Ofsted
raising standards
improving lives

Inspection of Middlesbrough local authority children's services

Inspection dates: 13 to 24 March 2023

Lead inspector: Louise Walker, His Majesty's Inspector

Judgement	**Grade**
The impact of leaders on social work practice with children and families	Requires improvement to be good
The experiences and progress of children who need help and protection	Requires improvement to be good
The experiences and progress of children in care	Requires improvement to be good
The experiences and progress of care leavers	Requires improvement to be good
Overall effectiveness	Requires improvement to be good

Since the last inspection in 2019, when Middlesbrough local authority children's services were judged inadequate, senior and corporate leaders have overseen gradual improvements to practice. Most areas identified for improvement have been addressed. The senior leadership team knows the service well; it knows what still needs to be strengthened and there are a number of plans to further develop services for children. Many of these plans remain in their infancy and have not had a significant impact on current practice. While ongoing improvement by senior managers is positive, significant recent changes at senior level bring a level of fragility to these plans and the improvements that have been made.

Most children and young people in Middlesbrough are receiving a timely and effective response when needs or risk are first identified. However, instability in the workforce means that not all children receive a consistently good response across all parts of the service. As children progress through assessment teams to safeguarding teams, work is not consistently strong. Several children have experienced drift and delay in their plans being progressed, which means that they have been left in harmful situations for too long. Children in care benefit from more stable teams, which enables more effective relationships to develop. Services to care leavers have not

been prioritised and the local authority is not yet demonstrating that it is an ambitious corporate parent to this group of vulnerable young people.

What needs to improve?

- The consistency of planning for children, including the quality of written children's plans, contingency planning and evidence of challenge when plans do not progress.
- Management oversight and the quality of supervision to demonstrate that this is consistently driving plans for children.
- Stability of the workforce to minimise the number of allocated workers for children.
- Arrangements for identifying and safeguarding children who are in private fostering arrangements.
- The corporate parenting response for ongoing support to care leavers, particularly those aged over 21, when they need it.
- The opportunities for children and young people in care to be involved in the development of services for them.

The experiences and progress of children who need help and protection: requires improvement to be good

1. Children and families in Middlesbrough receive timely and proportionate support from early help services. Initial screening ensures that appropriate thresholds are applied. Early help assessments are thorough and family history is considered. Early help work is focused on strengths and children's wishes and needs. Family plans are developed collaboratively with families and this means that families engage with them and receive the right level of support to meet their needs.

2. The interface between early help and statutory work is clear. When children's needs change or risks increase, 'step up and down' processes are effective and children's cases are escalated or stepped down appropriately. This means that children's needs are responded to effectively. At the time of this inspection, early help workers were deallocated if children stepped up to statutory services. For some children and families, this has resulted in multiple changes of worker and strong working relationships not being maintained. When this was highlighted to senior leaders, they were responsive, and allocation and closure processes changed while inspectors were on site.

3. Contacts received by the multi-agency children's hub (MACH) are screened promptly and effectively by social workers. Detailed information is considered to inform the decision-making. Social workers contact parents or carers to gather their views and speak with older children directly when appropriate. Parental

consent is considered appropriately for most children. Partner co-location in the MACH supports effective information-sharing. Responses to concerns out of hours are appropriate and proportionate and passed to daytime services for follow-up action where needed. Management oversight in the MACH is effective throughout to enable timely and effective outcomes.

4. When safeguarding concerns are identified, decisions to hold strategy meetings and child protection enquiries are not consistent. Although no children were found to be at risk, this means that not all children experience an appropriate, thorough and timely response to reduce the risk of harm. When they do take place, strategy meetings are attended by relevant professionals and child protection enquiries are thorough and lead to informed decision-making.

5. Not all assessments are of a consistently high quality, and not all are completed in a timescale that is right for the child. Some children receive support and interventions during the assessment process to mitigate any impact of delayed completion of assessments. Management oversight of overdue assessments is not consistently effective and some children wait too long in situations of unaddressed need. In stronger assessment work, children and families are seen promptly. Assessments are informed by numerous visits, including unannounced visits. Children are seen alone and social workers complete direct work with children to gain their views and understand their circumstances.

