

Middlesbrough

Inspection of services for children in need of help and protection, children looked after and care leavers

and

Review of the effectiveness of the Local Safeguarding Children Board¹

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Children’s services in Middlesbrough require improvement to be good	
1. Children who need help and protection	Requires improvement
2. Children looked after and achieving permanence	Requires improvement
2.1 Adoption performance	Good
2.2 Experiences and progress of care leavers	Good
3. Leadership, management and governance	Requires improvement

¹ Ofsted produces this report under its power to combine reports in accordance with section 152 of the Education and Inspections Act 2006. This report includes the report of the inspection of local authority functions carried out under section 136 of the Education and Inspections Act 2006 and the report of the review of the Local Safeguarding Children Board carried out under the Local Safeguarding Children Boards (Review) Regulations 2013.

Executive summary

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. The local authority accepts these concerns and has designed a new structure with significantly enhanced management capacity to be implemented in January 2016. Decisive and swift action was also taken in accepting and fully implementing recommendations arising from an early help peer review, carried out by the Local Government Association, which reported in September 2015. As a result, a new set of arrangements that ensure a more consistent and robust response to requests for both early help and statutory social work services are now in place and beginning to have an impact. 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 and social workers have manageable caseloads. This means that children and young people in Middlesbrough are likely to be able to build a good relationship with their social worker and not experience multiple changes of worker.

When young people are at risk of sexual exploitation, radicalisation or female genital mutilation, effective multi-agency working ensures that they are protected. However, further work is needed to ensure that all children who have been missing are offered and receive return interviews. Work with Middlesbrough's diverse communities, particularly asylum seekers, lacks sufficient focus to ensure that the needs of these children and families are fully understood.

Performance management does not sufficiently help to improve practice. Some data is not accurate and management reports lack the analysis that could identify both poor practice and possible solutions. A lack of audits in the last few months limits the local authority's understanding of the quality of frontline practice. Although children and young people's views are well considered on an individual basis, and there are some good examples of the Children in Care Council influencing practice, the number of children attending child protection case conferences is low and their views are not routinely used to develop or understand the impact of services.

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. In particular, this lack of alignment between agencies has limited the ability of the local authority and partner agencies to deliver a comprehensive and joined-up early help offer to children and their families.

Corporate parenting is a strength in Middlesbrough, with a clear commitment from the council to children and young people. There is very good support for children's emotional well-being and improvement in the performance of the youth offending service has led to a significant reduction in the number of children looked after entering the criminal justice system. Decisions for children to become looked after are appropriate and effective support packages are being used to try to keep children at home with their families when this is achievable and in their best interests. Action taken to address the high number of children looked after is resulting in numbers stabilising. The 'returning children to Middlesbrough' project is successfully helping children living in placements outside of the borough to return to their families or to placements much nearer to them; this is very good practice. Further improvement in children's outcomes is hindered because most care plans lack detail, clear actions or timescales. In addition, a small minority of visits to children looked after do not always take place within expected timescales. The independent reviewing officer (IRO) service is under-resourced, limiting the service's ability to track children's progress between reviews. The educational attainment of children looked after is improving but the rate of improvement is not fast enough and progress is fragile. Too many children looked after are not helped to manage the transition between primary and secondary education well, with the result that their attendance and attainment declines. Educational plans are not focused sharply enough on the key determinants of pupils' progress.

The fostering service is effective, helping to ensure that there is an appropriate range of placements for children and young people. Foster carers speak positively of the support that they receive. However, a very small number of children and young people have been inappropriately placed temporarily in unsuitable placements. The local authority stopped this practice immediately after it was identified by inspectors during the inspection.

Adoption work is strong and the local authority is committed to pursuing adoption for all children who could benefit, including those for whom it is hard to find an adoptive placement. However, insufficient rigour in the system for tracking children's progress towards adoption is limiting further improvement.

Strong planning and a good range of support helps care leavers in Middlesbrough make good transitions into adult life. The co-location within the Pathways team of a range of other professionals is a particular strength.

Effective commissioning of child and adolescent mental health services (CAMHS) and other services that provide emotional support to children ensures that consideration of the emotional health and well-being of children is impressive. This is the case from early help services, where a number of innovative schemes widen access to services, through to services for care leavers who have access to a dedicated CAMHS therapist co-located within the Pathways team.

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The local authority

Information about this local authority area²

Previous Ofsted inspections

- The local authority operates four children's homes. Two were judged to be good or outstanding in their most recent Ofsted inspection.
- The previous inspection of the local authority's arrangements for the protection of children was in July 2011. The local authority was judged to be adequate.
- The previous inspection of the local authority's services for children looked after was in July 2011. The local authority was judged to be adequate.

Local leadership

- The Director of Children's Services (DCS) has been in post since June 2014.
- The DCS is also responsible for adult services.
- The chair of the LSCB has been in post since October 2010.

Children living in this area

- Approximately 33,700 children and young people under the age of 18 years live in Middlesbrough. This is 24% of the total population in the area.
- Approximately 33% of the local authority's children are living in poverty.
- The proportion of children entitled to free school meals:
 - in primary schools is 27% (the national average is 16%)
 - in secondary schools is 28% (the national average is 14%).
- Children and young people from minority ethnic groups account for 18% of all children living in the area, compared with 22% in the country as a whole.
- The largest minority ethnic groups of children and young people in the area are Asian/Asian British and mixed ethnicity.
- The proportion of children and young people with English as an additional language:
 - in primary schools is 16% (the national average is 19%)
 - in secondary schools is 14% (the national average is 15%).
- Middlesbrough has the highest proportion of asylum seekers of any local authority in England, with one in every 186 of the population being an asylum seeker.

² The local authority was given the opportunity to review this section of the report and has updated it with local unvalidated data where this was available.

Child protection in this area

- At the time of the inspection, 2,012 children had been identified through assessment as being formally in need of a specialist children's service. This is a reduction from 2,069 at 31 March 2015.
- At the time of the inspection, 219 children and young people were the subject of a child protection plan. This is a reduction from 231 at 31 March 2015.
- At the time of the inspection, two children lived in a privately arranged fostering placement. This remains the same as the figure at 31 March 2015.
- Since the last inspection, three serious incident notifications have been submitted to Ofsted and one serious case review has been completed or was ongoing at the time of the inspection.

Children looked after in this area

- At the time of the inspection, 367 children are being looked after by the local authority (a rate of 115 per 10,000 children). This is an increase from 360 (113 per 10,000 children) at 31 March 2015. Of this number:
 - 214 (or 58%) live outside the local authority area
 - 57 live in residential children's homes, of whom 72% live out of the authority area
 - 267 live with foster families, of whom 60% live out of the authority area
 - 28 live with parents, of whom 12% live out of the authority area
 - one child is an unaccompanied asylum-seeking child.
- In the last 12 months:
 - there have been 25 adoptions
 - 16 children became subject of special guardianship orders
 - 184 children ceased to be looked after, of whom 5% subsequently returned to be looked after
 - five children and young people ceased to be looked after and moved on to independent living
 - 10 children and young people ceased to be looked after and are now living in houses of multiple occupation.

Recommendations

1. Ensure that all children and young people receive the right services without delay and that their progress is tracked by strengthening management oversight, supervision and recording.
2. Ensure that managers review the progress of assessments within timescales that match individual children and young people's circumstances and needs.
3. Improve performance management and quality assurance systems, including data quality, to effectively monitor and improve the quality of services.
4. Work with partner agencies to build a stronger strategic vision of the shared priorities for children's safeguarding and social care needs, particularly for early help services.
5. Engage with partner agencies to increase the number and quality of early help assessments completed and to ensure that a full range of agencies are taking on the role of lead professional.
6. Ensure that the independent reviewing officer service is adequately staffed to provide a consistently effective service to children and young people, including the timely circulation of minutes from review meetings.
7. Support improved outcomes for children looked after by ensuring that care plans contain sufficient detail, clear actions and timescales.
8. Improve the systems for progressing cases in a timely way following adoption process meetings, so that they are effective in all cases and that the reasons for matching decisions are clearly recorded.
9. Develop systems to improve the participation of children and young people, including in child protection case conferences and how their views are collated and used to improve services.
10. Strengthen the provision and use of return home interviews to ensure that individual children and young people are safeguarded and that patterns of risk are better understood and addressed, particularly where they relate to child sexual exploitation.
11. Further develop work with Middlesbrough's diverse communities, particularly asylum seekers, to better understand and meet the needs of these children and young people.
12. Make sure that children looked after receive statutory visits within expected timescales to more effectively monitor progress.

13. Help social workers understand the historical context and risk factors for the children and families they are working with by making better use of chronologies.
14. Improve the attainment levels of all children looked after, but particularly those of secondary school age, by improving attendance and better supporting the transition between primary and secondary school.
15. Sharpen the focus of personal education plans on addressing the specific actions that children looked after and their teachers need to take to improve progress, as well as on setting out in detail how the school will use the pupil premium to improve behaviour, attendance and attainment.
16. Further increase the numbers of care leavers securing sustainable education, training and employment by maintaining and improving existing good partnership work with education and training providers.

