

Middlesbrough Borough Council

Inspection of children’s social care services

Inspection dates: 25 November 2019 to 6 December 2019

Lead inspector: Jan Edwards, Her Majesty’s Inspector

Judgement	Grade
The impact of leaders on social work practice with children and families	Inadequate
The experiences and progress of children who need help and protection	Inadequate
The experiences and progress of children in care and care leavers	Inadequate
Overall effectiveness	Inadequate

Since the last inspection in 2015, the quality of children’s services in Middlesbrough has deteriorated and services are now inadequate. There are serious and widespread failures that leave children in harmful situations for too long. Risks to children and young people, including those who are being exploited, are not appropriately recognised, and insufficient action is taken to help and protect children. Leaders had recognised that significant improvements still need to be made, but had not fully identified the extent of the inadequacy at the point of inspection.

Children experiencing longstanding neglect come into care too late, and decisions for them to do so are made in response to a crisis. Senior leaders have recognised that there are serious delays in achieving permanence for most children in care. However, the action taken by the service to address this has not shown an impact on reducing delays for children. Management oversight in this regard is not sufficiently robust. Insufficient attention is given to ensuring timely care planning, particularly for very young children. This creates instability for children and hinders them in forming secure attachments.

A new senior leadership team from 2017 recognised that the quality of social work practice was too inconsistent and, in some areas, inadequate. They led improvements, including increasing social work capacity and introducing a new performance and quality assurance framework, but these have not been enough to

make a positive impact for all children. Partnerships are under-developed and this has posed significant challenges for the service. Partnerships have been recently strengthened with the creation of a jointly commissioned multi-agency children's hub (MACH) and the extension of early help services. However, progress in raising the quality of practice has not been sustained, and leaders have not sufficiently focused on the significant areas of weakness to ensure that the needs of children and care leavers are properly met.

What needs to improve

- The identification of and response to risk, particularly in relation to long-standing concerns of chronic neglect and wider exploitation.
- The understanding by partner agencies of threshold decisions for social work support and the quality of referrals.
- The quality and screening of referrals so that history is well understood, and appropriate information is sought to inform decision-making.
- The quality of social work assessments and plans and the extent to which they reflect the child's history and risks to children.
- The response to children who go missing from home, care and education.
- The response to children with specific vulnerabilities, including children aged 16 to 17 years who present as homeless, disabled children and children held overnight in police custody.
- The oversight and monitoring of and response to allegations against professionals working with children.
- The timeliness and effectiveness of pre-proceedings and care proceedings work, including the quality of contingency planning.
- The availability of sufficient, suitable local homes to meet the needs of children in care and care leavers.
- The quality and timeliness of permanence planning, including the appropriate use of early permanence.
- The provision of life-story work for all children in care.
- The access to emotional and mental health support for children in care and care leavers.
- The educational outcomes for children in care and the proportion of care leavers who are engaged in employment, education or training.

- The effectiveness of management direction and challenge by leaders and managers at all levels, including the effectiveness of oversight from independent reviewing officers.
- The effectiveness of strategic partnerships to work together to improve outcomes and protect children.

The experiences and progress of children who need help and protection: inadequate

