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Dear Stuart

Monitoring visit to South Tyneside children's services

This letter summarises the findings of the monitoring visit to South Tyneside children's services on 21 and 22 March 2024. This was the second monitoring visit since the local authority was judged inadequate in May 2023. His Majesty's inspectors for this visit were Jan Edwards and Catherine Heron.

Areas covered by the visit

Inspectors reviewed the progress made in the following areas of concern identified at the last inspection:

- The response to contacts and referrals for children and families at the 'front door' of the service.
- The response to children aged 16 to 17 years old who present as homeless.

This visit was carried out in line with the inspection of local authority children's services (ILACS) framework. A range of evidence was considered during the visit, including electronic children's case records, performance management information, children's case file audits and other information provided by senior managers. In addition, inspectors spoke to a range of staff, including social workers and managers.

Headline findings

Since the last inspection, published in May 2023, when services were judged to be inadequate, the response to concerns about children at the front door, including the multi-agency safeguarding hub (MASH) and the out-of-hours service, has been improved. Children's needs are now promptly identified and responded to when requests for services are made. This has been achieved through increased social work and manager capacity, a streamlined single point of contact for early help and children's social care and improved partnership arrangements. Furthermore, the response to children aged 16 to 17 years old who present as homeless has improved, although the recording of their right to be cared for is not made explicit and children

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are not offered the support of independent advocates. Professional referrals about children are not always of sufficient quality to support efficient screening and immediate identification of children's needs. While the early help offer has improved for children and families, there are capacity issues to manage the increasing demand for support and targeted interventions.

The new leadership team is delivering on some key objectives in their improvement path. While this visit looked specifically at the local authority's response at their front door, there have also been further improvements across the wider service. In addition to the improvements outlined at the first monitoring visit, further changes have been made to include an improved early help offer, a greater willingness to learn from the sector and continuing improvements to quality assurance. A corporate commitment to improvement for children is also at the heart of the re-establishment of a multi-agency children's partnership, and a move to a separate South Tyneside Safeguarding Children's Partnership (STSCP).

Findings and evaluation of progress

Senior leaders have addressed the issue of confusing pathways for services through the integration of early help at the front door and the development of a full MASH. This means there is a seamless single point of contact for professionals and families seeking help and advice from early help and statutory services. This is a significant improvement since the judgement inspection. There is increased capacity and expertise in the MASH through the participation of multi-agency partners who are making positive contributions to information-sharing and decision-making for children. Social work capacity has also increased with the addition of four new social workers.

MASH screening by social workers is thorough and supported by the work of experienced triage workers who complete basic checks and summarise the history of involvement. Social workers undertake extensive checks, speaking to the referrer, partner agencies, parents and increasingly to other family members in the family network to determine an appropriate course of action. Since the last inspection, the MASH has improved the recording of parental consent, making it explicit about what it is parents have consented to. The social work analysis of the information gathered focuses appropriately on the child's experience of parental behaviours. Managers provide improved oversight and direction at the outset of the screening process to advise on the tasks required and at task completion to agree recommendations for next steps.

The daily MASH triage meeting with co-located partner agencies provides a forum for the initial screening of all police concerns and notifications. The multi-agency information-sharing, alongside the social work manager's advice, supports swift prioritisation of children who are at most risk. Consequently, referrals for children are

responded to promptly with appropriate decisions for the right threshold of service for children to meet their needs and manage risks effectively.

Referral information from some professional referrers has remained stubbornly of poor quality. Although the police have worked with their officers looking at situations 'through the eyes of a child', the quality of police contacts seen in the daily triage meeting remains variable. Inspectors saw excellent examples of information shared by the police, but most is very limited leading to triage workers searching to establish the relevance to the child. This can impact on the time spent on individual screening. MASH managers address the issue of the quality of referral information in real time with partners at the point of referral. However, leaders recognise that the new STCSP and the multi-agency partnership is an opportunity to seek a resolution to the quality of partners' referral information, at pace.

Transformation of early help services has seen the roll-out of 12 new family hubs which are delivering a core offer under the umbrella of the 0 to 19 start for life. The development of the family help and adolescent services has increased the number of families who are receiving earlier targeted support and interventions. However, the growth has not been matched by the equivalent increase in capacity to manage the high demand. While the triage of early help contacts is thorough, it is taking longer than the service's own expected standards. This is exacerbated by the variable quality of the referral information and so it is taking longer to understand the issues and what is required. A lack of initial manager oversight of early help contacts is a missed opportunity to prioritise the work and provide a timescale for triage. At the time of this visit, there were 32 families who had been in the process of triage for up to two weeks. This is not providing a timely response for these children and families.

Early help has been consolidated at the front door over the last 15 months. Managers have spent time embedding the infrastructure for a single point of contact for children and their families. Leaders recognise there is more to do to iron out the barriers to a seamless service provision and in the challenges of merging the electronic management system to support more effective screening and intuitive performance monitoring.

There are very clear processes for stepping children's cases down from statutory services. A recently formed weekly step-down clinic ensures that any identified unmet need for children and their families, following children's social care intervention, is clearly identified. Social workers and early help practitioners use the helpful threshold wheel tool to identify unmet need and the right intervention to meet that need. Early help assessments seen are of high quality. They identify and analyse the risk for children, often using evidenced research. There is a clear focus on the child's identified need to form an achievable plan of intervention which is resulting in positive outcomes for most children.

