

26 October 2022

Martin Gray  
Director of Children's Services  
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Dear Martin

### **Focused visit to Stockton-on-Tees children's services**

This letter summarises the findings of the focused visit to Stockton-on-Tees children's services on 21 and 22 September 2022. His Majesty's Inspectors for this visit were Jo Warburton and Victoria Horsefield.

Inspectors looked at the local authority's arrangements for the front door, including decision-making for referrals, child protection enquiries, the decision to step down or step up from early help, and child in need assessments.

This visit was carried out in line with the inspection of local authority children's services (ILACS) framework.

### **Headline findings**

Children experience delay in having their needs for help and protection assessed and met following a referral to Stockton-on-Tees children's services. While immediate safeguarding concerns are identified and responded to swiftly, a significant number of children in need of assessment and support are currently unallocated due to a lack of social work capacity. Front door services are under significant pressure from increasing volumes of referrals, many from the police which are not triaged before sending to the front door. When assessments and child protection investigations do take place, not all of them consider the presenting issue and not all consider the history and full extent of the risks to the child. This leads to children being stepped down to early help, or having their cases closed or being re-referred to children's social care for the same reason, some on numerous occasions.

Front-line management oversight has been weak, and social work turnover has been high for several months. While these issues have recently been addressed, this has had a significant impact on the quality of children's experiences and has led to delays in children receiving help, protection and support when it is needed.

Senior leaders have an accurate understanding of the weakness in the service area. However, improvements are not being implemented with sufficient pace.

### **Areas for priority action**

The local authority needs to take swift and decisive action to address the following areas of weakness and delay for children at its front door:

- The identification and screening of risk and need.
- The quality of assessments and decision-making.
- The quality and effectiveness of managerial oversight, timely case allocation, and supervision.

### **What needs to improve in this area of social work practice?**

- Decision-making and the premature case closure for children who remain at risk, or for whom the extent of the risk is unknown.
- The analysis and use of all relevant information about children's experiences when making assessments, including previous history, cumulative risk and neglect.
- Multi-agency working, including partners' understanding of thresholds and their application, for example the quality, volume and arrangements for police referrals.
- The quality and effectiveness of children's case file audits.
- The effectiveness of the interface between children's social care and early help to ensure that the right children are stepped down at the right time.

### **Main findings**

Stockton-on-Tees children's services commissions its contact and referral functions from a neighbouring local authority. The service is known as 'The Children's Hub' (CHUB). The CHUB screens contacts, assesses immediate risk and refers children on to Stockton-on-Tees children's services when children are identified as needing support, help and protection.

The increasing volume of referrals into the CHUB from professionals in relation to Stockton-on-Tees children and their families is significantly higher than this local authority has previously seen. Too many contacts from the police are passed to the CHUB without any triage. This is placing significant and additional demands on staff, who are already working to capacity.

There is a timely and effective response when children need immediate protection. Child protection strategy meetings are convened swiftly, although full advantage is

not taken of partner agencies who sit within the CHUB to share all available information about the child and their family. There are some gaps in the recording of strategy meetings, meaning that full information about the discussion is not always clear.

Subsequent child protection enquires and investigations are not thorough. They are overly focused on the presenting risk and do not consider well enough the child's family history, the child's views, or previous referrals. A significant number of strategy meetings do not result in initial child protection conferences, or a robust assessment of need.

While there is a refreshed and accessible early help service which is well managed, the interface and threshold between early help and statutory social work is not clearly understood or effectively applied. A significant number of children are stepped down to early help, or their case is closed following referral without a full understanding of the level of need. In too many children's cases, this is due to parental consent to share information, or to agree to an assessment, not being robustly pursued. This is contributing to the increasing re-referral rate. Most importantly, it means that children are not receiving help and support when they need it.

When children are in need of a social work assessment, insufficient social work capacity in the assessment teams, together with the increased demand for assessments, is leading to children's cases remaining unallocated for too long. Eighty children were waiting to be allocated to a social worker at the time of this visit. While the waiting child's needs are triaged by a duty social worker and manager, too many families experience delay waiting for social worker availability before the assessment commences.

Assessments seen during the visit were mostly poor. Some staff describe a process of 'proportionate assessment' which is not in keeping with the service assessment policy. These assessments only consider the presenting reason for referral and do not fully explore the child or family history and relationships. Not all assessments involve parents or professionals in the assessment process and, where they do, they are overly focused on the adult's voice. The child's voice is absent in many assessments seen during the visit, as is an understanding of the child's lived experience.

Social workers do not fully consider or explore extra familial risks when there is a concern about child exploitation. There is too much reliance on the need to gather hard evidence, or a child's disclosure, to meet the threshold for statutory intervention. This means that some children at risk of exploitation are closed to social care or stepped down to early help and remain at risk.

The emergency duty team responds appropriately to safeguard children out of office hours. The manager promotes information-sharing between day and out-of-hours social workers so that children's risks and how to respond are better understood.

There is a very effective response to children aged 16 to 17 years who become homeless. Assessments of need are undertaken, and children are provided with immediate support with appropriate offers of suitable accommodation. Children are informed of their rights and social workers re-explore risks as they emerge.

Recently appointed managers are beginning to provide improved management oversight for the early help service, assessment teams and emergency duty team. However, this is against a backdrop of some very recent poor management oversight and decision-making. This period of poor management has impacted negatively on the retention and turnover of the workforce. Managers still do not oversee well enough the quality of assessments, and therefore are not driving progress in children's plans. They are not providing social workers with consistent guidance and direction to develop their practice and help them make decisions to work towards achieving sustainable and safe progress for children.

Senior leaders have very recently evaluated the effectiveness of their front door service. They have undertaken thematic reviews to help them understand why increasing numbers of children and their families are in need of help and support and the reason for the increase in re-referral rates. As a result, senior leaders have invested financially to improve the workforce by increasing manager oversight and social work capacity to fill vacancies. However, this is not yet leading to a reduction in social work caseloads, or creating sufficient capacity within the workforce to meet demand.

Recently introduced performance information, including audits of children's case files, does not provide senior leaders with a sharp enough focus on understanding children's experiences. Some data provided during the visit, for example the numbers of children stepping down to early help, was inaccurate. Leaders have not used learning from the thematic review of children who are having repeat child protection enquiries to address areas for development quickly enough. The current quality assurance framework is not helping senior leaders to understand their effectiveness or drive improvement in this service area.

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

We have notified the Department for Education of the areas for priority action. You should submit an action plan that responds to these areas within 70 working days of receiving this letter. It would be very helpful if you can share an early draft of the action plan with us within 20 working days of receiving this letter.

Yours sincerely

Jo Warburton  
**His Majesty's Inspector**