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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 28 and 29 November 2023. This was the first 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 local authority's response to children in need of help and protection.
- The quality of assessments, plans and planning.
- The quality and impact of pre-proceedings interventions.

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 records, performance management information, 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 inspection report published in May 2023, when children's services were judged to be inadequate, there has been early progress made to strengthen the infrastructure necessary to support service improvement for the children of South Tyneside. There have been significant changes to the senior leadership team and in middle management. A new permanent director of children's services (DCS) and head of service have only recently come into post. They are taking forward the implementation of the wide-ranging whole-service improvements initiated by the interim leadership team.

There has been some progress made in improving the response to children in need of help and protection, although some children continue to experience drift and delay in having their needs met. Thresholds are not consistently applied, meaning that some children are subjected to unnecessary social work assessments. Some children have experienced repeat periods of child protection planning due to previous poor practice. In addition, overoptimism has led to some children having too short a period of child protection planning. At times, this overoptimism extends to when decisions are made to close children's cases, which means that some children are the subject of repeated interventions. There is an improving picture regarding managers' oversight through refreshed practice standards, which have explicit expectations of managers. There is greater visibility of the DCS and the management teams, and social workers feel more confident that they are supported in their practice and that they are valued.

Findings and evaluation of progress

Assessments conducted by the assessment team are increasingly completed within timescales but remain of variable quality. The weaker assessments do not analyse the information to understand the impact on children, and resultant plans are not sufficiently individualised and focused to fully meet children's needs. Better quality assessments are detailed and comprehensively address the concerns supported by an understanding of the family history and agency involvement. Furthermore, the views of significant adults are clear, and children are seen, often multiple times, to gain an understanding of their lived experience. Social workers use well-evidenced tools to develop a deeper insight into specific issues, such as child exploitation, domestic abuse and alcohol misuse.

There are several assessments of children's needs which are closed without any further social work intervention required. These assessments are not always proportionate to the initial concerns raised, resulting in an unnecessary level of statutory intervention for children and families.

When safeguarding concerns increase, most strategy meetings are held in appropriate timescales for the child. They are attended by most of the key professionals, with the notable exception of health services. Consequently, meetings do not have all the key safeguarding partners present when making decisions regarding the appropriate threshold for intervention. The recorded actions from strategy meetings do not consistently demonstrate the person responsible for the actions and the timescales to be met.

Subsequent child protection enquiries are thorough and include all agency information and checks. In many, the voice of the child and parents is clear. Manager oversight has improved overall, although this is not always recorded on the newly initiated eight-day check on the progress of the enquiries. This means that managers are not consistently demonstrating oversight of progress of work to be completed, in line with the service's own practice standards.

When child protection enquiries identify ongoing safeguarding concerns, child protection conferences are mostly effective forums for information-sharing. Meetings are well attended by most professionals, although there is a lack of consistent attendance from health services, limiting their contribution to decision-making. Children's participation in their meetings requires further development and the service is currently exploring more creative ways of encouraging participation to promote meaningful plans for children.

A strengths-based approach is used in child protection conferences which enables partners to identify protective factors balanced with risks. For most children, child protection planning is leading to an appropriate level of support to address their needs and risks. Some children have experienced a short period of child protection planning when lower levels of intervention could have been considered.

Child protection chairs have an improved footprint across children's case records, and they are raising concerns directly with social workers about planning for children. However, this is not always effective in supporting the required changes as they are not escalating concerns to senior managers to ensure that children's plans are progressed appropriately.

The interventions identified through children's plans are enabling improved outcomes for many children. However, the recording of child-in-need and child protection plans is not of a consistently high quality. Not all are sufficiently focused on specific actions and services required to meet need and reduce risk in a timely way for children. Contingency planning remains poor. For some children, this has contributed to drift and delay in improving their circumstances as it is unclear for parents what would happen, and in what timescale, should there not be the desired improvement for children.

Multi-agency children-in-need and core group meetings to review plans are mostly regular and well attended by the relevant professionals, which supports the planning for children. However, case file records of these meetings are not all demonstrating that plans are updated as situations change, and that progress is being made. Social workers regularly gather children's views, wishes and feelings, but these are not translated into updated, meaningful plans for children. Social workers know their children well. They visit regularly and some complete 'My Plans' with children. However, these would not help children to understand their plans and what is happening for them.

Social workers have access to a range of tools to support the assessment of specific risks to children, for example neglect and domestic abuse. At times, there is a lack of professional curiosity and an acceptance of parental self-reporting which can skew the understanding of the actual risk to children. For some, decisions to close children's cases are based on parental non-engagement rather than the result of successful outcomes and change. For other children, parental self-reporting has led to overly optimistic decisions rather than sustained change being evident. These

decisions have led to some children not having their needs met in a timely way and receiving repeat interventions.