6. Practice is not consistent across all teams and some children continue to experience delay in allocation to the right team. Although most children are now receiving the right level of intervention, many children have experienced significant neglect throughout their childhood and social workers are now addressing the legacy of drift and delay spanning several years that had left some children experiencing ongoing neglect while receiving social work services.

7. Assessments and plans for disabled children are noticeably stronger. Children with complex needs are well supported through effective planning and intervention. Families and partner agencies contribute well to assessments and plans, resulting in appropriate support being provided.

8. Child in need and child protection plans are not of a consistent quality. Many do not give clear direction, and actions are not explicitly linked to outcomes for children. Contingency planning is weak. This means that some families do not know what progress will look like or what will happen if progress is not made.

9. There is appropriate partner attendance and contribution to planning at child protection meetings. Not all core group meetings take place at the required frequency and partner agencies and child protection chairs are not challenging drift effectively. The lack of progress and improvements in some children's situations means that they remain subject to child protection plans for too long without their outcomes improving.

10. Not all children are seen alone at visits and the voice of the child is not routinely captured to inform planning. Workload pressures, and competing demands, mean that some children are visited by different duty social workers. This reduces the value of these visits and children do not have the opportunity to speak with a trusted adult who knows them well.

11. When direct work is undertaken by a consistent worker, this is often creative, purposeful and culturally sensitive. It has impact and informs planning. Changes of worker or delays in transfer of some children from short- to longer-term teams mean that direct work is not always started at the time when children need it.

12. Management oversight and social work supervision are not always progressing plans and effecting change for all children. Stronger supervisions evidence reflective discussions about practice, leading to clear direction to progress plans for children.

13. There have been recent improvements in the pre-proceedings stage of Public Law Outline (PLO) processes. However, for some children, historical poor practice has resulted in them living for too long in situations of ongoing risk, harm and neglect without effective action being taken. More recently, improved practice and effective tracking by senior managers are ensuring that swift action is taken and further delay is prevented. There is recent evidence of effective interventions and support that have resulted in families being stepped down from PLO processes.

14. Leaders make rigorous checks to locate children who are missing education. They liaise effectively with other agencies and, as a result, most children are found and only then removed from the school roll. Leaders make regular checks on the attendance, educational progress and welfare of children who access education on a part-time basis and return them to full-time education where possible. Effective systems are in place to monitor the welfare of children who are electively home-educated.

15. Private fostering processes are not robust. There is not an effective process in place to ensure that children who may be in private fostering situations are recognised and safeguarded.

16. Arrangements to respond to and manage allegations in respect of adults who work with children are effective. Allegations are treated seriously and responded to promptly, with oversight of subsequent actions.

17. There are services to support vulnerable, exploited, missing and trafficked children and these are being developed further. Children at high and extremely high risk of exploitation receive intensive and effective interventions from workers in the Aspire team. Workers are enabled to visit frequently and build relationships with the children they work with. This is helping to reduce risks of further exploitation. Most children who go missing are offered a return home

interview, but records do not always evidence in-depth information-gathering. This means that return home interviews are not effective for all children in preventing further missing-from-home episodes.

18. When children present as homeless or at risk of becoming homeless, swift allocation ensures that a timely assessment of their needs takes place and that appropriate accommodation is identified. Where possible, steps are made to reconcile the child with their parent and support them to return home. However, records do not evidence that explicit conversations are taking place, with children being advised of their legal rights to become a child in care.

The experiences and progress of children in care: requires improvement to be good

19. Children are now being brought into care when it is in their best interests. Recent management oversight has improved and decisions for children to come into care are more timely and appropriate. There is effective monitoring through the legal gateway panel. A history of missed opportunities to escalate interventions means that the majority of children who have recently come into care have had significant involvement with children's services. Care proceedings applications are not made at the right time for all children. For many children, consideration should have been given to intervene more purposefully at an earlier stage. Social work evidence is of the required standard to enable the courts to make the right decisions for children.