Summary for children and young people

- Children's services in Middlesbrough do well at helping most children. A few children do not get help as quickly as they should. Some services for children need to be better and managers are working hard to improve these services.
- Adults who work with children and young people in places such as schools do not always understand when they should organise support to families who need it or when they should contact the council to get support from a social worker. The new 'early help hub' set up by the council is beginning to improve this but it is still very new.
- Managers do not always check that social workers know what help they need to give children or make sure that things are getting better. Because of this, a few children have not been given support quickly enough.
- Social workers in Middlesbrough spend time with children, they get to know their wishes and feelings and children do not have to keep telling their story to new people. This is because most social workers in Middlesbrough have worked for the council for more than three years and they do not have to work with too many children at the same time.
- Children and young people only come into care when they really need to. Most children are given support so that they can stay living with their families. Children who do need to be looked after are given good support and either remain in care or are helped to safely return home when things are better.
- When adoption is best for children, the council is good at organising this. They work really hard to find the good families for children to live with, to make sure brothers and sisters can stay living together and to give help and advice to birth parents and adoptive parents.
- Young people who leave care, including disabled young people, are well supported. They are encouraged to remain with their foster carers until they are ready to move on, when they are helped to find suitable places to live. Their personal advisers keep in regular touch with them and give them support with important things like their health and learning. Middlesbrough council is doing better than many other councils at making sure that care leavers are in education, training or employment.
- The council needs to do better at understanding the particular needs of children and young people who come from different cultures, particularly asylum seekers. Social workers are doing some good work but they could do better.
- The council has been good at using the views of some children looked after and care leavers on the Children in Care Council to help understand how well services are doing and to help design new services but needs to involve more of the children and young people it is working with.

The experiences and progress of children who need help and protection

Requires improvement

Summary

The local authority is not working effectively enough with partners to improve the coordination and impact of early help services as thresholds and pathways are not fully understood or applied. The lead professional role is undertaken by partner agencies in only half of early help assessments and the overall number completed remains low. However, children’s centres provide a comprehensive range of services to meet identified need and there is good engagement by families in the early help services they offer.

A children’s hub provides the single point of contact for referrals, advice and consultation. The hub brings together staff from the local authority with professionals from a broad range of relevant agencies. In a very few cases, contacts about children have resulted in a decision to refer to early help services when the information received should have led to a statutory social work service. Although no children were left at immediate risk of significant harm as a result of this, some children have not received assessments or services proportionate to their needs. At the point of the inspection the local authority had recently put in place measures to strengthen decision making by ensuring that all referral decisions are now taken by a social work qualified manager. When children are at immediate risk of significant harm, cases transfer swiftly to the duty team. The majority of child protection investigations are timely and focused, both within and outside normal office hours. Good individual work with children is undertaken to seek their wishes and feelings. While this is reflected in and influences assessments and plans for children, children’s attendance at conferences is low.

There are gaps in supervision and management oversight of staff in assessment and care planning teams and the quality and timeliness of children and family assessments is not consistently good. Assessments are not routinely supported by chronologies or always reviewed by managers in timescales that match children’s individual circumstances. As a result, some children experience delays in their needs being assessed and met.

Good multi-agency coordination protects young people at risk of radicalisation, forced marriage, and female genital mutilation. The support available for asylum-seeking families requires further work to ensure that the needs of this diverse population are fully understood and met. Young people at risk of child sexual exploitation are protected by well-coordinated services and effective interventions. However, children and young people who have been missing do not always receive return home interviews as quickly as they should and intelligence from these interviews is not collated and compared with that about children at risk of sexual exploitation to better understand patterns of risk.

Inspection findings

17. The local authority has not yet ensured that early intervention and prevention services are fully coordinated across the partnership and are appropriately targeting all relevant children and families. The early help hub has only been in place since November 2015 and so early help pathways are not fully embedded. Although improving, not all agencies have a thorough shared understanding of pathways into early help and the thresholds for escalation or step-down. A training programme is underway to ensure that all family support workers have the necessary skills to carry out their roles. Plans are in place to provide briefings to partners on the referral pathways to early help and to statutory services; this work is not yet complete and some professionals from other agencies remain unclear about these processes (recommendation 4).
18. The quality of early help assessments is variable, with most assessments seen by inspectors requiring improvement. This variance reflects the lack of understanding by some staff of the impact of complex family circumstances. In some cases, this leads to delay in children and their families receiving services that reflect their needs. Family casework consultations and locality forums to support lead practitioners through focused discussions have been introduced to improve the effectiveness of early help. This is a positive move but too recent to be able to measure the impact on practice. Despite work to engage partners in the early help assessment process and undertaking the lead professional role, the number of assessments remains low, with 50% of assessments being completed by the local authority stronger families team and only 20% by schools (recommendation 5).
19. Children's centres provide a wide range of services targeted to identified need and there is good engagement from families. Established partnerships with health service providers deliver a good range of early help services. The addition of three senior practitioner posts to the early help hub has enhanced capacity to provide advice and guidance and is beginning to help identify support needs at an earlier stage.
20. A number of new schemes have widened the range and coverage of early help services, for example 'Headstart' promoting early support for possible mental health concerns in children and young people. All school-aged children and young people can use an online link, 'Toot Toot', to record any mental health-related worries such as low mood or bullying. Increased awareness across partner agencies about this approach is being developed through training and clinical supervision. Strong targeted early help provided through the children's services operational risk-taking behaviours meeting has had significant success in reducing teenage pregnancies. Nationally published data show that the local authority and its partners have achieved a 39% reduction in under-18-year-old conceptions between 2010 and 2013, from 65 down to 40 teenage girls per 10,000. However, despite this success, Middlesbrough still had the fourth highest rate of teenage pregnancies in England and Wales in 2013. The local authority's arrangements for monitoring home-educated pupils are good. There

are currently 29 children and young people being home educated, spread across most school years and all key stages.

21. The 'troubled families' programme sits within the early help delivery model and staff work with families across all levels of need. Middlesbrough have 'turned around' 570 troubled families during phase one of the project. This constitutes a 100% success rate, demonstrating improved outcomes in employment, educational engagement, reduced criminal activity and anti-social behaviour. Middlesbrough is now in stage two of the troubled families programme. Early indicators are good, with a further 89 families who meet the enhanced criteria having been 'turned around' this year.
22. The local authority is currently developing systems to monitor the quality of joined-up early help and prevention interventions through a common recording and monitoring system. The system is currently underdeveloped, which means cases do not always benefit from consistent management oversight and direction.
23. The referral threshold for statutory social work services is not fully understood by staff across all partner agencies. The local authority has responded by establishing a children's hub as the single point of contact for referrals, advice, consultation and support. The hub brings together staff from the local authority with professionals from a broad range of relevant agencies. In a very few cases seen, contacts about children had been managed by early help services when the information received should have led to a social work assessment; although no child had been left at risk. Parental consent to share information is routinely sought when contacts are received. Some decision making at the point of referral to children's services was, until recently, not being undertaken by a qualified social worker. The local authority is now ensuring that a social work qualified manager has oversight of all incoming work.
24. When children are at immediate risk of significant harm, cases transfer swiftly to the duty teams, where most child protection investigations are undertaken in a timely and focused way, both within and outside normal office hours. The local authority has made significant improvements in the timeliness with which they hold initial child protection conferences. At November 2015, 97% were held within the statutory timescale of 15 working days, compared to 75% in similar local authorities. Child protection enquiries are thorough and timely, informed by strong strategy discussions. Child protection conferences lead to effective child protection plans, of which 96% are reviewed within timescales, which is better than similar local authorities and this is a strength.
25. Manageable caseloads in the assessment and care planning teams allow social workers to spend more time with children and their families. This supports stronger and better relationships with children and families, leading to interventions that are more effective. However, gaps in supervision and management oversight are a concern in assessment and care planning teams. Although in most cases this has not led to delays in children being assessed or

having their needs met, a few children have experienced delays. No children were left at immediate risk of significant harm but in one assessment and care planning team, five of 24 children's cases looked at by inspectors showed some delay that had not been picked up and addressed by managers. The local authority took prompt and immediate action during the course of the inspection to review these children's cases, put in place remedial actions and to assure themselves that such delay was not more widespread (recommendation 1).

26. The quality and timeliness of children and family assessments is not consistently good. Assessments are not always completed in a timescale that is appropriate to children's individual needs or that meets the local authority's own target of 45 days. The most up-to-date figure, from the local authority's own data, of 77% for November 2015, is below their published 2014–15 performance of 99%. This means that some children are experiencing delays in having their needs assessed and met (recommendation 2).
27. In good assessments, the wishes and feelings of children are actively explored, inform the assessment and are reflected in plans. Safety goals, although broad, result in clear, specific and measurable actions that lead to improved outcomes for children. No assessments seen by inspectors were inadequate, most were good, but some lacked evidence of thorough consideration of the individual needs of children, particularly those from minority ethnic cultures. Assessments and plans are not consistently supported by chronologies. This means that historical risk and emerging patterns are not always recorded, considered and understood sufficiently. Family group meetings are not being used to support alternative family arrangements to proactively support planning for later stages of the child's journey. Child protection case conferences are able to agree 'neglect medicals' for children subject to a child protection plan under the category of neglect to measure progress against key developmental factors such as height and weight. This provides a helpful way of measuring the impact of interventions in improving children and young people's welfare. Inspectors saw how information from 'neglect medicals' was helpful in making decisions regarding 'step-down' to child in need services or escalation to care proceedings (recommendation 13).
28. There are a number of risk assessments tools designed to support the consideration of specific risks, such as child sexual exploitation, missing from home, sexually harmful behaviours and domestic abuse. However, use is inconsistent and impact has been limited. In some cases seen, tools were used as a tick box exercise, in others, more comprehensive consideration resulted in clearer evidence of appropriate risk reduction and support. Research and theory-based methodology does not underpin analysis strongly enough, particularly where neglect is a persistent feature. Of the 219 children currently subject to a child protection plan, neglect is the main risk in 62% of cases. Effective and consistent consideration of the impact of the 'toxic trio' in presenting need is not prominent enough in assessments.