A recently implemented short-term intervention pilot is delivering focused direct interventions by the early help coordinators. The impact of this work is not clearly evidenced as currently the early help module on the electronic case management

system does not allow for the recording of this work, which remains mostly hidden. Manager oversight of this work is also not clear.

When risks for children increase, strategy meetings held in the front door are timely, effective, and well recorded. This includes strategy meetings for missing children and children aged 16 and 17 and who are homeless. There is effective multi-agency information-sharing by the relevant agencies and a shared decision for threshold for child protection enquiries. These enquiries are strong and clearly evidence the voice of the child, resulting in appropriate decisions to safeguard children and offer services at the right level to mitigate risk. Strategy meetings held on children in the locality teams are not as strong. Some of these meetings are not quorate, with health services often missing.

The out-of-hours service works effectively and extensively to ensure that concerns about children are responded to in the evening and at weekends. They make swift analysis of the risks to children with appropriate safety planning, supported by strategy meetings so children are not left in situations of harm. Daytime colleagues follow up with further work and there is no delay in children receiving the right service.

The timeliness of the assessment of children's needs has improved. Managers have addressed this through the implementation of a 25 or 35-day completion deadline and manager checkpoints to support assessments being undertaken in the child's time frame. While many are still done in the longest time permitted, there is starting to be a shift towards more proportionate assessments.

Children's assessments in the front door part of the service are thorough. They include a contribution from partner agencies and a clear voice of the child as well as those adults who are important to the child. The analysis considers the impact of parental behaviour on the child, and the history of concerns. This helps reach appropriate decisions for next steps and the development of plans to meet the child's needs. In some cases, social workers are using family network meetings effectively while in the assessment process and this contributes to the understanding of the family support. This is good practice, but it is not embedded across the service.

The missing coordinator based in the MASH works across the service to share expertise and knowledge of the risks associated with missing children, in addition to the local intelligence built from engaging children and young people in the area. The coordinator provides advice, guidance and training to workers at the front door which enhances their knowledge about how to respond more effectively to children who go missing.

When 16 and-17-year-old children present to the local authority as homeless, there is a well-coordinated joint response from housing and children's social care. Assessments for children at risk of homelessness explore the child's wide-ranging needs and their voice is clear. Although children's wider family are consulted and mediation is often undertaken between the child and parents to support the child to

return home, formal family network meetings are not used. This means valuable opportunities are lost to support children to remain living with their wider families when mediation fails. Social workers' tenacity in building relationships with homeless children or those at risk of homelessness supports children to consider and accept offers of help and has increased children's safety in these instances.

However, while workers told inspectors that children are provided the opportunity to become cared for, case file records do not demonstrate that they are informed of this, nor of their other rights and entitlements. Independent advocacy is not offered as per the joint housing protocol.

Following the last inspection, the new leadership team has recognised the poor response for children who are exposed to domestic abuse as well as its pervasive nature. As a result, the multi-agency response to domestic abuse now sits in the public health domain and is recognised as a public health issue. This has led to improvements to the range of services provided through the domestic abuse service, including perpetrator programmes and services for women and children. Governance of the multi-agency risk assessment conference (MARAC) and the representation of partners is starting to be addressed through a new MARAC steering group overseen by the domestic abuse partnership board. However, this is still very much a work in progress.

One of the significant cultural changes that inspectors saw on this visit has been the improvement to partner agency relationships and collaboration. Professional challenge is now encouraged and is constructive. The introduction of the MASH is providing opportunities for improved communication, information-sharing and shared decision-making across partners for the benefit of children.

The director of children's services (DCS) and senior leadership team have a candid understanding of practice shortfalls for children and their families, gained through a range of quality assurance practice and peer reviews. Leaders are developing an open culture of learning for their workforce and there is a strong commitment to sector-led improvement. This self-awareness underpins their iterative improvement plan and their determination to improve services for the children of South Tyneside. The unwavering commitment of the corporate leadership, the lines of accountability to the improvement board and the support from the Department for Education adviser and the improvement partners are supporting the DCS and his team to take forward the improvements planned at a steady pace.

There are clear lines of reporting to the chief executive. He is holding the leadership to account for the quality of practice with children and for the service's improvement plan, chairing the newly formed leader's assurance group of the STSCP and is a member of the improvement board. Astute financial management through a two-year budget cycle has ensured that the improvements required in children's social

care are being adequately financed. This has enabled an increase in manager and social work capacity and reduced caseloads.

Inspectors have previously reported on the strengthened approach to performance management and quality assurance. Auditing has continued to improve and is more consistently undertaken with practitioners as live learning on specific practice. The use of feedback from children and families to improve practice remains underdeveloped. Leaders have built on learning from audit and listened to inspection feedback, resulting in the introduction of monthly learning meetings. There is now a mechanism for collating learning from all quality assurance activities, enabling the service to be responsive to specific practice issues and to target resources to support practice development. The more recent recruitment of the assurance and improvement officer is supporting learning from audit at individual practitioner and service level.

Staff seen at this visit report a significant improvement to the culture of the service led by the new leadership team. They told inspectors that they feel confident and safe to practise because of supportive and constructive line management. They are proud of their work and enthusiastic about making changes for the benefit of children and families.

I am copying this letter to the Department for Education.

Yours sincerely

Jan Edwards
His Majesty's Inspector