20. Social workers are able to articulate the detail of children's care plans but the written plans are not always specific or reflective of children's individual needs. Not all plans are updated when children's circumstances change, and progress cannot always be measured. Most child in care reviews are well attended by key professionals involved in children's lives. Children are involved in discussions prior to their reviews with social workers and independent reviewing officers (IROs) but meetings are not well attended by parents and very few children attend. This means that parents and children are not fully involved in discussions about their progress and plans for their future.

21. Permanence planning is effective for most children. Improved management tracking and effective parallel planning are reducing delay in securing permanence for children if they are unable to return to their family.

22. Children's family-time needs are well considered, with their wishes integral to planning for this. This means that children are able to maintain safe relationships with their family.

23. Family members are considered as potential carers for children at the earliest opportunity to allow children to remain with family and be cared for alongside their siblings. When these arrangements are recognised as connected carer arrangements, assessments are thorough and completed in a timely manner. Some children remain with family members when assessments are not

approved but when it is the right place for a child to live. These placements receive increased management oversight while alternative arrangements are considered.

24. There are insufficient foster carers to meet the needs of all children who need to be in care. Children are often placed out of area, resulting in a change of schools and reduced opportunity to grow up in their local community. Most children who live out of area continue to receive the same level of service as those closer to home. They are visited regularly by social workers who know them well, and visits capture their views well. There has been recent investment to increase recruitment of in-house foster carers and retain those already approved, with some early success evident.

25. Children are in placements that are meeting their needs, through foster care, family care or residential placements, and they are making progress.

26. Some children have experienced multiple disruptions to their care arrangements. Placement disruption meetings are held for some children but are not always effective at reducing breakdowns.

27. Most children in care are visited regularly by their allocated social workers. Social workers speak warmly about children and gain their wishes and feelings. Social workers take time to develop trusting relationships with children, which supports children to share their views and experiences.

28. Virtual school leaders have high aspirations for all children who are looked after to achieve and lead healthy, happy lives. They know the needs of the children and young people well and want them to have the same support as they would have from a parent. Personal education plans (PEPs) are completed jointly by the school, PEP adviser, social worker and carer. They consider all aspects of the child's experience, and targets are captured effectively. The voice of the child is paramount to this.

29. Not all children are supported to understand their life histories. Life-story work is not being completed routinely by social workers. This work is referred to the life-story team, but the team's lack of capacity, and changes in social worker, mean that work is often delayed. When informal life-story work is undertaken, it is creative and sensitive and gives children an understanding of their experiences and history.

30. Children's identity needs are not consistently well understood. For unaccompanied asylum-seeking children in care, there is consideration of their ethnicity, culture and religion. This small group of children receives an effective initial response with appropriately matched placements. For some children in care, this understanding of their heritage is less well developed.

31. Children in care have access to a regionally commissioned advocacy service. Children do not widely access this service to ensure that their views are

independently represented. It is used effectively to support and advocate for the small number of children in unregulated provision.

32. Formal arrangements for capturing the voice and participation of children in care are not well developed. Only a small number of children are regularly involved in the children in care forums and they are focused on gathering the views of other children in care. This group of children has recently started to meet with senior leaders and, while their impact on shaping and informing service development is limited, the children said that they feel valued and that their opinions are listened to and acted on.

33. Children in care enjoy a range of leisure activities and hobbies with their carers and friends. This gives them opportunities to develop new skills and interests.

34. Children in care who go missing from care or are at risk of exploitation receive an appropriate response. Return home interviews are completed by the missing-from-home team and repeat episodes of children going missing from care have management and multi-agency oversight with timely strategy meetings and thorough child protection enquiries to assess risk and identify next steps. When risks escalate, there is multi-agency response through the risk management group. This is helping to reduce the risk for some children.

35. Middlesbrough is part of a regional adoption agency (RAA), Adoption Tees Valley. For children placed for adoption, permanence planning is timely. The RAA identifies Middlesbrough as the strongest performing local authority in the use of early permanence planning. There is clear adoption support in place for adopters to support children once they are living with them.

The experiences and progress of care leavers: requires improvement to be good

36. Services for care leavers have improved, but not all care leavers in Middlesbrough are receiving a consistently good service. The offer for care leavers has been reviewed in consultation with young people but is still to be finalised. The local authority does not have a dedicated care leavers strategy or an active care leavers forum and the offer lacks ambition for this group of young people. Although personal advisers (PAs) make young people aware of the offer, not all care leavers are aware of their entitlements.