29. Escalation of concern leads to an appropriate and proportionate response to risk when cases are 'stepped up' from child in need to child protection. The new locality forum system is beginning to provide effective multi-agency oversight for children's cases at the point of 'stepping down' from statutory social work to early help services.
30. Statutory visits to children are timely and focus on the child's well-being. Core group and child in need meetings listen to the voice of children and effectively drive plans. There is good use of child-centred tools in direct work with children. The use of direct work to obtain the wishes and feelings of children who are the subject of court proceedings is effective. The use of the 'visual plan' used with disabled young people by social workers in the transitions team is good practice. Consideration of an independent advocate is not routinely given for children and young people in need of help and protection. Social workers in the disabled children's team and the transitions team use a number of communication tools to ensure that the views of children are fully understood.
31. Good multi-agency coordination helps protect young people at risk of radicalisation, forced marriage, and female genital mutilation. In the majority of cases, early identification of risk leads to proactive and immediate safeguarding of young people supported by a well-organised multi-agency response. Proactive responses by the police and the use of legal orders have effectively addressed concerns and reduced the risk of radicalisation or forced marriage. This has been supported by effective use of intelligence and information sharing.
32. Middlesbrough has the highest number of asylum seekers in proportion to its population of any local authority in England, with one person in every 186 being an asylum seeker. Despite this, the consideration of the impact of seeking asylum and settling into a new culture is not consistently seen in assessments where these issues are relevant. Social workers spoken to by inspectors could usually explain how this was part of their thinking and analysis but this is not reflected in case recording (recommendation 11).
33. Improvements in safeguarding children from risks associated with going missing and sexual exploitation have been put in place following Ofsted's child sexual exploitation thematic inspection in November 2014. There are increasing numbers of appropriate referrals to the vulnerable, exploited, missing and trafficked (VEMT) meetings. Practice is not yet consistent for return home interviews and relevant information is not fully used to identify risks and themes. Where children are at risk of or subject to child sexual exploitation, there is an effective support response from a number of providers. This includes diversionary work through street-based activity, as well as pre and post court proceedings work. Improvements in safeguarding children from risks associated with going missing and sexual exploitation have resulted in increasing referrals to the VEMT and children receiving appropriate support services, leading to improved outcomes (recommendation 10).

34. The prevalence of domestic violence in Middlesbrough continues to be higher than in similar local authorities. Operation Encompass, involving schools, the police and the local authority, was introduced in November 2015 to support school-aged children who witness domestic violence incidents. As this project is so new, it is too early for it to have had a significant impact. The Multi Agency Risk Assessment Conference (MARAC) Coordinator provides consistent and effective representation at the steering group. There is direct provision through early help services to support children who are affected by domestic abuse. Multi-agency public protection (MAPPA) arrangements work well. The local authority's data at the time of the inspection showed that they were working with 746 children in need. There has been a steady reduction in the number of children in need in Middlesbrough over the past three years. However, the rate of 651 per 10,000 of the population under 18 is still significantly higher than similar local authorities by 153 points. Middlesbrough has the second highest level of deprivation of the 152 local authorities in England, with 33% of children living in poverty compared to the England average of 20%. Despite this high number, child in need plans are effective in making real change to children's circumstances and arrangements for reviewing child in need plans are appropriate and timely.
35. At the time of the inspection, 219 children were the subject of a child protection plan. In all of the cases seen by inspectors, decisions to make children the subject of a child protection plan were appropriate. Effective review mechanisms and oversight has resulted in no children or young people being subject to a child protection plan for any longer than two years. Children and young people are invited to conferences and reviews. Conference chairs report that although social workers are good at talking to children before conferences to seek their views and explain what the conference is for, children's attendance remains low. Not only are children insufficiently engaged in their own conferences but also feedback from young people does not sufficiently inform practice development. Minutes are completed and disseminated in a timely manner, although they are not recorded in a way that makes them easily accessible to children and young people (recommendation 9).
36. Effective commissioning of interpreting services helps families who speak English as a second language to be able to participate fully in formal meetings. Inspectors did see translation well managed during meetings, although reports and minutes are not translated, which results in families not being wholly involved in the process.
37. Attention has been given to private fostering at a strategic level but this is not resulting in increasing numbers of private fostering placements being notified or identified; in November 2015 there were two arrangements in place. There is a quarterly multi-agency steering group in place, a communication strategy, six monthly audits of all private fostering cases and an annual report. Assessments contain detailed analysis of the children's needs; children are seen regularly and seen alone to seek their views. Relevant services are secured to support

children, such as child and adolescent mental health services (CAMHS). Children in need meetings review the plans for these vulnerable children.

38. The Designated Officer service provides an effective interface between agencies and is actively developing operational links with faith organisations and community cohesion groups. The management of allegations is robust and effective; data shows that there were 60 referrals to the Designated Officer in 2014–15, 93% of which were resolved satisfactorily and in a timely manner.

The experiences and progress of children looked after and achieving permanence

Requires improvement

Summary

Services for children looked after in Middlesbrough require improvement. In almost all cases seen, decisions for children to become looked after are in their best interests. In the cases of a very few children, the inappropriate practice of placing them in unsuitable placements, seen during the inspection, was stopped by the local authority immediately after it was identified by inspectors.

Action taken to address the high number of children looked after is resulting in the number stabilising. Effective support packages are being successfully used to keep children at home with their families and to move children placed out of the area back to Middlesbrough. Very good direct work with children ensures that their voices are well considered in decision-making for matching and placements. However, the voice of the child is not as consistently present in care planning and assessments. The independent reviewing officer (IRO) service is under-resourced, limiting the service's ability to track children's progress between reviews. The fostering service is effective, ensuring that there is a good range of placements for children and young people. Foster carers are positive about the support that they receive. In the majority of care plans for children looked after, the quality is not good. Plans lack timescales and are too broad in their actions to promote and progress positive outcomes for the children and young people. Although there is effective work with both children and carers during statutory visits, the timeliness of visits is not good enough to monitor progress and support children.

Corporate parenting is a strength in Middlesbrough, with a clear commitment to children and a good understanding of relevant issues and challenges. There is very good support for children's emotional well-being and mental health needs. Improvement in the performance of the youth offending service (YOS) has led to a significant reduction in children looked after entering the criminal justice system. Strong planning and a good range of support helps care leavers in Middlesbrough make good transitions into adult life. The co-location within the Pathways team of a range of professionals to support young people is a particular strength.

The educational attainment of children looked after is improving but progress is fragile and not fast enough. Too many children looked after do not manage the transition between primary and secondary education well, resulting in declining attendance and attainment. Educational plans are not focused sharply enough on key determinants of pupils' progress and use of the pupil premium is not driving improvement sufficiently.

Good practice is evident in all areas of adoption work, with examples of innovative approaches demonstrating positive impact. The local authority is committed to pursuing adoption for children, including those for who it is hard to find a placement. However, insufficient rigour in the system for tracking children's progress towards

adoption is limiting further improvement.

Inspection findings

39. There were 367 children looked after by Middlesbrough at the time of the inspection. This is slightly higher than the numbers for 31 March 2014 and 31 March 2015 of 355 and 360. Although the rate of children looked after per 10,000 of the population under 18 is higher than in similar local authorities (113 compared to 96 at 31 March 2015), the rate at which the numbers are increasing has slowed and stabilised. This is in part due to recent development work through the 'returning children to Middlesbrough' project as part of the transformation programme board. This has been very effective in preventing some children coming into care through the use of detailed support packages. Decisions for almost all children to become looked after are timely, and the decision making is appropriate. Effective packages of support are provided to help children remain at home with their families when this is in their best interests and to prevent them becoming looked after when this is avoidable. However, a very small number of children and young people have been inappropriately placed temporarily in unsuitable placements. The local authority stopped this practice immediately after it was identified by inspectors.
40. Social workers have meaningful relationships with the children, and assessments of the circumstances of children looked after are good. Full consideration of the views of children, parents and all relevant people in the children's lives, including wider family members, is sought and used to inform assessments. Direct work with children and young people is used well, especially to ensure that their views are considered in assessments. Although historical information is routinely reported in assessments, chronologies are not regularly used to help analyse or identify patterns of risk.
41. While the views of children and young people are seen in case recording and well considered in assessments, they do not inform plans well enough. In the majority of care plans for children looked after, the quality is not good. Plans lack timescales and are too broad in their actions to promote and progress positive outcomes for the children and young people (recommendation 7).
42. In 2014–2015, 72% of statutory visits were undertaken within expected timescales and the frequency of visits is increased when individual children would benefit from additional support. Case recording demonstrates that some effective work is achieved during these visits, both with children and their carers. However, the timeliness of visits is not good enough to support children and young people and monitor their progress (recommendation 12).
43. Use of the Public Law Outline (PLO) is effective. PLO letters to parents or carers set out the reasons for the meeting in plain English. They explain why children are at risk of harm, what needs to change, by when and what is expected of parents. The letters clearly set out what action is being considered by the local authority if children's welfare does not improve. However there is currently no

process in place to ensure monitoring and oversight of the cases of children subject to the PLO who are either in, or likely to be in, care proceedings. A panel to do this is due to be introduced in January 2016. Social workers and legal services liaise effectively to ensure that the quality and timeliness of applications and assessments placed before the court are good; almost all applications are accepted by the courts.