Some children have had repeated periods of child protection planning. This has been a result of previous poor practice and a lack of authoritative action taken at critical points for the child. Decisions not to proceed to child protection enquiries or to close assessments with no further action have been overoptimistic, made without progress being tested and are not based on the child's lived experience. More recent practice has ensured appropriate escalation of children's cases into the pre-proceedings phase of the Public Law Outline (PLO) when risks are not reducing for them.

PLO processes are not ensuring timely outcomes for children. This is a deterioration from practice seen at the last inspection. There are many children who have experienced delay in having an outcome determined due to a lack of front loading of assessments, which take too long. The monitoring of children in pre-proceedings is not robust and does not ensure that there is no drift and delay in progressing children's plans. Although timescales are monitored, the PLO tracker and PLO panel meeting minutes do not clearly evidence how the panel is challenging practice to ensure that there is no delay for children. The letter before proceedings sent to parents has improved since the last inspection. It now clearly specifies what the concerns are and the expectations of parents to prevent care proceedings from being issued. Leaders know they need to refine this further and ensure consistency in the quality of these letters.

Leaders know that significant improvements are needed in how disabled children are supported and have commissioned a review of the service. Social workers are trying to fill the gap for children in the absence of commissioned services. Some disabled children have benefited from periods of children in need and child protection support and intervention. Social workers have used their skills in relational social work practice to develop trusting relationships, often with parents who are reluctant to engage to effect change. Assessment quality for disabled children is variable. Better assessments are based on multi-agency information, history-taking, and the voice of the child, which brings the child to life. Other assessments are not updated to understand children's current circumstances and needs. Furthermore, there is drift in planning, particularly when children are in pre-proceedings, with little impact for children. Direct work with disabled children is undertaken using communication strategies which meet the child's needs. This has helped disabled children to understand their concerns and to voice their feelings.

Manager oversight and supervision for social workers have shown some improvement since the last inspection. However, both remain inconsistent in the impact they are having for children. Social workers told inspectors that they value regular reflective supervision. Written records of supervision do not consistently demonstrate the reflection on cases and the testing of ideas to ensure that plans are progressed in the child's time frame. Efforts are made to write to the child in a variety of children's records, including supervision records, although there is inconsistency in how well this is achieved.

Leaders have been successful in reducing workloads for social workers. This is resulting in manageable workloads, supporting social workers to build relationships with children and families and undertake more direct work, some of which is creative. Workers use their skills to engage families and develop positive relationships with children.

A strengthened and more robust approach to understanding the quality of services for children is currently being implemented, with an updated quality assurance and performance framework. This includes a wide-ranging cycle of quality assurance activity through the auditing programme, and the introduction of performance dashboards. The quality of case auditing has improved. It now, more successfully, attempts to balance the requirement to check compliance with practice standards with reflection and curiosity about what might be happening for the child.

The development of the quality assurance and performance framework remains an iterative process. The DCS has accepted inspectors' findings that there remains more to do to ensure that there is a robust learning loop and monitoring of the outcome of audits as a test of assurance on the quality of practice.

Most of these developments are in the early stages and are starting to become embedded. Performance information has improved. Performance reports show an improved compliance with key performance indicators but are descriptive rather than analytical to understand what it means for children. Changes in data and monitoring of trends in activity are followed up through themed audits and dip sampling to support leaders' line of sight to practice. The suite of data and reporting mechanisms is supporting more effective scrutiny and challenge and lines of accountability by executive leaders, elected members and the improvement board.

Corporate and political leaders in South Tyneside are determined to improve services for children and their families. This includes additional investment in the service to increase the social work workforce and improve their renumeration, as well as increasing management capacity. Successful bids have been made for additional department for education (DfE) funding. The leadership team shares this determination and is working collaboratively with their DfE adviser and the improvement board to implement the improvement plan. They know they are at the beginning of their improvement and are not complacent about what work is still required to achieve good and better services for children.

Social workers are positive about the change in culture in South Tyneside, citing a supportive working environment with a highly visible new leadership team. The loyal workforce is as equally determined as their leaders to see improvements made for the benefit of their children and families. A range of strategies, guidance documents and practice standards have been written which set out guidance to staff and partners while the leadership team determines the best fit model of practice for South Tyneside. Staff like working in South Tyneside and are positive about the changes implemented by senior managers and can see the benefits in terms of capacity, workload and process.

I am copying this letter to the Department for Education. Because this is the first monitoring visit to your local authority, we will not publish this letter on the Ofsted website. You may share this letter with others if you wish.

Yours sincerely

Jan Edwards
His Majesty's Inspector