37. When young people have the opportunity to have a stable relationship with a consistent worker, the relationship is positive. Workers know young people well and talk about their strengths and personalities with warmth and affection. They are proud of their achievements and advocate on their behalf to ensure that they are supported.

38. Although the number of young people in education, employment or training (EET) is low, the local authority is aware of this and is seeking ways to encourage young people to access EET opportunities. This is having some

impact, with the numbers of young people in EET increasing. There is a monthly not in education, employment or training (NEET) panel, and young people are supported to access other opportunities, such as the 50 Futures work experience programme and apprenticeships within the council. Young people who have accessed these opportunities spoke with pride about their achievements and experiences. Care leavers are supported to make informed choices about their education, employment and training. Young people are encouraged to continue with their PEP and a PEP adviser, with whom they already have an established relationship.

39. All young people have a pathway plan but not all pathway plans are effective in ensuring that all young people receive the right level of support as they prepare for independence. Pathway plans are not routinely updated to reflect young people's changing circumstances. Stronger plans consider young people's individual goals and include recreational activities and support to help them keep in touch with important family members and friends.

40. Some young people benefit from 'staying put' arrangements, and an accommodation link officer based with the pathways team provides support and guidance to workers and young people to make housing applications and bids. The accommodation offer to care leavers is limited and a small number are homeless or at risk of being homeless. Workers describe difficulties accessing suitable and permanent accommodation for young people with more complex needs as they do not meet the criteria for many housing providers.

41. Care leavers are being seen but not all are visited at times of increased need or at key transition points. Visits are not always at a frequency to be meaningful or when circumstances change, which reduces the effectiveness of support to these young people.

42. The pathways service provides support to young people up to the age of 21. There are some young people who are benefiting from support up to the age of 25, where this is requested or where the service has identified ongoing support needs. For others, the onus is on them to seek this support. This means that some care leavers may not be accessing support when they need it.

43. Care leavers' physical health needs are identified and addressed and healthy lifestyles are promoted. Some young people have benefited from emotional well-being support from a dedicated child and adolescent mental health services worker. This post has recently been filled after being vacant for some time, which meant that this support was not available for some months.

44. Most young people have the relevant essential documents they need as they move into adulthood and independence. PAs advocate for young people to ensure that they receive ongoing support into adulthood from adult social care if this is needed.

45. Risks and vulnerabilities, including exploitation risks, are well considered by workers in the pathways service. Risks of exploitation are not always discussed through the vulnerable, exploited, missing and trafficked process. This means that there is a lost opportunity for police to take protective or disruptive action.

46. Care leavers who are parents are supported to develop their parenting skills and maintain attachments to their children in mother and baby placements.

The impact of leaders on social work practice with children and families: requires improvement to be good

47. Since the last inspection in 2019, senior and corporate leaders have overseen gradual improvements in children's services. However, very recent changes to key leadership positions and a high number of interim roles mean that there is a level of fragility in sustaining these improvements. The current interim executive director of children's services and director of children's care are known to the workforce and have begun to deliver improvements in some key practice areas. They are committed to delivering continued improvement until more permanent arrangements are made. This is to provide a level of consistency to the workforce while recruitment to these senior roles and a handover take place.

48. The local authority has been open to external challenge and support. It has engaged effectively with the Department for Education improvement adviser, partner in practice and external partners. Successive monitoring visits from Ofsted inspectors have found improvements across most areas of practice identified for improvement in the previous inspection.

49. The self-evaluation demonstrates that the local authority knows itself well. The leadership team is realistic about the areas of practice that still need to strengthen and develop further. There are a number of recently developed strategic and service plans for improvement, but many are not fully embedded and not yet having an impact on current work.

50. There are some effective partnership arrangements in place, particularly in respect of the MACH and initial responses to concerns about children. There remain some partnerships that require strengthening, such as with health, to enable further improvements to take place. The Children and Family Court Advisory and Support Service and the family court report that Middlesbrough is responsive to feedback and learning. When cases are escalated to the local authority, challenges are accepted and learned from.