1. Services for children who need help and protection in Middlesbrough are inadequate because there are serious and widespread failures that do not protect children, and that leave them in harmful situations for too long. Not all children with specific vulnerabilities, such as those who receive a short break service and homeless young people, receive a social work assessment of their needs. Thresholds to access a social care response are too high, and, as a result, some children do not get the right help when they need it. Risks for children vulnerable to exploitation are insufficiently explored and poorly understood. There is a high tolerance to risk, and, as a result, most safety planning is weak. Children live in situations of chronic neglect for too long before action is taken to improve their circumstances.
2. Since the focused visit to the front door in August 2018, which raised concerns about the quality of initial responses to children, a recently commissioned MACH now provides an improved, accessible single point of contact for all concerns. However, most referrals about children do not provide sufficient information to inform decision-making. There are delays, mainly from the police, in referring children quickly, even when concerns are serious. The quality of screening and decision-making in the MACH is not consistently effective. Managers prioritise contacts that need a quick response, but a lack of management direction leads to inconsistencies in information-gathering by social workers. Screening does not sufficiently consider or analyse family history, and too often lacks professional curiosity in verifying and seeking additional information to have a good enough understanding of children's experiences to inform decision-making. Consequently, some children experience repeated referrals to children's social care because they do not receive the right level of support when concerns first emerge. The local authority monitors repeat referrals, but does not identify the numbers of concerns made about children that do not progress to referral.
3. When significant concerns of harm are received, the MACH quickly and effectively responds with timely strategy meetings and good information-sharing in order to understand risk and identify next steps. However, for children already receiving social work support, partners do not consistently attend strategy meetings, and this inhibits effective information-sharing and joint decision-making. A specialist coordinator for domestic abuse cases facilitates immediate

responses by contacting victims to identify dedicated specialist services at the earliest opportunity.

4. The quality of assessments, including some child protection enquiries, is not good enough. Children needing a social work assessment are quickly transferred to Middlesbrough's assessment teams. Although assessments are timely, and children are promptly seen, most fail to understand children's experiences, lack clear analysis of cumulative harm, and rely on parental self-reporting to consider parents' capacity to make and sustain change. This leads to overoptimistic decision-making for children. Thresholds to access social care support are too high, and some children are inappropriately stepped down to early help when they need a social work response to meet their needs.
5. Some disabled children do not have the benefit of sufficient social work oversight in order to ensure that their needs are assessed, identified and met. A significant number of children receiving a short break service have not had their current needs assessed by social workers as they are regarded to be below the child in need threshold. When there are concerns for these highly vulnerable children, social workers rely too heavily on parental self-reporting without verifying information. Inspectors identified two children who did not receive a timely and effective response when they had suffered clear and significant harm.
6. Early help services are well established in Middlesbrough. More families are benefiting from services, and an increasing number of partner agencies are becoming more confident in leading this level of support. A broad range of services are delivered through a multi-agency family-based approach, which, for some families, is effective in meeting their needs. If concerns escalate, the dedicated early help coordinator provides advice and guidance for partners, and appropriate services are identified.
7. Senior managers are aware that the quality of social work practice is inconsistent. More effective practice was seen in the safeguarding and care planning teams as a result of the implementation of a back-to-basics training programme. Children are seen regularly and alone by social workers, who mostly know their children very well, and understand their needs through age-appropriate direct work. Children's plans are regularly reviewed, and critical meetings are well attended by partner agencies. Children and families benefit from a broad range of specialist services. When families are well engaged, children's situations improve.
8. The quality of children's plans is too inconsistent. Some plans are too broad to identify children's unique needs. Others lack timescales, limiting their usefulness in identifying the right support and measuring change and progress, particularly in response to the cumulative impact of neglect. This lack of focus on measurable change leads to delays in recognising when children's situations do not improve. Contingency planning is weak and not specific enough for parents

to understand actions to be taken should change not be achieved. There are a significant number of children experiencing multiple child protection enquiries as risks are not adequately understood or effectively addressed. The vast majority of these children are already receiving social care help. Senior managers have not sufficiently explored why risks remain for these children who are already benefiting from social work support.