44. Social workers and independent reviewing officers (IROs) work effectively with local authority legal services, Cafcass, and the courts to ensure that delays in proceedings before the court are kept to a minimum. The local authority is currently completing 87% of care proceedings within 26 weeks, which is good. Permanence plans for children are considered early in their time in care, with clear plans being identified by the time of children's second looked after review.
45. There is effective work with children to prepare them for permanent placements. Matching for both adoption and long-term fostering placements is subject to family placement panel consideration and senior manager oversight and decision making by the Agency Decision Maker. The planning and management of transition to permanent placements is thorough, and children's wishes and feelings are well considered. Children who return home to the care of their parents receive a robust offer of support and ongoing intervention from the local authority, which ensures that their move is safe and supported.
46. IRO caseloads average 100–120, which exceeds the statutory guidance recommendation of 50–70. Despite the high caseloads, IROs are very committed and prioritise their work. The high caseloads have an impact on IROs' ability to meet with children before their reviews, and to monitor their progress between reviews, particularly if children are placed some distance away. In 2014–2015, of the 954 children who had a review of their care plans, a total of 744 (71%) children were seen by the IRO prior to their review meeting. In addition to this, the minutes and outcomes recorded from reviews lack detail and clarity and are not circulated to attendees in a timely manner. This makes it more difficult for children and professionals to know if actions agreed at reviews have been met, and for some children this leads to delays in progressing improvements in their welfare (recommendation 6).
47. Despite these capacity problems, performance on reviews undertaken within expected timescales is good: 92% from April to December 2015, compared with 85% for 2014–2015. IROs are clear about their role in challenging practice and timeliness and demonstrate good practice through the routine auditing of children and young people's case files before every review meeting. Evaluations are undertaken of the areas of challenge made on children's cases. The use of advocacy is well established and all children are offered an advocate and/or an independent visitor within their review meetings.
48. All young people coming into care receive a welcome pack. There are two types: a 16 years or older pack and another one for younger children. These packs help children and young people to be aware of their rights, entitlements

and other useful information. Foster carers are also well aware of the rights and entitlements for the children in their care.

49. Children live in homes that meet their needs and that provide stable and safe care for them. They are supported to develop secure attachments to their carers. Children and young people experience less changes of placement than either the national average or that of similar local authorities, and this is continuing to improve. In 2014–15, 10% of children looked after in Middlesbrough lived in three or more placements during the year, compared to 11% for both similar local authorities and nationally (2013–14). The local authority's own figure for the year up to 31 September 2015 is 4%. This is a significant further improvement and means that children have an increasingly secure base from which to achieve positive outcomes.
50. There is a strong commitment to placing brothers and sisters together. Inspectors saw examples of therapeutic work that had been commissioned to guide carers in providing care appropriate to the complex and sometimes very different needs of brothers and sisters in sibling groups who have been placed together. This is good practice. Good-quality life story work is undertaken for children placed for adoption, although this is not as comprehensively in place for children who are fostered.
51. Social workers ensure that children have contact with their families, including brothers, sisters and other people who are important to them. Workers who supervise or support contact between children looked after and their families not only facilitate contact but also undertake a range of work with families as part of the resource and development service. This supports the process and helps ensure that children and young people have a positive experience when having contact. Careful consideration is given to these arrangements and the quality of recording from supervised contact is good.
52. Family finding is underpinned by clear assessments of children's needs, including assessments of risk when this is needed. When consideration is being given to placing brothers or sisters apart, specific assessments are commissioned to decide if this is the right decision, to inform placement choice and to help identify support needs. Available local authority placements are considered promptly and, where these are not appropriate to a child's individual needs, external placements that do match their needs are quickly identified. When long term and permanent placements for children and young people are being sought, early and comprehensive planning meetings take place which effectively identify key actions required to progress plans. For a small number of children, the local authority has taken too long to find them a permanent placement.
53. The recruitment and assessment of foster carers is carried out in line with national regulations and is supported by a good range of recruitment strategies, including via editorials in the local press, adverts in magazines, social media and membership of the multi-authority Tees Valley Recruitment Group. This has

resulted in increased local authority provision and there are currently 117 local authority foster carers, an increase from 112 in March 2015 and 95 in March 2014. Assessments of prospective carers are thorough and there is effective support, training and career-focused reviews in place, which is appreciated by the carers.

54. Work with connected persons has improved since the appointment of a dedicated worker in June 2015. The quality of viability assessments is good. In a small number of cases, more timely identification of those prospective carers who are unlikely to meet fostering standards could have been achieved through more effective joint working between the child's social worker and the connected person's worker. Assessments for special guardianship are good, effectively identifying children's needs, ongoing support requirements and contingency plans. The number of special guardianship orders has increased, from 24 in 2014–15 to 25 already made in the first half of 2015–16. Although the local authority has a priority to improve support to special guardians, good support is not consistently offered.
55. The successful 'returning children to Middlesbrough' project was established following the success of intensive support packages provided to some disabled children living out of the local authority area, which enabled them to move back to family or carers in Middlesbrough. The project now considers children living out of Middlesbrough who could be supported to move back with the right level of multi-agency support in place. It is an example of strong practice by the local authority that is promoting positive outcomes for children and young people by helping them to return to live closer to their families, friends and community.
56. For children who live out of the local authority area, arrangements for their education and the information provided to their new placements is inconsistent, as key health and education colleagues are not routinely involved in all placement planning. In spite of this, outcomes are good for the majority of children living in other local authority areas. Good arrangements are in place for notifying other local authorities when Middlesbrough children are placed in their area.
57. Effective work is being undertaken through a commissioned service for young people who have alcohol and substance misuse problems. This service is valued by young people and their families and 93% of young people left the service in a planned way, with 50% being free of alcohol and drugs. Sixty-one per cent of young people also continue to engage with the youth offending service or children's services at this point.
58. Good work by the youth offending service has resulted in a significant decrease in the number of children looked after entering the criminal justice system. Restorative justice training is provided to children's home staff and has been used well. The impact of this has been complemented by the police also adopting a restorative approach. In 2013–14, 11% of children looked after received a caution or conviction, which was higher than either the national

average of 6% or that for similar authorities of 9%. In 2014–2015, this has reduced to 6% (11 of 176) of children looked after receiving a caution or conviction.

59. The local authority has recently commissioned a national charity to provide return interviews to children and young people who have been missing from home or care. This new service is not yet fully embedded and children do not always received return home interviews after they go missing or as quickly as they should. This is particularly true if they have been missing on several occasions in a short space of time. However, for those who go missing persistently, effective multi-agency meetings are held that draw up detailed and realistic plans that help reduce risk for these young people (recommendation 10).
60. Effective commissioning of child and adolescent mental health services (CAMHS) and other services that provide emotional support to children ensures that the emotional health and well-being of children looked after is well considered and addressed. CAMHS support extends to children and young people up to the age of 21, to ensure that vulnerable care leavers receive services to support them in the community. The maximum waiting time for an initial CAMHS assessment is four weeks, but children looked after are typically seen within two or three weeks. Appointments for follow up are offered immediately. There are currently no children waiting to receive a service.
61. Children who spoke with inspectors said that schools deal with bullying well. Foster carers reported that their relationships with schools are good and that bullying is tackled when necessary.
62. The health needs of children and young people who come in to care are well considered and met through timely and thorough health assessments. At the time of the inspection, 100% were being completed on time, along with 88% of health reviews and 92% of dental checks. The quality of health assessments is audited and learning taken forward to develop practice. When need is identified, there are timely referrals to support services for drug and alcohol misuse and good planning and support for young people who become pregnant.
63. The virtual school is currently responsible for the education of 258 children looked after: 142 in education in the borough and 116 educated out of the borough, aged between two and 16 years old. The gap between the educational attainment of children looked after and their peers at all key stages in Middlesbrough has gradually closed over the past two years, but still remains wide at Key Stages 2 and 4. Children looked after in Middlesbrough achieve better results than their looked after peers in the rest of the country. However, this improvement has not been sustained into the current year, with less than half of all children looked after making expected progress across all age groups and key stages (recommendation 14).

64. At Key Stage 1, children looked after achieve better than pupils in the rest of Middlesbrough in reading, writing and mathematics, and well above their peers nationally. At Key Stage 2, they perform better than their national comparators, but are 30% below their peers in the borough for English and 20% in mathematics. In 2015, 16% of looked after children achieved five A* to C GCSE grades, including English and mathematics, compared to 45% of pupils in the rest of the borough (recommendation 14).
65. The virtual school is effective in supporting children looked after in schools that are rated less than good. There are currently five young people looked after at Key Stage 4 who are in schools that require improvement or are inadequate, making up 17% of the total cohort. Where three or more children are in a school rated less than good, an additional teacher from the virtual school is assigned to support the children's progress (recommendation 14).
66. Overall attendance in education by children looked after requires improvement. At primary schools, attendance is at the same high level as their peers. However, from Year 7 onwards, attendance deteriorates, with a negative impact on attainment. The number of days missed through fixed-term exclusions by children looked after has halved in the last year and no children have been permanently excluded in the past two years (recommendation 14).
67. The quality of personal education plans (PEPs) requires improvement. The majority of PEPs are based on targets that are overly focused on the achievement of qualification grades and not on the specific steps that inform pupils what it is they need to do to progress. For pupils in Years 10 and 11, there is not enough focus on career options based on good information, advice and guidance. There is insufficient information on the actions to be taken to address identified those issues with behaviour and attendance that go on to have a negative impact on the pupils' progress. PEPs do not contain sufficient clarity or direction about how schools will target the use of the pupil premium to raise the attainment of children looked after (recommendation 15).
68. The local authority's systems for recording and tracing children who go missing from education are effective. Between January and July 2015, 66 children were reported missing, with 58 of them being traced. The local authority continues to actively pursue children's cases once they are put on the 'historic records of destination of unknown pupils'. A multi-agency 'children missing education/vulnerable pupils' working group identifies children at risk of missing education and is proactive in coordinating additional support to keep them in learning (recommendation 14).
69. There is a good range of alternative provision available to children looked after who do not engage well in mainstream schools. There are 30 children looked after currently placed in some form of alternative provision. Of these, three are not undertaking 25 hours per week of education, but one of these is on a phased plan to build up to the required hours, while the other two can access online learning packages (recommendation 14).

