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Dear Ms Shaw

Focused visit to Redcar and Cleveland local authority children's services

This letter summarises the findings of a focused visit to Redcar and Cleveland children's services on 11 December and 12 December 2018. The visit was carried out by Her Majesty's Inspectors, Lisa Summers and Rachel Holden.

Inspectors looked at the local authority's arrangements for the 'front door', the initial response to children in need of help and protection, and the management of allegations of abuse, mistreatment and poor practice by professionals and carers.

Inspectors looked at a range of evidence, including case discussions with social workers, evaluations of children's case records and meetings with senior managers. They also looked at local authority performance management and quality assurance information, peer review documents and relevant action plans.

Overview

Since the last Ofsted inspection in January 2017, senior managers have acted to improve their response when children need help and protection. The functions of the first contact team have been reviewed and restructured. The team now undertakes assessments as well as reviewing contacts and referrals. There is increased management capacity and strengthened performance information and quality assurance. However, increasing workloads, recruitment challenges, budgetary pressures, and a lack of robust improvement planning have impeded the pace of change. Managers recognise that improvement has not been quick enough. Despite their actions, weaker practice identified at the last inspection is still evident. This includes the quality of assessments and plans, a lack of effective management of allegations against professionals, and a lack of confidence of partners to undertake the lead professional role. This places an additional burden on the local authority to

undertake this task themselves. In addition, the screening of contacts is not always effective, and social workers in the first contact team are not suitably trained to undertake all the duties to support children following their arrest and interview, for example to act as the 'appropriate adult'.

What needs to improve in this area of social work practice

- The screening of contacts to consistently take account of multi-agency information, including historic factors.

- The assessments of children, to consistently include the full analysis of all risks and children's experiences.

- The response to managing allegations against professionals.

- The confidence of partners to undertake the lead professional role.

- Social workers' knowledge and skills in delivering all aspects of their role, namely their appropriate adult duties.

Findings

- Senior managers have a good understanding of the quality of their services through improved performance information, quality assurance systems, and the use of external scrutiny through peer reviews and specialist consultation. Performance data is improved, making this more meaningful for managers at all levels, and better supports their monitoring of work.

- Audit activity is routine, with a broad range of auditor experience and skills from across the workforce. However, themes and learning from audits are not routinely translated into clear action planning to effectively improve practice. This impedes the pace of change. Although, more recently, areas of practice requiring improvement have been considered through service improvement clinics, this has not yet impacted on improving the quality of social work practice.

- The newly developed 'front door' has only been in full operation for six weeks, as challenges in recruiting social workers delayed its implementation. The first contact team provides a single point of contact for agencies to access early help, and statutory services when children need help and protection. Front door processes have been reviewed, and management oversight of decisions have been strengthened.

- Since the last inspection, senior managers have worked strategically with partners, through the local safeguarding board, to refresh the early help strategy. However, this is not fully embedded operationally. Despite monitoring and challenges from the local safeguarding board, partners lack confidence to

undertake the lead professional role. This places an additional burden on the local authority to undertake this task.

- Decision-making is timely when children's cases need directing to early help services and escalating to children's social care. However, there are sometimes delays in the timing of initial early help visits and provision of support to families. Waiting lists for targeted youth support mean that some children do not get help soon enough.

- When children are identified as being at risk of significant harm, the response to protect them is swift and appropriate. The majority of strategy meetings are timely and well-coordinated, with good information-sharing between key partners to identify risk, inform actions to keep children safe, and plan subsequent child protection enquiries. Strategy outcomes are appropriate, and, where necessary, the coordination of joint enquiries with the police is effective.

- Child protection enquiries in the cases seen are thorough, and outcomes are appropriate. Children's views are not always clearly recorded as part of the enquiry, despite social workers knowing their children well and being able to articulate children's views.

- Most contacts and referrals seen are progressed quickly, with appropriate management oversight. Managers provide reflection and challenge to support social work thinking and decision-making.

- The quality of information provided by agencies when they have a concern about a child is not always sufficiently clear or detailed to inform decisions about next steps. Too much time is spent clarifying information at this stage. This makes the screening of contacts less effective. Relevant multi-agency information is not consistently gathered to inform decision-making, and children's experiences are not always well enough understood. In some cases, staff focus too much on the presenting issue, to the detriment of fully understanding the cumulative impact of harm. For a small number of children, there is delay in having their needs assessed early enough through a social work assessment. This results in repeat contacts for some children as they do not consistently have their needs met at the earliest opportunity.

- Concerns about children out of office hours are effectively managed by the emergency duty team. Clear and detailed recording identifies steps taken and any further actions to be followed up by day services.

- Most assessments seen by inspectors are not good enough. Information is not always sought or considered from significant members of the wider family, even when they provide a caring and protective role for children. Assessments do not routinely reflect children's unique characteristics within their family or community. For these children, their world is not sufficiently analysed or understood to inform decision-making, and this leads to weaker plans to manage risk and meet

children's needs. Senior managers are aware that assessments vary significantly in quality and are focused on improving the quality of work through a series of practice workshops.

- Inspectors did see examples of good-quality assessments that reflect children's histories well, are informed by good information-sharing and identify appropriately risk and needs.

- Inspectors reviewed a very small number of children's cases where they had recently entered care. For these children, decisions were timely and appropriate.

- Social workers are very positive about working in Redcar. They feel well supported, listened to and valued by managers and senior managers. The views of social workers were central to the development of the new front door. They told inspectors that the new structure has brought a refreshed sense of job satisfaction. Senior managers' initial evaluation of the service is underway. Workload pressures are impacting on some workers' ability to maintain up-to-date records. The first contact team manager has introduced weekly reviews for each social worker to monitor and better manage workloads. Supervision on children's cases is thorough and reflective.

- Senior managers are well focused on improving the quality and consistency of social work practice, introducing mandatory getting-to-good sessions, and, more recently, practice workshops. There have been some improvements in practice with the increased use of chronologies. However, some social workers in the first contact team were not aware of any recent workshops taking place. Social workers act as 'appropriate adults' for children who have been arrested. However, staff have not received training to enable them to effectively undertake this specialist role.

- The management of allegations against professionals is not robust and senior managers are aware of this. For example, in one case seen, an allegation management meeting should have been convened to coordinate a multi-agency response, and this did not take place. Since the last inspection, tighter management oversight and better tracking and recording systems have been introduced. More recently, senior managers have introduced audits to test and further monitor the appropriateness of decision-making.

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

Yours sincerely

Lisa Summers
Her Majesty's Inspector