9. Timely authoritative action is not always taken to improve children's circumstances. This includes both escalation into pre-proceedings and into court proceedings. Letters before proceedings are adequate for parents and carers in detailing local authority concerns and identify the actions that need to be taken to prevent escalation. However, actions are too task-based and do not identify what needs to improve for children, to facilitate effective monitoring of their progress. Although children's progress is regularly reviewed through legal planning processes, there is insufficient focus on their experiences. Plans lack clear timescales for changes to be achieved and are too optimistic about parents' capacity to sustain improvements. This leaves some children in seriously neglectful and harmful situations for too long, because supporting children in their family homes is pursued even when this is no longer in their best interests. During the inspection, the local authority took action on cases referred to them by inspectors and they were assured that no children required immediate action to remove them from harmful situations.
10. Safety planning for children who go missing from home and care and those vulnerable to exploitation is mostly ineffective. Some social workers do not have a good enough understanding of the vulnerabilities of children who go missing from home and care and the complex nature of exploitation, and, therefore of how to tackle concerns. Children are too often seen to be making choices and placing themselves at risk, and this leads to a culture in which harm is tolerated, rather than one in which there is a focus on how to protect children. When children go missing outside of normal working hours, the response is ineffective and does not focus on immediate risk reduction. Return home interviews for children who go missing are well conducted, and effective support from a dedicated team is having a positive impact on reducing missing episodes for some children. The multi-agency vulnerable, exploited, missing and trafficked (VEMT) group shares intelligence and effectively coordinates targeted disruption activity for those children up to the age of 18 who come to their attention, but is not fully used for all children and young people who may be at risk of exploitation. The local authority recognises the need to strengthen its systems to regularly monitor children missing education for long periods of time, and the number of children affected is increasing.
11. Young people who present as homeless do not always have their needs assessed, nor are they consistently provided with suitable accommodation when needed. As a result, a small number of 16- and 17-year-olds live in potentially unsafe, inappropriate accommodation, including bed and breakfast accommodation. These children are not consistently informed of their right to

become looked after and are referred to early help services rather than receiving a social work assessment of need. The local authority was not aware of the number of children held overnight in police custody and recognises the need to strengthen systems and processes for managing this with the police.

12. There have been gaps in overseeing the management of allegations against professionals. Senior managers recognised that this has not been effective for a number of months, and only recently have taken action to address this. Risks are not always fully considered, and the response is not always timely. The recording of allegations is not sufficiently robust. Consequently, senior managers in Middlesbrough do not have enough assurance that actions to manage allegations against professionals are sufficient. The designated officer role is now delivered by another local authority.

The experiences and progress of children in care and care leavers: inadequate

13. Services for children in care and care leavers have deteriorated. Most children come into care in an unplanned way following a crisis, which means that planning is overly focused on the immediate needs of children. Initial care planning is ineffective, and insufficient attention is paid to the need to achieve stability and permanence for children. Crisis management and an overly persistent focus on seeking connected carers leaves children vulnerable to poor planning and instability. The lack of effective parallel planning creates delay for most children in achieving permanence.
14. Middlesbrough has a particularly high rate of children in care against national comparators, and this level is increasing. The local authority recognises that edge of care services, which are to prevent children from coming into care, are under-developed and there is more to do to ensure early, timely planning for children to avoid crisis responses. The local authority has been successful in attracting funding as a trailblazer to roll out the 'no wrong door' initiative led by North Yorkshire, but this work has yet to commence with families. Family group conferences have recently been introduced, and there has been some limited positive impact. They are not currently fully used at the earliest opportunity in order to prevent children from coming into care. The large number of older children and adolescents in care has reduced placement choice.
15. Early permanence is not prioritised for children in Middlesbrough, and there is a lack of parallel planning, which creates delay in achieving stability. Missed opportunities to place children early for fostering for adoption means that babies experience unnecessary moves, and this does not promote secure attachments. Family arrangements are pursued sequentially, and for too long, when children cannot live at home. This is at the expense of exploring broader options and undertaking parallel planning to secure future permanence within children's own timescales. Children's individual needs and ages are not well considered in their care planning, and very young children wait far too long for their permanence

plan to be determined. In addition, children experience delay in having their foster homes ratified as long-term matches, which creates unnecessary uncertainty for them. There are delays in securing special guardianship orders for connected carers, although the support provided to many of these arrangements is good. Over-optimistic assessments of family and connected carers have resulted in placement breakdowns for children, as well as avoidable placement moves that create instability and distress for children who cannot live at home.