70. Children looked after benefit from good access to leisure facilities and receive support to help them pursue hobbies and interests. For example, children are given discount cards to access local leisure facilities and foster carers recently organised a dance workshop. Celebration events are held and, although children and young people who spoke to inspectors had mixed views about how enjoyable and valuable such events are, they all stated that they regularly attend and receive awards.
71. There is an active Children in Care Council (CiCC) whose members are clear about their role in improving things for children looked after and care leavers. However, not all children looked after are currently aware of the existence of the CiCC. The members of the corporate parenting group demonstrate a strong commitment to their role. They visit residential homes, attend adoption and fostering support meetings, undertake a range of relevant training and challenge poor performance. They listen and respond to the views and wishes of children looked after, for example by ensuring that they have access to computers and free passes for leisure facilities. They work very effectively with the CiCC and with the forum for looked after children (FLAC). Membership of the FLAC includes elected members, health representatives, children and young people and other agencies. The FLAC also works closely with a care leaver who is an active part of the group and highly effective in ensuring that issues for children, young people and care leavers in Middlesbrough are addressed.
72. Consideration of how children and young people's faith, language, race and other factors such as culture and sexuality may shape their identity and give rise to particular support or assessment needs is not consistently thorough. In a minority of cases it is not good enough. Ethnicity and diversity are often identified on children and young people's case files, but any needs they may have arising from this are not always specifically addressed through assessment and planning processes. However, short break support for disabled children is strong and shows a 79% rise in the number of children receiving support, from 300 in 2009–10 to 539 in 2014–15.

The graded judgement for adoption performance is that it is good

73. Adoption is considered at an early stage for all children who may benefit and parallel planning is well established. An experienced worker is dedicated to the task of overseeing family-finding activity. In all cases where adoption is being considered, a comprehensive adoption process meeting ensures that the actions and responsibilities required to progress the adoption are identified promptly. This supports early family finding in the local authority area. When appropriate carers are not identified locally, regional and national processes are used in a timely way to identify families. Although initial decisions to pursue adoption for children are made quickly, the systems for tracking the progress of individual children's cases after process meetings are not robust enough to ensure that agreed actions always happen as quickly as they could. There are

currently two children who are subject to a placement order but not yet matched, potential carers have been identified for those children (recommendation 8).

74. The local authority demonstrates a commitment to pursuing adoption for children, including those for whom it is hard to find an adoptive placement. There have been no decisions to cancel an adoption plan in the last year. Adoptive placements have been successfully achieved for children, despite this taking significantly longer than the national thresholds for some harder-to-place children. There is no evidence that the length of time taken has impacted negatively on the children involved and careful support and planning is evident in these cases. Overall, the number of children being adopted has increased from 22 in 2013–14 to 29 in 2014–15.
75. The timeliness with which children are placed for adoption after becoming looked after is improving. The average time in the three years 2012–15 is 603 days. While this does not meet the national threshold of 487 days, this performance is better than the Middlesbrough three-year average for 2011–14 of 610 days and the national average of 628 days. The timeliness from when the court makes the order enabling the local authority to place a child with adopters until the child is placed is declining. The average number of days has increased from 277 days in 2011–14 to 302 days in 2012–15. This performance is worse than the national average of 217 days and does not meet the government threshold of 121 days. However, the positive action of the local authority in securing adoption for a number of older children who had been in care for a number of years has also had the negative effect of significantly contributing to this reduction in timeliness.
76. A large majority of child permanence reports provide comprehensive and current information about the child and their identified needs. When new information is identified, children's permanence reports are quickly updated. This means prospective adopters have the most up-to-date information available about children.
77. The recruitment and assessment of adoption applicants is undertaken in line with national regulations. The quality of the prospective adopter reports (PARs) is good, with clear analysis of applicants' strengths and vulnerabilities underpinning approval recommendations and effectively supporting matching considerations. While some assessments take longer than national timescales, delays are not excessive. The local authority is aware of this and the reasons for any delays. Adopters spoken to by inspectors were very positive about the prompt and helpful responses to initial enquiries, the quality of preparation courses and the support they received. The authority also offers innovative group sessions for extended family members of adopters, effectively developing their understanding of adoption and reducing any pressure they may unintentionally put on adopters. The evaluations and feedback from these sessions are very positive.

78. There is proactive work with, and weekly consideration of, approved adopters who are waiting for a placement. The local authority currently has 10 adopter households waiting to be matched. All 10 are approved for younger children. There is a group run for adopters who are waiting and there is also a group run by and for adopters themselves that they can also attend. Adopters value these groups. Adopters who are waiting are linked to the national adoption register and other regional and national processes and are supported in identifying potential adoptive placements.
79. The number of children identified as requiring adoption has reduced from 39 in 2013–14 to 32 in 2014–15. This is in line with national trends. The innovative practice of carefully planned early meetings between prospective adopters and children, known as chemistry visits, have been effective in initiating and developing relationships and attachments. Adopters are very positive about this practice. Careful matching with prospective adopters takes place at matching meetings, although the recording of these meetings does not always clearly evidence the reasons for deciding the choice of adopters. Where fostering for adoption has been utilised, it has been effective and appropriate and it is routinely considered in relevant cases. The right balance is given to securing the best placement that will meet the holistic needs of the child and seeking an exact ethnic match.
80. The family placement panel functions effectively in meeting adoption and fostering requirements. The chair is independent and experienced, with a sufficiently wide range of panel members who are knowledgeable about fostering, adoption and permanence. This includes adopted adults, adopters, and foster carers. The Agency Advisor provides robust quality assurance on the papers prepared for the panel, identifying deficits early, so that these can be rectified before panel meetings. This avoids delay and helps the panel focus on key issues. Panel members carefully consider all applications and make reasoned and effective contributions which underpin clear recommendations to the Agency Decision Maker. While the panel gives and gains verbal feedback from attending workers and applicants, this is not systematically collated and disseminated to support continuous practice improvement. The Agency Decision Maker provides appropriate consideration of and challenge to reports and recommendations and there is clear evidence of the rationale for decisions.
81. Adopters are well supported by social workers when children first move to their care, with careful consideration given to the transition arrangements. Foster carers are an integral part of these arrangements and help prepare children well for the move to their new family. Examples of good practice involving birth parents meeting with adoptive parents and effective engagement with the wider birth family, to contribute to life story work, were seen by inspectors. The vast majority of life story books are good. They are presented in age-appropriate language and will effectively support children to have a clear understanding of their history. 'Later life' letters are provided to help children when they are older to understand the plans that have been made for them.

82. Effective adoption and post-permanence support is provided to all those who need it, including services to birth parents and adopted adults, as well as children and their adopters. Adoption support plans are detailed, with clear actions and responsibilities, including appropriate financial support in line with identified need. Requests for post-adoption support receive a prompt and consistent response, and effective in-house work is undertaken with birth families to support appropriate letter-box contact. Examples of effective work facilitating direct contact between adopted adults and their birth families were seen by inspectors. Additional post-adoption support services are effectively commissioned, and are accessed following an assessment by the adoption service. The authority have started to utilise the adoption support fund for therapeutic work with adoptive families and services commissioned and offered are appropriately reviewed.

The graded judgement about the experience and progress of care leavers is that it is good

83. The arrangements for keeping in touch with care leavers are effective, with contacts being maintained with 95% of the 123 current eligible care leavers. Care leavers report that their personal advisers (PAs) keep in regular touch and are always accessible to them, with the result that they feel well supported. They particularly appreciate the birthday presents and cards they receive. Care leavers do, however, want to be kept better informed of when their PAs are on leave and what arrangements are in place for cover.
84. The range and level of support for care leavers through the Pathways Team is very good. Co-located with the social workers and PAs are a looked after children (LAC) nurse, a CAMHS therapist, a worker responsible for sourcing and supporting care leavers in accommodation and a worker leading on the coordination of education, training and employment. This level of planned and integrated service provision is good practice and results in care leavers being able to access services quickly and when they need them most. The co-location of these professionals from a range of agencies also helps ensure that social workers and PAs develop a better understanding of what each of these services can offer and this in turn makes a positive difference for care leavers.
85. The physical and mental health needs of care leavers are addressed well. Ninety-six per cent of care leavers in Middlesbrough have a current health assessment, which is 4% higher than for similar local authorities and 8% higher than the national average. Ninety-eight per cent of Middlesbrough care leavers are registered with a dentist, which is 14% above the national average. A new, attractive and useful health passport has been produced following an extensive consultation and endorsement process with the Children in Care Council. Care leavers say the information in it is valuable to them as they become more independent.

