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Dear Helen

### **Focused visit to Middlesbrough local authority children's services**

This letter summarises the findings of a focused visit to Middlesbrough local authority children's services on 25 and 26 April 2019. The visit was carried out by Her Majesty's Inspectors Matt Reed and Rachel Holden.

Inspectors looked at the local authority's arrangements for children in need and those subject to a child protection plan.

Inspectors looked at a range of evidence, including case discussions with social workers and managers. They also looked at local authority performance management and quality assurance information, audits of current practice and children's case records.

### **Overview**

Middlesbrough local authority children's services are actively addressing shortfalls in the provision of services to children and young people through a comprehensive programme of improvement. Their self-assessment accurately reflects where they are in their improvement journey and what more they need to do to improve quality and consistency of practice. There has been substantial investment and support from the council, peers and partners to improve services for children in Middlesbrough. A focused visit last year of the 'front door' highlighted weaknesses in practice in relation to management oversight and decision-making, assessment timeliness and partnership working. Data analysis wasn't sophisticated enough to allow the local authority to have an accurate understanding of the demand for

services and to provide appropriate levels of staffing. The improvement plan needed to measure success in relation to how the lives and outcomes for children are improved. At that visit, inspectors saw weaknesses in the quality of practice for children in need of help and protection. Since that time, the local authority has taken decisive action, including restructuring services and increasing capacity in frontline social work teams.

During this visit, no cases were seen where risk was unassessed or not being managed at the right level. Social workers and managers were positive about the changes and the benefits to their work. Strengthened performance management and management oversight are ensuring improved compliance, for example work being completed within the timescales of the child. However, the quality of social work practice is inconsistent. Assessments do not have a sufficiently strong focus on the analysis of risk and what this means for children. Plans do not sufficiently focus on children's individual needs, and the child's voice is not clear within assessments and planning. At times, practitioners overly focus on the needs of parents, and children do not remain at the centre of the work. Although plans are reviewed, progress against actions and the impact this has on a child's circumstances are not sufficiently clear to support assessment of whether parents have made the changes needed.

### **What needs to improve in this area of social work practice**

- Chronologies to be concise and consider the impact of events on children's lives.
- The quality of risk analysis and identification of children's individual needs within assessments.
- The embedding of a model of social work practice to inform risk assessment and decision-making and to support consistency of practice.
- The voice of the child in assessments and plans
- The quality of planning and social work plans to demonstrate a clear focus on the child's needs and the impact and outcome of interventions.
- Contingency planning should outcomes not be achieved.

### **Findings**

- Senior leaders know themselves well. An increased focus on performance management and quality assurance has improved compliance, including completion of work within timescales that are right for children. However, the quality of social work practice is not sufficiently consistent. The local authority's self-evaluation clearly identifies the shortfalls seen at this visit and there is a clear improvement plan which is effectively overseen by the chief executive and executive director of children's services.

- Appropriate investment by the council has resulted in the recent creation of two additional posts to support further improvements in relation to change management and quality assurance. It is too soon to see the impact that this has made on service delivery.
- Social work capacity has increased, and plans have been developed to address recruitment challenges and ensure a balance of experience across the workforce. Children's social care has been restructured, with the creation of additional assessment, children in need and child protection teams. Social workers and managers spoken to were positive about working for Middlesbrough local authority, and the restructure has been welcomed in this part of the service. The local authority is sighted on areas of the service where further attention is needed, for example in the looked after children teams. Social workers report that caseloads are manageable, which allows them more time to plan and complete work with families, although there is some variability across the service.
- Children and families receive a service that is proportionate to their needs, and thresholds are applied appropriately. Interventions are timely, and children are not left in situations of unassessed risk. A clear transfer process between the assessment teams and the child in need and child protection teams ensures that children do not wait for a new worker and that there is no delay in formulating longer term plans and providing services to meet children and family's needs.
- Children are being visited regularly and in line with their needs and there is some effective direct work done with them to gather their wishes and feelings. However, children's voices do not come through clearly in assessments and plans to demonstrate that the practitioner has reflected sufficiently on the child's experiences. Although this did not affect the intervention provided, it does not demonstrate that the child's voice has been at the centre of the planning.
- Assessments are completed within a timescale that is right for the child and are detailed. They cover the pertinent issues, and risks are appropriately identified. However, they are overly descriptive, with a focus on parental needs rather than the needs of the child. The analysis of risk and of the impact that this has on the child is not sufficiently focused to support effective monitoring of the outcome of interventions. Investment has been made in a model of social work practice to assist with risk analysis, but this is not sufficiently embedded to have made a significant impact.
- Plans lack a clear focus on improving children's circumstances. Most plans are adult focused rather than focusing on how interventions should improve the situation for the child. The child's individual needs are not clearly articulated, and, therefore, decision-making and reviews are not directly aligned to an assessment of whether outcomes for the child have improved.

- There is effective multi-agency involvement and attendance at meetings to contribute to the child's plan and to support families to make necessary changes. Families have access to a wide range of support services and parents and children are appropriately involved in the decision-making process.
- Plans are reviewed regularly, but ongoing progress in meeting needs and improving the outcomes for children is not clearly recorded. Written records focus on the completion of tasks. They do not demonstrate a clear assessment of the outcomes of interventions that have informed decision-making for children to come off plans, and whether plans have been effective in achieving sustainable change for families. As a consequence, some children are subject to repeat child protection plans for similar concerns.
- There is clear management oversight of casework and at key decision-making points. This is ensuring that children are seen, and that work is completed in the child's timescales. Decision-making is appropriate, but the rationale for decisions is not always clearly recorded and does not facilitate an understanding of why decisions have been made. Supervision is taking place and is action focused. However, records do not reflect how managers ensure that plans remain on track and that the impact of the work with the child is considered. Contingencies are not clearly recorded should the current plan not secure the change needed.
- Decisions to escalate matters to child protection or de-escalate to child in need or early help are appropriate and proportionate to the identified needs. Children with additional needs receive appropriate support and the risk of increased vulnerabilities is considered appropriately and informs the safeguarding intervention.
- Children at the edge of care or at risk of family breakdown receive necessary support, including the involvement of wider family members to enable them to remain at home or within the wider family wherever possible. When children need accommodating to ensure their safety, this is done in a timely way and in line with their needs.
- When safeguarding concerns have escalated families, are entering the public law outline (PLO) process at the right time. Families are offered appropriate interventions to support change and if concerns increase or incidents occur, there is timely consideration of children entering care. The letters before proceedings make clear the concerns and areas that need to change but, typically, they are overly descriptive and use professional language that could be difficult for families to understand. A newly introduced gateway panel supports monitoring of the PLO process effectively. This minimises delay in decision-making and supports the securing of appropriate legal status for children.

Ofsted will take the findings from this focused visit into account when planning your next inspection or visit. Ofsted will send a copy of this letter to the Department for Education and will publish a copy of this letter on our website on 21 May 2019.

Yours sincerely

Matt Reed  
**Her Majesty's Inspector**