16. Senior management panels and inconsistent legal advice provide insufficient scrutiny for understanding children's experiences and to ensure that their needs are met in a timely way. Some children subject to care orders have lived at home for several years, without timely and purposeful review of whether the care order is still required. Not all decisions to return children home are informed by up-to-date assessments to understand their needs and ensure that carers have the support to meet them. Independent reviewing officers provide inadequate scrutiny to ensure that children's planning is proportionate and that they are not subject to social work involvement unnecessarily. Some children, particularly those affected by long-term neglect, have waited too long for protective action.
17. Social work assessments of children in care and care leavers are of a poor quality. Although most children in care are seen regularly by social workers and have timely care planning and review meetings, most care plans are not good enough. There are insufficient risk assessments to ensure that children's circumstances consistently improve. Poor quality plans contribute to delays in care proceedings and create more instability for children. Many care plans lack sufficient detail to understand children's needs and how they will be met. They do not always show effective or timely parallel planning for children. Too many changes in social workers also affect the quality of decision-making because new workers do not know children well enough to be confident about the plans that are proposed and agree to changes at short notice. There is insufficient communication with children's guardians to ensure that changes are agreed for children to safely return home.
18. Family networks and family time are carefully considered and promoted for children in care, which helps children to retain their important relationships, including with their brothers and sisters.
19. Children benefit from opportunities to meet with their independent reviewing officers, with whom they develop good relationships over time. Their care planning and review meetings are well attended by professionals, but delays in achieving permanence are not sufficiently challenged by these professionals. Life-story work is not prioritised, and direct work with children is not consistently undertaken to ensure their experiences are understood by those responsible for them. Minutes from reviews are not written for children to help them understand their plans in a child-centred way. Advocacy is routinely offered to children, but

there is very low take-up of this service as children have good relationships with their social workers, who advocate on their behalf.

20. Opportunities are provided for children in care to give their views and provide feedback on the help and support they receive. The development of the Mind of My Own App has helped to provide an opportunity for children to express their thoughts and feelings independently when they otherwise might not feel able. The local authority has recently revived its children in care council for younger children. Although the membership is very limited, they are a lively group who enjoy the opportunity to meet and play a part in the council's running of services. Older children in care have not been meeting and do not have the opportunity for their voices to be heard in a forum.
21. The virtual school is not effective in ensuring that all children in care and care leavers access education opportunities or benefit from enhanced activities to develop their skills and confidence. Children in care make reasonable progress in their education from their starting points in key areas of learning. Too many children are fixed-term excluded from school, are not attending school or are frequently absent from school. There is insufficient challenge of this by leaders. Systems are not robust enough to get children back into school in a timely manner. The quality of children's personal education plans remains variable. Targets are not clear, and there is not enough clarity about what support should be provided to ensure that children's needs are met. There has not been enough done to improve on this, despite it being identified as an area for improvement at the last inspection.
22. Children benefit from timely health assessments, but wait too long to have their emotional health and well-being needs met by the specialist child and adolescent mental health service (CAMHS). The needs of vulnerable children and adolescents are not well prioritised in Middlesbrough, and there is a lack of specialist and dedicated services to meet the needs of vulnerable care leavers. For instance, when young people turn 19, the specialist looked after children's health nurse is no longer able to provide support, and care leavers have to use adult services to access specialist support.
23. Although, too often, children come into care in a crisis, placement matching decisions are effective for most who require foster or residential care. This helps provide stability for children. Local foster carers are successfully recruited and trained and report feeling valued. However, not all foster carers receive training that will help them to identify risks of exploitation so that they can help protect children from harm. When children's placements become fragile, there is a lack of coordinated support for both children and their carers to prevent disruption. Some children, including very young children, have experienced too many changes in placement before their permanent placement is identified. For these children, disruption meetings are not well used in order to understand and identify lessons learned to inform children's future planning, or training issues for carers and learning for the wider service.