86. The LAC nurse based with the Pathways Team is readily available to care leavers, who drop in for medical check-ups, immunisation, pregnancy testing and advice on healthy living. The in-house CAMHS therapeutic practitioner has a positive impact on working with referred care leavers to identify the mental and emotional barriers that prevent them from making progress. Counselling for drug and alcohol dependency is readily available through a commissioned service.
87. The range of accommodation available to care leavers is appropriate, reflecting the well-developed partnerships that the Pathways Team has with housing providers. Of the 117 care leavers with whom the local authority is in touch, 109 are in suitable accommodation. Of the eight care leavers who were in unsuitable accommodation at the time of the inspection, six were in custody.
88. Almost all care leavers feel safe in their accommodation, although some say that their shared and supported accommodation is not always located in areas that they want to live in. Work with homeless 16- to 17-year-old young people is compliant with legislation and statutory guidance. In 2015, there were 10 referrals to assess the circumstances and support needs of homeless 16- to 17-year-olds, the same number as for the previous year. Of these, four became children looked after and were provided with accommodation by the local authority, with the rest being appropriately supported to return to their previous accommodation. There is an effective mediation service to help resolve issues that have led to young people becoming homeless.
89. The local authority has had a 'staying put' policy in place for a number of years, and this provides an effective transition for care leavers who wish to remain living with their foster carers. This is good practice and, as a result, there were nine care leavers with local authority foster carers and eleven with independent agency foster carers at the time of the inspection.
90. Pathway planning by social workers and PAs is effective. Pathway plan reviews are held on a six-monthly basis and more regularly if needed, with a good level of input from care leavers in stating their choices and preferences. There is an effective balance in the plans between young people taking responsibility for their own actions and professionals providing directed support. The plans sampled by inspectors were comprehensive, with specific and timed targets whose implementation was routinely monitored at the following reviews.
91. Transition planning for disabled young people is carried out skilfully. Planning starts early, involves young people in all main decisions and at all key stages, and care packages are personalised to meet the specific needs of individuals. For example, a group of three young people with profound and complex needs about to move into specialist accommodation have been involved in the recruitment of their carers and planning the décor of their rooms. The location of the transitions team within adult social care and health facilitates joint working.

92. Care leavers are supported well to develop their independent living skills. Providers of supported accommodation are commissioned to equip young people with the skills and knowledge they need to make the transfer to independent tenancies. Structured courses and one-to-one advice on shopping, cooking, budgeting and how to access benefits all feature prominently as agreed actions in Pathways plans.
93. Work to support care leavers into education, training and employment (ETE) is increasingly effective. There are 12 care leavers currently on degree courses at university. These positive outcomes are a direct result of the partnership work with further education colleges, independent learning providers and universities, who have agreed protocols for identifying and supporting care leavers to progress with their education. Named individuals within each provider provide a link with the Pathways Team to monitor and report on individual care leavers' progress, and provide additional support if there are any problems, such as with poor attendance. Although an improving picture, there are still a significant number of care leavers who are not in education, training and employment (recommendation 16).
94. Care leavers understand their entitlements and how to access them. Pathway plans make frequent reference to the use of grants to help care leavers move into accommodation and to contribute to the costs of their further and higher education. The long-established and active Children in Care Council, which includes post 18-year-old care leavers, has a good track record of co-producing policies and procedures. This includes the care leavers' pledge, and suggesting ideas that are subsequently implemented, such as the use of the leisure card in the borough.
95. The local authority pays a great deal of attention to ensuring that it celebrates the achievements of its care leavers. As well as an annual awards evening for all care leavers, there is strong focus on the achievements of individuals. For example, one care leaver who has been an active member of a council scrutiny panel was taken out to lunch by staff and councillors to mark her graduation from university.

Leadership, management and governance	Requires improvement
<p>Summary</p> <p>The local authority is not yet providing a consistently good service. Social workers in some teams do not always receive sufficient management oversight and guidance of their work. Consequently, work with a small number of children is not progressed as quickly as it could be and decisions not always clearly recorded on children’s electronic case files. For children in need of help and protection, including in early help services, management had not identified that a few children were experiencing delays in being seen and having their needs addressed. Management oversight is much more evident in work with children looked after but has still not been consistently ensuring progress. This includes examples both of poor care planning and delays in updating reports, which had not been identified by managers.</p> <p>Performance management is generally not well used to improve practice. Some of the data is not accurate and management reports lack analysis that could help identify both areas of poor practice and possible solutions. A lack of audits has limited the local authority’s understanding of the quality of frontline practice. Although the views of children and young people are well considered on an individual casework basis and there are some good examples of the Children in Care Council influencing practice, the views of children and young people are not routinely used to help understand the impact of services or to shape their development.</p> <p>Strategic partnership working is under-developed. None of the existing multi-agency bodies provide a strong enough focus for agreeing how agencies plan to meet the safeguarding and social care needs of Middlesbrough’s children. In particular, this lack of alignment has limited the local authority’s ability to deliver a comprehensive and joined up early help offer to children and their families.</p> <p>Although early help services are currently underdeveloped, there is a strong commitment to early help from the local authority’s senior leaders and managers. Decisive and swift action was taken in accepting and fully implementing the recommendations arising from an early help peer review that reported in September 2015. Despite the authority’s wider need to identify savings, significant additional funding has been identified to further develop the early help offer.</p> <p>The local authority has been successful at retaining and recruiting staff. As a result, the Middlesbrough workforce is relatively stable, with a majority of the workforce having been in post for over three years. Social workers also have manageable caseloads. This means that children and young people in Middlesbrough are likely to be able to build a good relationship with their social worker and not experience multiple changes of worker. All of the social workers met during the inspection spoke enthusiastically about working for Middlesbrough. They reported good support and an ‘open door’ policy by managers, at all levels.</p>	

Inspection findings

96. There is a strong commitment by the Mayor, Chief Executive and Lead Member to children's services. They have a good oversight and knowledge of key issues. This is as a result of the wide range of meetings with the Director of Children's Services to ensure a clear 'line of sight' across the council. These include quarterly meetings with the Mayor; monthly meetings with the Chief Executive; and fortnightly meetings with the Lead Member. These key individuals also regularly meet with: the Middlesbrough Safeguarding Children Board (MSCB) Chair; with members of the Child in Care Council (CiCC); and attend detailed briefings and seminars including, recently, in relation to child sexual exploitation and radicalisation.
97. The oversight provided by the council scrutiny panels is good and these regularly review thematic issues relating to children's social care, including child protection and children looked after and, more recently, early help. The records of these meetings clearly show the challenge by these groups and their focus on driving improvement.
98. Partnership working between agencies at a strategic level in relation to the social care and safeguarding needs of children and their families is underdeveloped. Following the local government elections in May 2014, a review was undertaken to evaluate the effectiveness of the health and wellbeing board (H&WB). This identified that the approach of looking at issues 'thematically' was not sufficient to improve services. Currently, the H&WB provides the 'overarching strategic overview' for improving Middlesbrough services. Work is ongoing for children's issues to be dealt with by the Middlesbrough achievement partnership (MAP), which at present is the partnership body to improve school attainment, and the more recently established Middlesbrough children's delivery partnership (MCDP). However, these new groups do not currently have a sufficient range of members from across partner agencies to support effective joint priority setting and targeted working or commissioning at a strategic level (recommendation 4).
99. The Teesside joint strategic needs analysis, produced by the four local authorities (Middlesbrough, Stockton, Redcar and Cleveland and South Tees) has a section for each, including Middlesbrough. Overall, though, the document lacks a sharp focus on the safeguarding and social care needs of children. There is a children and young people section that is good. It identifies key issues in Middlesbrough, such as the high number of children in need and children looked after, locating them in the broader local context of poverty and high numbers for domestic abuse, alcohol/drug misuse and mental ill health. There are links to the relevant local priorities such as developing early help and ensuring that agencies are working together. However, this child focus is not reflected in the broader document, in which sections on drug misuse, alcohol misuse, offenders and domestic abuse do not adequately focus on the safeguarding needs of children. This means that this key document is not

providing a consistently good basis for driving multi-agency prioritisation, service commissioning and impact measurement for the welfare and safeguarding needs of children and young people in Middlesbrough (recommendation 4).

100. The 'Middlesbrough health and well-being strategy 2013–23' is a broad, high-level document that highlights some appropriate priorities for children, including the need to develop the early help offer, children's emotional well-being, and maternal health. It does not address other key priorities, such as the number of children looked after, rising referrals and child in need numbers, and the impact of the high levels of the toxic trio (parental mental ill health, substance misuse and domestic abuse) on children's safety and welfare. The 'Public health annual report' is much stronger, including a detailed statistical analysis. However, overall, this lack of focus on children's safeguarding needs is not a consistently good basis for planning and monitoring services for children. The impact of this lack of strategic coordination is evidenced in the underdeveloped early help services which, up until very recently, have lacked sufficient prioritisation and commitment across partner agencies (recommendation 4).
101. The corporate parenting group (CPG) demonstrate a strong commitment to their role. They work very effectively with the CiCC and with the forum for children looked after (FLAC), which meets quarterly. FLAC comprises elected members, health representatives, children and young people and other agencies. The CPG work closely with a care leaver who is an active part of the group and ensures that issues for children, young people and care leavers in Middlesbrough are addressed. Good outcomes have been achieved, including ensuring that children and young people have access to computers and have leisure passes.
102. The Director of Children's Services and her management team focus appropriately on the key priorities for delivering a quality service. Managers have a good understanding of the key operational challenges in delivering children's social care services in Middlesbrough, although they were not aware of some weaknesses in practice prior to them being brought to their attention during this inspection.
103. The local authority responded promptly and appropriately when any concerns were identified by inspectors during the course of the inspection. For instance, as a result of concerns raised about a lack of sufficient management oversight in the six assessment teams, the local authority revised their existing plans for restructuring the teams by designing a revised structure with significantly enhanced management capacity. The Director of Children's Services secured the agreement of the Chief Executive and the council to this new model during the course of the inspection and has set an implementation date of January 2016. This focus on improvement mirrors the prompt response by leaders and managers to the findings of peer review of early help in September 2015. As a result of that review, managers established arrangements aimed at ensuring a more consistent and robust response to requests for both early help and

statutory social work services. This was fully implemented from November 2015, although further work will be needed to embed this.

