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Dear Jacqui

Focused visit to North Tyneside children's services

This letter summarises the findings of a focused visit to North Tyneside children's services on 9 May 2018. The inspectors were Jan Edwards, Her Majesty's Inspector, and Graham Reiter, Her Majesty's Inspector.

Inspectors looked at the local authority's arrangements for the 'front door', the service that receives contacts and referrals, both single and multi-agency. The findings in this letter relate only to cases seen during this visit.

Overview

There is strong corporate leadership and ambition to improve services for children and their families, reflected in a determined transformation programme of children's services. Senior leaders know the service well, and this is reflected in the local authority's self-assessment.

Inspectors found evidence of sound social work practice in the multi-agency safeguarding hub (MASH) and social work assessment teams. Contacts and referrals are progressed in a timely manner. No children were found to be in situations of unassessed or unmanaged risk.

Senior managers have been resolute in implementing a newly reconfigured and effective MASH over the last eight months. There is a strong commitment from a wide range of partner agencies and effective integration to the social work assessment teams, ensuring that children are safeguarded. Local authority staff have been effectively engaged with the service developments and value the leadership, support, supervision and training that is provided for them.



What needs to improve in this area of social work practice

- Ensure that the key issues and rationale for decisions arising from designated officer meetings are clear, that support for the alleged perpetrator is identified and that actions have clear timescales for completion.
- Fine tuning of the new electronic system is required to introduce consistency of practice across the service. This includes improvement to the way that social workers are using contingency planning to be clear and meaningful to families.
- Ensure that manager guidance with clear timescales is provided at the outset of an assessment.

Findings

- Since the last Ofsted inspection in March 2017, senior managers and leaders have led an extensive transformation programme. This has seen the establishment of a fully functioning MASH, the very recent implementation of a new fit-for-purpose electronic system, and a whole-system approach to the introduction of a recognised and evidence-based model of practice.
- In the cases audited and in all other work considered, the local authority had acted appropriately to safeguard children and keep them safe. The MASH works effectively to safeguard children. Partners are well engaged, which ensures timely information-sharing, the consistent application of thresholds and proportionate responses for children and their families who need help and support.
- In all cases seen, relevant information, including historical information, was gathered and analysed well using the preferred model of practice. This means that risk is at the forefront of decision-making, with a well-embedded and rigorous system of management oversight and challenge.
- On those contacts seen that took more than 24 hours for a decision, this was appropriate to ensure that all information was gathered and analysed to inform decisions relevant to the needs of the child.
- Parental consent to share information and for service referrals is understood and consistently sought and recorded in the MASH. The rationale for decisions to dispense with parental consent are clear and appropriate. Referrers are routinely contacted and informed of the outcome of their referral to children's services.
- Immediate risk of significant harm is identified effectively and responses are prompt and well-coordinated. Strategy discussions and child protection enquiries are timely and thorough and lead to effective action to safeguard children. Analysis and decision-making are supported through the use of danger statements, safety goals and individual professionals' scaling of risk. Actions for



s47 enquiries were clearly identified. A strength is how well the child's world and voice is understood through direct work during the course of s47 enquiries. Clear management oversight provides examples of appropriate challenge to social workers' recommendations on completion of their analysis.

- When children are referred out of hours, the emergency duty team responds appropriately to contacts and communicates effectively with the MASH. Work is currently being undertaken to make recordings consistent with the new model of practice, although there was clear evidence of actions taken and of what further work was required to be carried out by the day service.
- Decisions to step down to early help from the MASH are clear, appropriate and seamless, informed by a clear analysis of risks and protective factors and effectively supported by liaison with the early help manager. When risks escalate, decisions to step back to children's social care are appropriate, and effective joint working between services and partner agencies is supported by the early help manager and coordinators.
- Regular multi-agency group supervision maps cases using the evidence-based model of practice. These meetings are well chaired, ensuring contributions from all participants, and effectively identify the range of risks, protective factors and unknowns which underpin a multi-agency discussion about level of risk and threshold. In the mapping exercise observed by an inspector, the decision-making was well supported by a scaling of risk, which led to a clear course of action.
- The arrangements for the designated officer ensure that children are safeguarded where allegations are made against people who work with children. Where meetings are held, these are timely, with appropriate multi-agency attendance. However, the recording of these meetings does not support clear identification of key issues and decisions and outcomes are not always supported by a clear rationale. Actions do not identify timescales for completion, including the timeliness for feedback to the designated officer. Support for the alleged perpetrator is not consistently identified.
- Risks to the most vulnerable young people, such as the risk of exploitation, and to those exposed to domestic abuse and homelessness, are well recognised and responded to, with the provision of appropriate support and services.
- Child sexual exploitation is identified effectively. The child sexual exploitation screening tool is used in a timely way to evaluate levels of risk. The front door benefits from the co-location of the child sexual exploitation worker from Operation Sanctuary, Northumbria Constabulary's established sexual exploitation operation, who offers immediate advice and guidance to support assessment and decision-making and offers direct work with young people. A range of tools support creative and effective engagement with young people.



- The risks associated with the complexities of domestic abuse, including coercive control, are well understood. Early notification by the police to schools and health visitors where children have been exposed to domestic abuse is well embedded. The daily multi-agency screening of all police notifications, including domestic abuse, ensures a responsive and consistent response to child care concerns, with appropriate actions to address risk to and safety of children. This will be further enhanced through the council's well-advanced plans to introduce a nationally recognised whole-family approach to domestic abuse.
- Good, thorough assessments were seen, balancing and analysing risk and protective factors to underpin decision-making and future planning. They encapsulate effectively the voice and experiences of the child, using some creative direct work, which is led by the needs of the child. Future planning is effectively supported by the use of danger statements, safety goals, and scaling and outcome decisions on all assessment seen were appropriate. Contingency arrangements, known as the bottom line, are often confused and require clarity around expectations for families.
- Clear management oversight at key points in the assessment and sign-off is supporting decision-making. This could be further enhanced with manager guidance and timescales set for completion at the outset of the assessment to ensure that assessments are routinely completed in a timescale which is meaningful for families.
- Inspectors saw some very good work with the absent parent and significant other people in the lives of children, but this was inconsistent.
- The stable staff group and the small team structure enable management grip of staffing issues and caseloads. Managers report that they are able to provide support to social workers and use new performance management information to promote consistent practice and the implementation of the practice model.
- Staff are extremely positive about working in North Tyneside and morale is high. They cite the support, supervision, training, clear career progression and the high visibility and approachability of senior managers as contributing to the positive learning culture in the council.

Ofsted will take the findings from this focused visit into account when planning your next inspection or visit.

Yours sincerely

Jan Edwards **Her Majesty's Inspector**