24. Children live out of the local area when it is appropriate for their needs. Therapeutic placements are commissioned for children who need specialist and intensive support, and, as a result, many children do well, and their risks are reduced. However, for a small group of children with more complex needs, there are insufficient placements, and these children experience far too many moves. When vulnerable adolescents are living in situations of high risk, assessments do not clearly identify all risk factors to ensure that their needs are met, and that risk is well managed.
25. Children experience significant delay in securing permanence through adoption. Middlesbrough is one of five partners of the Adoption Tees Valley regional adoption agency that recruits, assesses and trains adopters. Currently, there are not enough adopters for the children who are waiting. Several children in Middlesbrough have been waiting too long for adoption. The local authority does not have clear plans to show how they will ensure that these children's permanence needs are addressed. Middlesbrough has a high proportion of relatively inexperienced social workers with limited knowledge of adoption work who do not receive the right training and support to ensure that children's adoption plans are progressed. Social workers wait too long for family options to be exhausted before adoption activity and family finding begins. There is insufficient management oversight of the timely progression of later life letters, life-story work and adoption introductions, to ensure that children's needs are met, that they understand their stories and that they are properly prepared for their next move.
26. Care leaving services have deteriorated. High caseloads limit personal advisers' ability to see care leavers regularly and to ensure that they have meaningful contact. Pathway plans are not updated when young people's circumstances change, which means they do not always reflect young people's current needs. Too often, these important documents are completed without young people's input. They do not adequately capture the risks and support needs of care leavers, and, therefore, have no meaningful purpose to the young people.
27. Young people leaving care receive a variable quality of service. For those care leavers who are encouraged to continue living in their foster carer arrangements, experiences are positive, and they benefit from enduring relationships with former carers who provide them with stability and a network of support. Vulnerable care leavers whose needs are complex do not always receive the right support. Not all risks to young people are recognised and too often care leavers are treated as independent adults who will seek support if needed. This results in a culture of seeing young people making 'lifestyle choices' despite the associated risks, including exploitation, and does not evidence a good understanding of young people's vulnerabilities. For young people who experience housing crises, there is little evidence of specialist interventions to support them. The housing service does not sufficiently prioritise the needs of care leavers. A majority of care leavers live in suitable housing accommodation,

although there are still some young people who live in unsuitable accommodation, including bed and breakfast, that fails to meet their needs. The absence of risk assessments has left young people at risk of harm.

28. Disabled children in care do not have the benefit of early transition planning into adulthood. This means that these young people and their families are unprepared for a significant change, and the delay in planning limits their choices.
29. Not all young people are familiar with the leaving care offer, and there is confusion about how they access their entitlements. Young people do not routinely get all the documents they need. Care leavers are provided with one form of identification, either passport or driving licence, and have to fund additional documents themselves. Health records are not consistently provided, and these documents are not stored should they become lost or damaged.

The impact of leaders on social work practice with children and families: inadequate

30. Leaders across the council and safeguarding partnership have not sufficiently addressed the serious and widespread weaknesses seen across children's services, and this has left children at risk of significant harm. During this inspection, the local authority took immediate action on cases referred by inspectors to ensure that children were safeguarded. Managers did not always demonstrate a good understanding of the concerns and risks identified by inspectors.
31. Senior leaders and an experienced DCS, appointed in 2017, quickly identified the deterioration of services for children in Middlesbrough and commenced improvement activity. The improvement plan was strengthened following the focused visit in August 2018, and there followed a period where some improvements began to have a positive impact on children's experiences. The focused visit in April 2019 identified improving compliance, the positive impact of a revised performance management and quality assurance framework, as well as increased social worker capacity to support reductions in caseloads, and thereby improving services for children.
32. However, the local authority experienced a further setback after investing in a service to respond to high levels of care proceedings. Following feedback from partners about the quality of social work, senior managers terminated the contract in July 2019, but this created more change for social work teams and had a detrimental impact on case management. From May 2019, the service experienced staff turnover in middle management which has limited the pace of improvement. Very recently, the DCS has strengthened the senior management for children's services.