104. Leaders and managers have appropriately prioritised further developments in children's services. In particular, they have focused on: reducing the numbers of children looked after and the high cost of these services; improving early help; and restructuring their frontline services to better meet demand. There has been good work through the transformation board focused on improving services for children looked after. This has included working to reduce teenagers coming into care and providing services for them to remain at home; ensuring that young people are placed locally; and increasing the range and quality of foster carers in Middlesbrough. The board's action plan considers better ways of commissioning and providing services to children looked after, including: developments such as the Tees Valley sub-regional approved provider list for residential care services; developing a sub-regional specialist foster care service; and completing the 'return to Middlesbrough' strategy. These activities both improve the quality of services for children and young people directly and facilitate further investment back into services. The local authority is committed to protecting frontline services in the context of an expected budget reduction of over five million pounds in the next three years. As a result of the work already undertaken, they have managed to reduce expenditure on placements and appoint additional frontline staff.
105. There are some examples of effective commissioning. For instance, the CAMHS service is very effective and ensures that the emotional health and well-being of children is addressed to a high standard. Effective working relationships between the local authority and health services have resulted in increased mental health support for older children looked after to prevent placement breakdown. In addition, good support by the school-based 'Headstart' and 'Kikkstart' initiatives, helping support children and young people with early or emerging mental health difficulties has helped ensure that there is a full range of effective emotional support and mental health services.
106. In the main, operational partnership working is good. For instance, the VEMT group and the South Tees youth offending service: accurately identify those at most risk; coordinate the work of the individual agencies; ensure that high quality services are in place; and then review the impact of that work. Senior managers are also involved in the Teesside strategic VEMT group, which coordinates this work to a high standard across the region.
107. Inspectors found many examples of good work in the social work teams. Adoption services and those for care leavers are good, with examples of innovative practice significantly improving the life chances of children and young people. However, inspectors also found significant variability in the quality of management oversight. Where management oversight was seen on children's case files, it was of good quality, giving clear direction to social workers. However, management oversight, including prioritisation, actions to be taken and their timescales, has not been consistently recorded. There are a

very few cases which, as a result, have not received a timely response; there have been delays in seeing children and in contacting other agencies to check out essential information. Similar themes were identified in some of the cases seen by inspectors in the early help services, including variable management recording and a lack of prioritisation and timeliness. In the children looked after teams, management oversight is much better, but has not consistently ensured progress. For example, in almost a third of children looked after cases looked at in particular detail by inspectors, issues of poor care planning and delays in updating reports had been identified by IROs and not by team managers (recommendation 1).

108. There have been challenges with capacity in the Middlesbrough legal team until very recently. This means that, although a local authority service manager does regularly attend the local family justice board, a representative from the local authority's legal services department has not attended Board during the past year. Feedback, though, from Cafcass is that there are positive working relationships with social workers and senior managers within the local authority and the quality of court work is good.
109. The lack of awareness by the Director of Children's Services and her management team of some of the weaknesses found during this inspection and in the peer review are a result of underdeveloped performance management and quality assurance systems. There is no authorised and accurate data set, accessible to and used by all senior managers, and this is a weakness. There is a wide range of activities, such as: monthly performance clinics, where service managers consider issues with team managers; quarterly produced service performance 'workbooks'; and quarterly corporate performance clinics which involve senior managers. However, the data reports lack narrative and analysis. Managers state that they challenge first-line managers about performance in their teams, but recordings of meetings and the individual supervision records of staff do not sufficiently document this. Some performance data is not accurate. The key data on children looked after's reviews being held on time was reportedly 50%. However, the managers reported that this was not correct and that further work was being undertaken to identify their true performance. Quality assurance is also limited. Team managers have been expected to audit their own cases, rather than another team's, and this does ensure sufficient scrutiny of their own practice. Regardless, due to recent capacity issues, team managers have not been auditing cases over the last two months (recommendation 3).
110. The Middlesbrough children's services workforce is relatively stable, with a majority of the workforce having been in post for over three years. There is a good range of workforce initiatives to retain staff in Middlesbrough. This includes the introduction of a 'nine day fortnight', and allowing suitably experienced social workers to progress to a higher pay grade. As a result, four experienced social workers who had intended to leave stated that they now intend to remain in Middlesbrough.

111. All social work teams are well staffed and use of agency staff is very low. This means that children and young people in Middlesbrough have a strong likelihood of being able to build a stable relationship with a social worker and are less likely to experience multiple changes of social worker. This stability supports the achievement of good outcomes. Teams vary, though, in their level of experience. In particular, the assessment teams have significantly less experienced workers. There are 30 newly qualified workers across the service and they receive good support from a dedicated worker who provides mentorship and professional development opportunities.
112. There has been a focus by the local authority on improving both the frequency and the quality of the supervision received by staff. However, while there have been some improvements in this, the quality of supervision, its frequency and recording, remains inconsistent. Some social workers are still not receiving sufficiently regular supervision, the completion of actions is not routinely tracked from one meeting to another, recording sometimes lacks clarity and does not show whether supervision contains any element of reflective discussion. However, inspectors did see examples of more frequent and better quality supervision, particularly for newly qualified social workers and in the children looked after team, where management oversight and supervision is more consistent and more sharply focused on children's progress and action plans.
113. Workforce development by the local authority is strong. There is a good understanding of the development needs of the workforce, including newly qualified staff, experienced workers and managers. There is a wide range of training, which receives highly positive feedback from almost all staff and for almost all training offered. There is good coordinated work with Teesside University to plan the training programme. Recent courses have included: back to social work basics; child sexual exploitation; making the most of supervision and appraisals; and effective complaint handling.
114. The local authority's workload management system provides a clear framework for assessing the appropriate caseload for social workers. It helpfully links to the supervision policy; includes a time allowance for training; and sets the caseload level for newly qualified workers at 70% of an experienced worker. As a result, frontline social workers in Middlesbrough have manageable caseloads, enabling them to build strong relationships with the children and families they are working with.
115. Over 50 social workers were interviewed during this inspection. They uniformly reported that it is good to work for Middlesbrough. They spoke with great enthusiasm and described that it is a 'brilliant place to work' and 'like a big family'. They described excellent support by their managers and visible senior management.
116. Most case files seen by inspectors showed good participation of children and young people. Advocacy services are widely available for children looked after

but are not consistently available for those in need of help and protection services. The annual complaints report is good. It captures: the numbers and types and analyses details of the complaints and compliments received; the service responses; and the lessons learned. There were few complaints directly from children, and the local authority does not know the reason for this. Overall, the systems for drawing out the views of children and young people, in order to further improve their services, are underdeveloped. In addition, although some good individual work was seen by inspectors, in considering the needs of children and young people from other cultures and backgrounds, there has been insufficient attention given as to whether children's services are meeting the needs of the changing and diverse communities, including asylum seekers, in Middlesbrough (recommendation 9, 11).

The Local Safeguarding Children Board (LSCB)

The Local Safeguarding Children Board requires improvement

Executive summary

Although the Middlesbrough Safeguarding Children's Board (MSCB) meets its statutory functions, its ability to act as a 'critical friend' to partner agencies is compromised by weak performance monitoring and auditing arrangements. With the important exception of its work through the vulnerable, exploited, missing and trafficked operational group (VEMT), the board has not sufficiently engaged with other agencies at a strategic level.

A good range of subgroups have appropriate involvement from partner agencies. However, secondary schools are not sufficiently involved and one lay member is not enough to represent the views of the community. There has been insufficient focus on involving young people in the MSCB and addressing the needs of diverse communities, particularly asylum seekers. Section 11 assessments have not been sufficiently regular to hold agencies to account. There is also no record of when agencies challenge each other over operational issues and how these are resolved.

Positive work with the four Teesside Local Safeguarding Children's Boards (LSCBs) includes: shared procedures; e-safety work; and strategic coordination to tackle child sexual exploitation. However, the joint child death overview panel (CDOP) has not ensured that there are appropriate 'rapid response' arrangements in the event of a child death. The MSCB 'threshold document' requires updating to be fully in line with statutory guidance.

Good training is wide-ranging and focused on improving practice. Attendance is good from most agencies, including GPs, but low from the Cleveland Police. Evaluation of the quality of the training is good. The development of action plans to improve practice and the dissemination of learning from a recent serious case review and five learning reviews has been effective.

The MSCB champions safeguarding issues well with the council and across partner agencies. The MSCB has a high profile with the local media, produces excellent newsletters, publishes a thorough annual report and runs campaigns to raise public awareness of safeguarding issues. Over 1,500 young people, across all secondary schools, have seen the 'Chelsea's Choice' drama, significantly raising awareness about child sexual exploitation. The MSCB provides effective leadership in tackling child sexual exploitation at both a strategic level and through the establishment of the VEMT group, which focuses well on those children and young people most at risk.

Recommendations

117. Ensure that the Board fully involves all agencies and groups in its work programme, including secondary schools and the appropriate number of lay members. This includes ensuring that the voices of children and young people, including those from the diverse communities in Middlesbrough, are integral to all of the work of the Board.
118. Ensure that the content of the MSCB 'threshold document' fully complies with statutory guidance and is well understood by all agencies.
119. Work more closely with strategic partnership groups such as the H&WB and Middlesbrough achievement partnership (MAP), to provide robust scrutiny of how well agencies coordinate their work and the effectiveness of the services they provide to children and families.
120. Ensure that performance monitoring and auditing arrangements are robust, including monitoring when agencies challenge each other over the effectiveness of local safeguarding arrangements.
121. Work with the other local LSCBs to better coordinate section 11 assessments and how Teesside agencies are held to account.
122. Work through the child death overview panel to ensure that 'rapid response' arrangements are in place in the event of a child death.