51. Decisions have previously been made to cease some services that have been successful in supporting children, including the edge of care service. This has impacted on the consistency and quality of services provided for children and their families. The local authority has recognised this and plans to reinstate this service are in place.

52. Although no widespread or serious failures have been identified, leaders and managers are still identifying and responding to legacy drift and delay for children. There are elements of good leadership and management now in place, but this is not consistent across the service.

53. Performance management information is available to managers at all levels, and this is reviewed at monthly performance clinics. There are currently no performance leads in post, which has resulted in there being no support for managers to analyse performance data and link this to ongoing practice improvement. This means that they focus on compliance rather than the quality of practice.

54. Quality assurance is supported by a wide range of audit activity across all service areas. The audit tool is of good quality but is not always used effectively by being used to complete audits collaboratively with the practitioner. This is a missed opportunity for workers and their managers to reflect on their practice and the impact of this for children.

55. There is evidence of wider council scrutiny and challenge of senior leaders in children's social care. There is a recognition that improvements and reporting have focused on compliance with tasks and that there now needs to be a greater focus on the quality of practice and the impact of this on children.

56. The council is not acting as an ambitious corporate parent for all children. Although there have been some improvements in services to children in care, the offer to care leavers is basic and this group of vulnerable young people has not been a priority for the council. There is acknowledgement by the corporate parenting board that there is a long way to go to fully engage children and young people and be able to demonstrate the impact of their influence.

57. Middlesbrough is investing in a 'grow your own' approach to recruitment and retention of social workers. There have been some initial improvements, but this has not progressed sufficiently to ensure that a stable, permanent workforce is in place. There is a commitment to reducing the reliance on managed project teams, but the move to end these contracts and replace them with agency workers means that some children will experience further changes of worker.

58. Management oversight of practice is not consistently strong across all service areas. Not all records evidence that supervision is taking place regularly enough to progress plans for children. The quality of supervision is inconsistent. Stronger social work supervision covers aspects of compliance alongside reflective discussions about practice and the impact on families. The rationale for management decisions is well recorded on some children's records. This means that, should children access their records in the future, they will understand how and why important decisions were made about them.

59. Workloads for frontline workers are reducing but there remain some workers with high workloads. Workers reported feeling busy but well supported by managers. Workload pressures in some teams create difficulties in progressing or transferring work to ensure that children consistently receive an effective service.

60. Newly qualified social workers in their assessed and supported year in employment feel well supported. They have managed workloads that allow them to develop their experience and skills at a pace that is right for them. Workers told inspectors that they enjoy working in Middlesbrough, and that they are supported well by visible, approachable and available managers. Workers, including agency workers, have access to training and development opportunities that assist them in their work with children and families.

The Office for Standards in Education, Children's Services and Skills (Ofsted) regulates and inspects to achieve excellence in the care of children and young people, and in education and skills for learners of all ages. It regulates and inspects childcare and children's social care, and inspects the Children and Family Court Advisory and Support Service (Cafcass), schools, colleges, initial teacher training, further education and skills, adult and community learning, and education and training in prisons and other secure establishments. It assesses council children's services, and inspects services for children looked after, safeguarding and child protection.

If you would like a copy of this document in a different format, such as large print or Braille, please telephone 0300 123 1231, or email enquiries@ofsted.gov.uk.

You may reuse this information (not including logos) free of charge in any format or medium, under the terms of the Open Government Licence. To view this licence, visit www.nationalarchives.gov.uk/doc/open-government-licence, write to the Information Policy Team, The National Archives, Kew, London TW9 4DU, or email: psi@nationalarchives.gsi.gov.uk.

This report is available at https://reports.ofsted.gov.uk/.

Interested in our work? You can subscribe to our monthly newsletter for more information and updates: http://eepurl.com/iTrDn.

Piccadilly Gate
Store Street
Manchester
M1 2WD

T: 0300 123 1231
Textphone: 0161 618 8524
E: enquiries@ofsted.gov.uk
W: www.gov.uk/ofsted

© Crown copyright 2023