33. Scrutiny and performance management have not sufficiently focused on priority areas, and insufficient critical challenge has resulted in poor improvement work, an inaccurate self-assessment and inadequate management of services for children. The extent of the weaknesses, and therefore of the scale of improvement required was not fully understood by senior leaders before the inspection. Insufficient prioritisation of critical areas to improve outcomes for children has led to a lack of progress to improve important areas affecting children's experiences. This includes improving the sufficiency of placements to support the most vulnerable children in care and care leavers, achieving timely permanence for children in care to provide them with the stability they need, and ensuring that all children have access to timely mental health and emotional well-being services.
34. Some strategic partnerships within Middlesbrough are now better established, and there has been some positive recent impact with the expansion of early help provision and the jointly commissioned MACH. However, the main safeguarding partners are not members of the Middlesbrough improvement board, and this limits effective challenge and shared accountability from the local area to support continued improvements. Insufficient challenge and limited performance reporting have meant that leaders are not sighted on the poor-quality services that children receive. Limited communication and escalation by the police and local authority of the numbers of children held overnight in police custody mean that leaders were unaware of this weakness in practice. Responses to vulnerable children have not been sufficiently understood by senior leaders, and this demonstrates the limited impact of safeguarding partnerships on addressing weak social work practice for children.
35. Corporate parenting is under-developed. Aspirations for children in care and care leavers are not good enough. The recently appointed lead member has not had the time to understand the issues for children and young people in Middlesbrough. The action taken to meet the collective responsibility of the council, elected members, employees, and partner agencies, for the need to prioritise housing, education and employment for children in care is not good enough.
36. While there have been improvements in performance management and quality assurance, performance monitoring is not sufficiently focused to provide managers and leaders with a good enough understanding of the quality of social work practice and the experiences of children and care leavers. There is a culture of high support, but challenge is hindered as leaders and managers do not have a sufficient understanding of some areas of practice. For example, leaders have not sought to understand some areas of performance management information, in particular about repeat child protection investigations and repeat contacts, in order to help them identify whether risk to children is being effectively managed.

37. Quality assurance is not sufficiently effective at identifying all risks to children or at raising the quality of social work practice. The local authority continues to rate a high proportion of audited cases as inadequate, and inspectors found that some managers did not adequately explore children's experiences and progress when auditing cases. Audits do not consistently lead to effective actions to address weaknesses. Recent audits of contacts at the MACH clearly show that concerns about some children are screened inappropriately, but no changes have been made to address this high-risk area. There are missed opportunities to explore weaker practice issues and identify learning themes, and good practice is not always identified. This was replicated in the local authority's response to some of the cases referred back to them by inspectors, and in management challenge and direction seen through the inspection.
38. Management oversight and supervision at all levels is not consistently challenging or directive, nor is it ensuring effective decision-making for all children. Managers are not sufficiently sighted on children's experiences, and there is a poor understanding of risk management and safety planning to ensure that children's circumstances improve.
39. Middlesbrough has a workforce characterised by a significant number of newly qualified staff, and with minimal use of agency staff. Additionally, there has been improvement in staff turnover and in vacancy and sickness rates. Staff are positive about working for Middlesbrough and feel well supported. Leaders are targeting the recruitment and retention of more experienced staff and are developing a 'grow your own' approach to ensure they have the staff with the right skills to deliver better practice. Pockets of better social work practice demonstrated positive signs of impact of the new strengthening core practice programme. More widely, responses to children are not sufficiently strong, and although Middlesbrough has introduced an established social work model of practice, the application of the model by social workers is not sufficiently focused on risk assessment and is therefore not used to its full potential.



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