Stoke-on-Trent City Council

Inspection of services for children in need of help and protection, children looked after and care leavers

and

Review of the effectiveness of the Local Safeguarding Children Board[1]

Inspection date: 1/06/2015 – 25/06/2015

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Children's services in Stoke-on-Trent require improvement to be good
There are no widespread or serious failures that create or leave children being harmed or at risk of harm. However, the local authority is not yet delivering good protection and help for children, young people and families and is not yet delivering good care for children and young people. It is Ofsted's expectation that all children and young people receive the level of help, care and protection that will ensure their safety and help prepare them for adult life.

1. Children who need help and protection		Requires improvement
2. Children looked after and achieving permanence		Requires improvement
	2.1 Adoption performance	Good
	2.2 Experiences and progress of care leavers	Requires improvement
3. Leadership, management and governance		Requires improvement

[1] Ofsted produces this report under its power to combine reports in accordance with section 152 of the Education and Inspections Act 2006. This report includes the report of the inspection of local authority functions carried out under section 136 of the Education and Inspections Act 2006 and the report of the review of the Local Safeguarding Children Board carried out under the Local Safeguarding Children Boards (Review) Regulations 2013.

Contents

The local authority

Information about this local authority area[2]

Previous Ofsted inspections

- The local authority operates 11 children's homes. Six were judged good or outstanding and none was inadequate in their most recent Ofsted inspection.
- The previous inspection of the local authority's safeguarding arrangements was in August 2011. The local authority was judged to be adequate.
- The previous inspection of the local authority's services for looked after children was in August 2011. The local authority was judged to be adequate.

Local leadership

- The Acting Director of Children's Services has been in post since March 2015.
- The chair of the Local Safeguarding Children Board (LSCB) has been in post since April 2015.

Children living in this area

- Approximately 55,077 children and young people under the age of 18 years live in Stoke-on-Trent. This is 22% of the total population in the area.
- Approximately 26.9% of the local authority's children (aged 0–19) are living in poverty.
- The proportion of children entitled to free school meals:
  - in primary schools is 27% (the national average is 17%)
  - in secondary schools is 21% (the national average is 15%).
- Children and young people from minority ethnic groups account for 18.5% of all children (aged 0–19) living in the area, compared with 25.1% in the country as a whole.
- The largest minority ethnic groups of children and young people in the area are Asian or Asian British (particularly Pakistani) and Mixed/Multiple Ethnic Group.

[2] The local authority was given the opportunity to review this section of the report and has updated it with local unvalidated data where this was available.

- The proportion of children and young people with English as an additional language:
  - in primary schools is 19% (the national average is 19%).
  - in secondary schools is 17% (the national average is 14.3%).

Child protection in this area

- At 31 March 2015, 1,766 children had been identified through assessment as being formally in need of a specialist children's service. This is a reduction from 3,381 at 31 March 2014.
- At 31 March 2015, 261 children and young people were the subject of a child protection plan. This is a reduction from 308 at 31 March 2014.
- At 31 March 2015, nine children lived in a privately arranged fostering placement. This is an increase from seven at 31 March 2014.
- Since the last inspection, seven serious incident notifications have been submitted to Ofsted and four serious case reviews have been completed or are ongoing at the time of the inspection.

Children looked after in this area

- At 31 March 2015, 609 children are being looked after by the local authority (a rate of 110.6 per 10,000 children). This is an increase from 535 (98 per 10,000 children) at 31 March 2014.
  - Of this number, 234 (or 38.4%) live outside the local authority area.
  - 38 live in residential children's homes, of whom 39.5% live out of the authority area.
  - Seven live in residential special schools,[3] of whom 100% live out of the authority area.
  - 418 live with foster families (including 58 with family and friends), of whom 46.9% live out of the authority area.
  - 68 live with parents, of whom 16.2% live out of the authority area.
  - One child is an unaccompanied asylum-seeking child.
- In the last 12 months:
  - there have been 29 adoptions
  - 26 children became subject of special guardianship orders

[3] These are residential special schools that look after children for 295 days or fewer per year.

- 216 children ceased to be looked after, of whom 9% subsequently returned to be looked after
- three children and young people ceased to be looked after and moved on to independent living
- of the children and young people who ceased to be looked after, none are living in houses of multiple occupation.

Executive summary

No widespread or serious concerns were found in the services provided to children and their families in Stoke-on-Trent. However, the quality of practice in both safeguarding and support teams and in services for children and young people in care and leaving care is not consistently good. Management oversight, while established, is not always effective, and in a small number of cases appropriate action is not taken quickly enough.

