollick and Matt Reed.

Areas covered by the visit

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

- The front door service that receives contacts and referrals.
- Child protection enquiries, such as strategy discussions or section 47 enquiries.
- Child in need assessments.
- Early help assessments.
- Step-up and step-down to early help.

This visit was carried out in line with the inspection of local authority children's services (ILACS) framework.

Headline findings

The corporate leadership team has continued to develop and improve services at the front door since the last inspection in November 2019. The multi-agency strategic improvement board has overseen positive service improvements since Ofsted last visited the front door service in a monitoring visit in September 2020. An area of improvement has been to expand the offer of early help support to vulnerable children. There are stronger and wider partnerships in the Multi-Agency Children's

Hub (MACH), which are improving the quality of referrals, the richness of information-sharing, and leading to better-informed decision-making. Workforce instability and increased demand in the assessment service have led to the slowing of throughput of children's cases in this service. This is placing additional pressure on some social workers' caseloads and the quality of practice. Unfinished assessments and incomplete records have led to delays for some children in their circumstances and risks being fully assessed. Senior leaders have identified the pressures within this service and have very recently added an additional managed team to add capacity.

Findings and evaluation of progress

The executive Director of Children's Services (DCS) and the senior leadership team continue to track and monitor improvements to services to children at the front door. Practice improvement is supported by a robust and comprehensive quality assurance programme including thematic audits, deep dive audits, and regular scrutiny of performance data. This enables leaders to have an accurate understanding of the quality of practice and the impact of this on children and families' experiences. Audits conclude that practice within the assessment service still needs to improve, with a quarter of audits rated as inadequate. Within the MACH and early help service, audits demonstrate a significant improvement with the majority of practice now rated as good.

A wide menu of support services and targeted interventions is available through early help services, coordinated by partner agencies as lead professionals. When children's needs escalate, families are offered early help assessments through the local authority 'stronger families' teams. In the children's cases sampled by inspectors, early help interventions at this level are preventing risks escalating and reducing the need for statutory social care intervention.

Managers in the 'stronger families' early help service have robust oversight of work. There is routine auditing and performance data scrutiny to ensure consistent quality of practice. There is timely allocation of children to practitioners, with prompt and meaningful initial contact. Children promptly step up and step down from early help in line with their needs. As a result, more families are working with early help and their circumstances are improving. There are high caseloads within the early help teams that impact on practitioners' capacity for intensive work. There has been investment in additional capacity within the early help service. Additional teams and team managers have been created, and recruitment is in process to increase the number of workers in line with the increased demand.

In the small sample seen, early help assessments are thorough and completed in partnership with families. They include direct work with children, the views of parents, and consider the needs of all the children in the family. The resulting 'my family plan' includes the family goals to develop a shared plan that families actively engage with. For a small number of children, actions in the plan do not always

include all the presenting risks from the initial contact. This can result in potential risks to children being lost and left unaddressed. During this visit, the manager identified these gaps and subsequently was able to direct the worker to improve the plans to ensure all risks were captured.

The remit and responsibilities of the MACH have increased in response to the volume of work at the front door and the need to improve partnership working. Leaders have correspondingly increased partner presence and social work management posts to ensure there is adequate capacity to manage this increased demand. Managers have worked with partner agencies to improve the quality of contacts and referrals into the MACH in line with the agreed threshold document. This has led to a significant number of police contacts being sent back when they do not meet the threshold and is leading to more appropriate police contacts into the MACH. This is ensuring that children and families referred through the MACH receive a well-co-ordinated response in line with their needs.

A daily multi-agency triage meeting screens police notifications to enable detailed information to be shared between agencies and facilitates effective decision-making. Actions from the meeting are promptly followed up by the social worker. This ensures that responses to police contacts are timely and families are not waiting for a response or outcome.

Managers in the MACH make appropriate and timely decisions regarding children's contacts. There is effective management oversight of all work and precise record-keeping. Appropriate management direction is provided to social workers when they are allocated new contacts to screen. This ensures they are clear about next steps and what actions need to be taken to gather information and safeguard children.

Concerns about children are appropriately 'RAG' rated by managers to ensure the most urgent children's cases are given priority. Timescales for screening children's contacts are monitored by managers. They ensure that any delays are appropriate and in the best interests of children, so that a well-informed decision can be made. Children whose risks are such that they need an immediate response are considered without delay. If an urgent visit is required, this is completed on the same day. This ensures that children and families are effectively safeguarded in line with the level of initial risk rating.

Social worker screenings of contact and referrals in the MACH are comprehensive and much improved since the last inspection. Screening considers past history to understand previous concerns, as well as considering presenting issues. Parents are routinely contacted to be made aware of the concerns, to clarify information and to confirm they give consent for information-gathering and next steps.

When there are escalating risks to children, strategy meetings are promptly held. Partner agency attendance at strategy meetings has improved since the last visit, and this enables a significant level of multi-agency information to be shared. This is

assisting in well-informed shared decision-making. Strategy meetings are identifying key risks and discussing immediate actions to safeguard children. In most strategy meetings, the decision-making is appropriate and informs the next steps. This is ensuring that children have a plan to protect them from escalating harm.

For a small number of children, the response is disproportionate to the level of risk and need. This means that some children and families are subject to strategy meetings and section 47 child protection enquiries unnecessarily, when a lower threshold of intervention would suffice. This is overly intrusive for families and provides a disproportionate chronology of risks on children's records. It also adds extra work pressures on social workers, who have to complete additional assessments and enquiries.

Children's section 47 child protection enquiries and child in need assessments are thorough and most are completed in a timeframe suitable for the child's needs. Good-quality direct work with children is ensuring that their wishes and feelings are clearly identified and included in assessments. The voice of the child in assessments is now consistently clearer. Parents, including non-resident parents, are consulted and included. Relevant partner information adds richness to the assessment. Analysis of children's risks and needs is clear and is leading to appropriate next steps in the majority of assessments.

A legacy of poor practice has left some children being referred back to the service as the quality of previous intervention has not met their sustained needs. Leaders have introduced a monthly panel to monitor re-referrals and to identify practice deficits. For some children transferred to the assessment service, consent for a child in need assessment has been withdrawn, leading to assessments not being completed and children's needs being unaddressed. Leaders have now strengthened senior management oversight of decisions to close assessments due to no parental consent.

In the past three months, there have been challenges in managing demand and throughput of work in the assessment service. There has been an increased volume of work, and children with more complex circumstances have required more detailed assessments and responses. For some social workers, this has created additional pressures in workload and higher caseloads. This has meant there have been some gaps in case recording and case records not being finalised. This leaves some children's records incomplete and can lead to gaps or delay in identifying and responding to their needs. For a small number of children, social workers have left the service before finishing the children's assessments, meaning that these have had to be re-allocated to a new worker. As a result, there has been a delay in the children's circumstances and risks being fully assessed. Senior leaders have identified the pressures within this service and have very recently added an additional managed team to add capacity.

Workforce instability remains a challenge and has contributed to some of the difficulties within the assessment service. Middlesbrough still has a significant

number of agency teams and social workers to cover permanent vacancies. The majority of these agency workers have worked in the service for a significant length of time and, therefore, have a good level of local practice knowledge. Leaders have developed a substantial workforce development offer to encourage permanent social workers to the service, including a generous financial package and a comprehensive training offer. Currently employed staff spoke positively about working in Middlesbrough and feel well supported by their colleagues and managers. The DCS and senior leaders are highly visible and hold regular engagement sessions with staff to keep them informed and motivated.

I am copying this letter to the Department for Education.

Yours sincerely

Louise Hollick
Her Majesty's Inspector