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Dear Ms Bates

Focused visit to Middlesbrough children's services

This letter summarises the findings of the focused visit to Middlesbrough children's services on 9 and 10 December 2025. His Majesty's Inspectors for this visit were Nabeel Hussain and Catherine Heron.

Inspectors looked at the local authority's arrangements for the 'front door'.

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

Headline findings

The quality of initial responses to children is inconsistent and does not always lead to proportionate decisions for children and families. While no children were seen to be at risk of immediate harm and most responses are timely, thresholds for intervention are not consistently applied. Too many children are subject to reactive decision-making and repeated statutory interventions when other forms of support would be more appropriate.

Instability of leadership at a senior level has impacted on long-term strategic planning for children in Middlesbrough. The new, permanent director of children's services (DCS) has quickly developed an understanding of the strengths and challenges faced by the organisation. She is supported by the chief executive, lead member and recently appointed Department for Education improvement adviser. Leaders' self-evaluation of the front door reflects a clear understanding of what needs to improve. There is an open and shared recognition of the need for service improvements to be delivered at pace.

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

- The consistency of parental engagement in the multi-agency children's hub (MACH). (outcome 2, national framework)

- The analysis of information and how it contributes to proportionate decisions in the MACH and strategy meetings. (outcome 3, national framework)

- The quality and impact of safety planning during child protection enquiries. (outcome 3, national framework)

- The response to children aged 16 and 17 who present as homeless. (outcome 3, national framework)

Main findings

Most children in need of early help receive a prompt response. Screening by early help coordinators considers family history alongside presenting needs of children. When children require targeted support, 'stronger families' workers quickly contact parents to commence the child's assessment.

Contacts from partner agencies are mostly timely and contain the necessary information to support screening activity. The Teeswide threshold document is helping managers prioritise work in the MACH. In more recent practice, workers and managers explicitly reference the threshold criteria within their analysis.

Most contacts are appropriately prioritised and result in timely responses to children. Management oversight is evident on all contacts and referrals but does not consistently result in proportionate outcomes to issues raised. Managers offer direction and prompt workers to complete enquiries to inform the overall analysis. While appropriate in many situations, in some instances, all potential outcomes, including support from early help, are not considered.

Social workers are not always persistent in engaging parents at the earliest opportunity. For many families, enquiries with partners commence before consultation with parents. Some children progress to an assessment without parents being spoken to, even when there are no overt safeguarding concerns. For some children and families, this has led to unnecessary statutory involvement.

Social workers in the MACH routinely gather information from other agencies to help them understand children's situations. Children's histories are considered but the extent to which information is analysed and recorded varies. The voices and experiences of children are not always explicit in screening records and this can lead to decisions that do not fully address their needs or reflect their experiences. For some children, decisions only consider the most recent incident and focus on

achieving short-term safety. Consequently, improvements are not sustained and some children experience repeated interventions. Repeat referrals have continued to increase and are very high.

The emergency duty team responds quickly to concerns about children out of hours and makes swift enquiries to establish the level of support that children need. Written records are clear and reflect the action taken and next steps. The interface with daytime services is effective, resulting in prompt management oversight and screening, with no delays for children.

While potential safeguarding concerns are identified, decisions to hold a strategy meeting are not always consistent and consideration is not given to whether the situation could be managed through lower-level interventions. As a result, some children and families experience unnecessary formal safeguarding processes.

Most strategy meetings are timely and well attended by relevant partner agencies. The information shared is extensive but is not always relevant or well analysed. Actions arising from strategy meetings are not always clear or specific to children's presenting needs.

The quality of child protection enquiries varies. Children are seen as part of most child protection enquiries but their voices and experiences are not always well recorded or clearly analysed. While no children were identified as being at risk of immediate harm, some records are vague and do not clearly detail the enquiries that informed the decisions made.

A new domestic abuse triage system has been implemented to help prioritise the high volume of police contacts. Observations of the triage meeting highlighted an absence of professional challenge or collaborative decision-making. The consideration of family history is often limited to the most recent involvement and professionals are not always sighted on the child's entire lived experience.

While the domestic abuse triage considers the threshold for statutory intervention, there is less consideration given to other types of support. Some contacts are logged as information only when the child or family may benefit from early help support. As a result, support is not always offered at the earliest opportunity.

Most social work assessments are completed in a timely way, although some are too parent focused and lack involvement from wider family members. Children's needs are not always analysed well and opportunities to secure support through family networks is not always explored early enough.

Management oversight is evident on assessments but does not consistently address potential shortfalls. Recommendations are rarely challenged and there is limited evidence of reflection or consideration of all support options for families. When

actions are assigned but not completed by workers, this is not consistently resolved through management oversight. This results in some children's needs not being fully understood and assessments being closed prematurely.

Safety planning during child protection enquiries is completed with most families but is not always realistic or meaningful. Safety plans offer limited additional safeguards and do not consistently engage the child's network or include the child's voice. Some are brief whereas others are too long and confusing for families, and place an overreliance on parental self-reporting.

Children aged 16 and 17 who present as homeless do not receive a child-focused response. Workers do not seek to understand the child's circumstances from their viewpoint prior to further enquiries being made. Records do not evidence the completion of joint assessments with housing and the vast majority did not demonstrate children being made aware of their rights and entitlements.

Workers speak highly about the positive impact of recent additional capacity in the MACH and assessment teams. This is supporting a growing focus on the quality of interventions alongside meeting compliance targets. Workers describe their managers as visible and available when they need direction. They feel well supported and receive regular supervision and guidance.

The quality and impact of audit practice is not consistently leading to improvements in practice. Not all audits are collaborative or include the experiences of children and families. The rationale for audit outcomes is not always clear, with some audits being overly optimistic about the quality of practice. While learning from audits is reviewed by each service area, it is not clear how learning will be taken forward to inform practice development.

Senior leaders are focused on developing a longer-term strategic plan to improve services for children. The new DCS has sought to develop supportive relationships with neighbouring peers, the Local Government Association and the sector-led improvement partner. Leaders are considering the most appropriate practice model following delays in previously planned implementation. They also have plans in place to stabilise the workforce through the launch of a new workforce development strategy. Throughout this visit, leaders demonstrated a unified, collective ambition to ensure that children in Middlesbrough benefit from safe, high-quality services.

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

Yours sincerely

Nabeel Hussain
His Majesty's Inspector