Stoke-on-Trent politicians and senior officers are highly ambitious and demonstrate a good understanding of issues for children and families living in Stoke-on-Trent. There has been a focus on early help with a 'cooperative working' approach among partners delivering a well-integrated offer across the city. This is helping to ensure good and improving early help services with many positive features including thorough and comprehensive early help assessments and effective multi-agency working. The local authority recognises that the corporate parenting strategy remains underdeveloped and further work is needed to continue to improve outcomes for children in care and particularly care leavers.

Although a good range of early help services are in place, the volume of contacts to children's social care remains high, placing pressure on front-line services. Further work is required to establish partners' understanding of thresholds for services in social care.

The large majority of young people in Stoke-on-Trent receive services appropriate to their needs. Child protection conferences and children in need planning meetings are timely and well attended by other agencies. Almost all children who require a statutory intervention benefit from thorough assessments of need and a plan that clearly identifies the outcomes sought and how they are to be achieved. However, for a few children the threshold for commencing child protection procedures was not rigorously applied or assessments of need took too long. For some cases plans were not specific about what needed to change and how change was to be achieved.

Case recording and supervision are variable in quality and do not always include analysis and reflection. Management oversight and case direction are not always recorded clearly enough to ensure an understanding of why decisions are made. Although there is a comprehensive performance management system, data and analysis are not sufficiently outcome-focused. There is poor compliance by some managers with the quality assurance audit process, which means that it is more difficult for the local authority to track continuous practice improvement and its effects on improving outcomes.

Arrangements to allocate and safeguard privately fostered children mean that these cases are not dealt with by knowledgeable staff and result in a poor service to a small but vulnerable group. Arrangements to support homeless young people demonstrate a lack of consistency of approach in a small number of cases.

There are well-established multi-agency approaches to safeguarding young people who are victims or at risk of child sexual abuse or who go missing from home, education or care. These demonstrate effective action taken by agencies working collaboratively to tackle child sexual abuse and show evidence of reduced instances of missing episodes. Any child missing from education is identified quickly and appropriate action taken to establish their whereabouts.

Local authority designated officer arrangements are not robust enough to ensure that there is a sustained focus on raising awareness of issues among partners.

Much decision-making is sound but in a small number of cases planning and decision-making are insufficiently rigorous or do not happen in a timely manner. Not all children are spoken to alone by social workers during assessments of need.

Many children looked after benefit from social workers who know them well but some young people said they had experienced too many changes of social worker.

Permanence outcomes for most children in care are good. Children placed for adoption are appropriately matched to local adopters who are being well supported. Use of special guardianship orders is high, further ensuring stable and permanent placements for young people. The authority is successful in achieving adoption for children with complex needs.

The majority of children in foster care live in good-quality stable placements that meet their needs. Many of these placements are intended to be permanent arrangements but in some of these cases the authority has been slow to ratify these.

Adopters in Stoke-on-Trent are very positive about their experiences of timely assessments and the process of identifying the right adopters for children. The work of the dedicated postbox service enabling adopted children to maintain links with birth family members is an example of particularly good practice.

The local authority is not yet effective in helping enough looked after children to achieve their educational potential. Not all children looked after attend good schools and attainment is low across all key stages.

Most young people leaving care live in suitable accommodation. A number of care leavers attend university and appropriate support is provided by the local authority. However, too many are not in education, training or employment.

Children in care are well represented by the Children in Care Council. The group is highly motivated and is helping to improve the experience of all young people in care.

The local authority has worked hard to establish and maintain a stable workforce with few vacancies and a staff group that is positive about senior managers who listen to them, and about working in Stoke-on-Trent.

Recommendations

1. Review quality assurance processes and their management to ensure that case audits consistently measure outcomes and managers comply with the requirement to undertake audits of work (paragraph 127).

2. Ensure that performance data links to the outcomes sought for children and young people and that this data and analysis are in a format that is readily understood and used by all staff (paragraph 126).

3. Working with the LSCB to ensure that partners fully understand thresholds for services in order to reduce the high numbers of unnecessary contacts made to social care. Identify why contact numbers are high but relatively few progress to referrals or an assessment leading to a service. Determine what action should be taken to reduce the volume of work in the advice and referral team (paragraphs 18, 28, 130).

4. Strengthen the work of the corporate parenting panel to ensure that it provides a critical analysis and effective challenge on whether outcomes for looked after children and care leavers are improving (paragraph 138).

5. Progress plans for permanence for young people in foster placements as quickly as possible by ensuring that they are formally assessed and promptly presented to the fostering panel (paragraph 90).

6. Improve the quality of personal education plans (PEPs) for looked after children, ensuring they are used effectively to help young people reach their full potential and achieve good GCSE results (paragraph 75).