Inspection findings – the Local Safeguarding Children Board

123. The Independent Chair of the MSCB has been in post since October 2010 and is well respected by senior managers from the council and children's organisations. There is a good range of regular meetings between the Chair and the Chief Executive, Director of Children's Services, Assistant Director and Lead Member. This enables good communication and understanding of the key safeguarding issues. The Chair has also delivered presentations to councillors on child sexual exploitation and radicalisation. According to attendees, these events challenged them to focus on what they could be doing to further improve safeguarding in Middlesbrough.
124. Strategic links between the MSCB and other partnership groups such as the H&WB and the MAP are underdeveloped. Consequently, strategic planning arrangements for safeguarding and social care services to children and young people lack cohesion. The MSCB has not sufficiently challenged this poor join-up or the lack of a shared set of multi-agency priorities to plan services and measure progress (recommendation).
125. The focus by the MSCB on performance management and audits has been insufficient to drive forward the improvement agenda. There is now a

performance data set, but limited analysis of this within the MSCB. The range of audits is insufficient to provide a comprehensive picture of the quality of frontline child protection services. The LSCB has carried out audits, this year, on work with children who are looked after, disabled, the subject of child protection work and under consideration by the VEMT operational group. However, only one child in each of these categories has been randomly audited. This is insufficient to identify themes about practice across Middlesbrough. There is also no monitoring of when agencies challenge each other over operational concerns about the effectiveness of local safeguarding arrangements. Overall, these deficits reduce the effectiveness of the MSCB in being a 'critical friend' to agencies and helping them to improve their practice (recommendation).

126. There has not been sufficient work to engage children and young people in the work of the MSCB. The board does not have either young person representatives or a children and young people's group to help prioritise and improve communications. More work is also needed to address safeguarding issues in the diverse communities in Middlesbrough, including for the high number of asylum seeking children from many different countries. The MSCB Chair and Board Business Manager participate as members of an inter-faith group network and have conducted a live community web-chat focusing on child sexual exploitation. The Chair has sought to respond to safeguarding concerns within the minority ethnic community through engagement with the community (Asian) radio station. This is not sufficient focus, though, to ensure that issues from these communities are embedded in the work programme of the MSCB (recommendation).
127. The MSCB subgroups progress the priorities of the board well and promote the safety of children. This includes focusing on neglect and early help, improving communication and participation, and improving links with adult services including in relation to domestic abuse, mental ill-health and substance misuse concerns. The groups are well coordinated by the MSCB Business Manager and administrative officer and include the performance and the quality assurance, safeguarding implementation, VEMT, and the safeguarding liaison groups. In the main, there is an appropriate membership from the local authority and partner agencies. Primary schools participate well, however there is limited engagement from secondary schools. Minute taking and recording of all the groups' meetings are sufficiently detailed, including of follow-up actions to be taken; these are then reviewed at subsequent meetings. The main board receives presentations on the work of the subgroups, at each meeting, enabling wider consideration of any issues identified by the groups (recommendation).
128. Overall, there is good joint working across the four Teesside LSCBs. For instance there are additional shared sub-groups around policy and procedures, child death overview panel, e-safety and the strategic VEMT group. To assist children's agencies working across Teesside, such as the Cleveland Police and health trusts, more could be done to agree one performance data set and a single framework for section 11 audits across Teesside. The frequency of

section 11 reporting is every three years in Middlesbrough, while it is two years for the other local LSCBs. This timescale results in some Teesside agencies being subject to unnecessary repeat assessments. Currently, the MSCB is reviewing the latest s11 audits, which were completed this year, and report that collectively there is a declared 97% compliance with national standards. There is one lay member who contributes well to the workings of the Board. However, this is not sufficient to ensure that there is lay representation across the subgroups and does not meet the guidance in 'Working together to safeguard children 2015', which identifies the need for two lay members (recommendations).

129. The procedures group, currently chaired by Stockton as part of rotating chairing arrangements across the four Tees LSCBs, is good and helps promote consistency across the region. For instance, there is a single referral form across Teesside. The subgroup produces and updates the procedures and maintains and updates the website. A task and finish group reviewed the requirements from the update of the national guidance and has ensured that all procedures are up to date. Recently issued procedures relate to: the management of allegations; managing situations where children are subject to children looked after reviews or child protection planning; and female genital mutilation. New guidance has also been published on case recording, information sharing and complaints.
130. The MSCB threshold document clearly outlines the differing levels of need at which children should receive universal, early help or statutory social work services. It does not fully comply with statutory guidance because it does not clearly distinguish between the different levels of need at which a child is seen to be either 'in need' or 'at risk of significant harm' and the levels at which a child may be accommodated in the care of the local authority under section 20 of the Children Act 1989 or the subject of an application for a care order. In addition to this, the 'threshold document' does not reflect the new expectations in 'Working together to safeguard children 2015', that it should include reference to the procedures and processes for children at risk of child sexual exploitation. Evidence from inspectors' scrutiny of decision-making for individual children and young people, during the course of the inspection, shows that decision-making at these thresholds is almost always appropriate to children's needs, despite their omission from the threshold document. Feedback from agencies to the MSCB is that the document is mostly well understood. However, there are ongoing examples where agencies, particularly schools, have felt uncertain and occasionally disagreed over threshold decisions. In response to this, the MSCB has recently provided two further briefing sessions on thresholds for agencies (recommendation).
131. The Teesside strategic VEMT group is good and coordinates this area of work across Teesside. For instance, the sub-group has recently revised the strategy for tackling child sexual exploitation across Teesside. There are also three Tees-wide subgroups focusing on children at risk, perpetrators and potential 'hot spots'. The local VEMT group is effective and focuses on: sharing information;

monitoring risk; and analysing data for Middlesbrough children and young people who may be vulnerable, exploited, missing or trafficked. It ensures that all agencies are working cooperatively and collaboratively and provides a much-valued forum for sharing individual case information and intelligence.

132. There is a good range of work to tackle child sexual exploitation coordinated by the MSCB. This includes the campaigns 'Silent victims', 'Say something if you see something' and 'In the wrong hands'. There is also coordinated work focused around the night-time economy and helping schools recognise the signs of child sexual exploitation. The MSCB Chair also presented a report to the council scrutiny panel, 'Protecting children from sexual exploitation', in December 2014. Further update sessions have been held, including to the full council during this inspection.
133. There is good consideration of cases by the Learning and Improvement subgroup. This includes an appropriately commissioned serious case review, which has not been published as yet due to pending court proceedings, and five learning reviews where there were potential concerns about partnership working. All of the reviews show: good consideration of the issues; the processes for analysing agencies' involvement; the drawing together of the action plans; and the dissemination of learning. There are no recurring themes.
134. The child death overview panel benefits from a cross-Teesside approach. Participation by agencies based in Middlesbrough is good and there have been no concerns about child deaths locally and no themes identified. However, the 'rapid response' team following a child death has not been operational across Teesside. Although staffing has now been agreed, at the time of this inspection this had yet to be fully implemented (recommendation).
135. Middlesbrough Safeguarding Children Board training is good. There is a wide range of good-quality courses, including internet-based basic safeguarding awareness for professionals who come into contact with children as part of their work. Twelve thousand people across South Tees have completed e-learning training designed to increase awareness of child abuse and neglect. There is also a good range of Level 2, 3 and 4 training courses to further improve the skills of practitioners. These courses are well attended by most agencies. Twenty-six GPs have attended, which is very good. However, there have only been seven attendees from Cleveland Police. Work is ongoing to provide courses at different times to improve attendance. Evaluators sit in on all courses, produce reports and collate information from attendees to further improve the courses. Feedback is mainly positive and includes how attendees have used their learning from the course to improve practice. All secondary schools in Middlesbrough have participated in the 'Chelsea's Choice' drama. This has raised awareness well and over 1,500 young people have completed questionnaires, mostly reporting a positive impact from the experience.
136. The MSCB website has a good range of information to support frontline professionals in Middlesbrough. This includes: a series of practical guides on the

local protocol for assessment; the early help competency framework; and the 'safer communication' guidance, which explains about gaining consent prior to referral to children's social care. There is good guidance on the signs of child sexual exploitation, including how these factors link with the assessment framework completed by social workers. The neglect strategy is good and is also available on the website. It focuses on: improving the awareness of neglect; improving assessments; getting involved earlier; improving the quality and effectiveness of the activities; and providing evidence for further work. It also identifies what works well.

137. There is a good local profile of the MSCB in the media. The Independent Chair is regularly interviewed on the radio about current safeguarding issues and this has helped raise awareness of these across Middlesbrough. The MSCB newsletters, aimed at keeping local professionals up to date, are very good, with a broad range of relevant topics and written in clear language. For instance, recent issues have included lay member recruitment, early help training, child sexual exploitation, early help assessments, and thresholds. The MSCB also have a strong private fostering communications strategy focused on raising awareness.
138. The annual report 2014–15 is a thorough document. It includes a clear description of the local context and what has improved over the last year. Successes detailed include the development of the VEMT groups, the neglect strategy and the learning framework.

Information about this inspection

Inspectors have looked closely at the experiences of children and young people who have needed or still need help and/or protection. This also includes children and young people who are looked after, and young people who are leaving care and starting their lives as young adults.

Inspectors considered the quality of work and the difference adults make to the lives of children, young people and families. They read case files, watched how professional staff work with families and each other and discussed the effectiveness of help and care given to children and young people. Wherever possible, they talked to children, young people and their families. In addition, the inspectors have tried to understand what the local authority knows about how well it is performing, how well it is doing and what difference it is making for the people who it is trying to help, protect and look after.

The inspection of the local authority was carried out under section 136 of the Education and Inspections Act 2006.

The review of the Local Safeguarding Children Board was carried out under section 15A of the Children Act 2004.

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The inspection team consisted of nine of Her Majesty's Inspectors (HMI) from Ofsted.

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