7. Ensure that independent reviewing officers have sufficient capacity to fulfil all their functions effectively (paragraph 65).

8. Ensure that supervision and all management decisions are recorded fully in a way that reflects the contents of the discussion, particularly in relation to plans and any changes (paragraph 29).

9. Ensure that all children and young people subject to social work intervention are seen regularly by social workers, including being seen alone (paragraph 30).

10. Ensure that all plans for young people, including pathway plans, have clear actions and timescales for progression and improvement, and that all older young people who return home from care have plans that meet their needs. Further strengthen arrangements to increase the number of care leavers engaged in employment, education or training (paragraphs 32, 58).

11. Ensure that care leavers are fully aware of their rights and entitlements and have sufficient information about their health history to inform future health choices (paragraph 114).

12. Ensure that all children subject to private fostering arrangements benefit from timely robust assessment of the suitability of the placement for their needs (paragraph 48).

13. Review the local authority designated officer arrangements to ensure that experienced staff have sufficient time to develop and ensure the quality of the service (paragraph 49).

14. Ensure that issues of diversity, including ethnic origin, are fully recorded and taken into account in assessments of need and planning (paragraph 55).

Summary for children and young people

- Social workers and managers work hard to help children and young people who need protection or who are in care. Many receive a good service, but not all of them do. Leaders know what needs to be done to improve and have started to make the changes needed.
- Agencies such as schools and health services provide good quality help when families first have problems. This often prevents their problems getting worse.
- Children who clearly need extra help from social workers get it quickly. However, sometimes agencies ask social workers to become involved when they do not need to. This can be frustrating for children and families and add unnecessarily to the workload of social workers.
- When social workers and others are really concerned about children they act quickly to make sure they are safe. Sometimes they do not talk to all children in the family or see them on their own. As a result, social workers do not always understand how children feel about what is happening in their family.
- When children need to be looked after, the local authority makes sure they live with carers who can meet their needs well. They live with their brothers and sisters unless this is not in their best interests.
- An independent reviewing officer meets regularly with everyone involved to make sure that children in care are getting all the help they need. They do a good job but they are very busy. They do not always manage to see children before the meeting to hear their views. This is important, especially if children have decided not to attend the meeting themselves.
- Not all children in care do as well at school or college as they should. Staff from the Virtual School provide lots of extra help to make sure children and young people stay on track.
- Children who need adoption sometimes have to wait because there are not always enough suitable families. The local authority does not give up easily and has found some very good families for children needing extra support even though it has taken a long time.
- Nearly all care leavers live in suitable accommodation and they can choose where to live. More needs to be done to ensure that they understand fully what they are entitled to so they take up all the help on offer.
- Care leavers aged 16 and 17 get good advice about training and job opportunities. Care leavers who choose to go to university get good support. Too many older care leavers do not have a job and are not in training. The local authority needs to do more to help these care leavers.
- Children told inspectors that the Children in Care Council, 'Tune In' and 'Out Loud', works well with the local authority to make the right changes, for example making sure that all looked after children get the right pocket money.

The experiences and progress of children who need help and protection	Requires improvement

Summary

Early help services are effective in supporting children and families. Despite this, and clear guidance on thresholds, the volume of inappropriate contacts to children's social care is high, placing pressure on the busy safeguarding and support teams.

The multi-agency safeguarding hub (MASH) delivers valuable information-sharing at the point of referral, allowing the advice and referral team to quickly access information from partners to inform decision-making. The management of domestic abuse cases in the MASH is highly effective, ensuring that cases receive a social care assessment where appropriate. A wide range of support services are available for victims of domestic abuse. In a small number of cases of neglect the threshold for commencing child protection procedures was unclear and this led to delay.

Child protection strategy meetings are timely, and good information-sharing leads to appropriate decisions based on sound risk analysis. The majority of child protection enquiries are thorough, but in a very small number of cases they were concluded without seeing all the children in the household or an adult who allegedly presented a potential risk. Child protection conferences are well attended. Experienced chairs provide appropriate challenge to agencies and families when plans are not progressing as they should. Core groups meet regularly and in the vast majority of cases timely action is taken if risk is not reducing or is increasing.

The quality of child protection plans is variable. A small number seen lacked clear actions or timescales resulting in a lack of improvement in conditions for children who were suffering neglect. Others were detailed and demonstrated that measurable progress was being made. This variability is replicated in planning for children in need, although most were well considered at regular multi-agency meetings supported by plans that lead to positive change.

In a small number of cases, management and oversight through case supervision and quality assurance processes have not succeeded in establishing consistently good standards preventing poor practice.

A lack of clarity about requirements in relation to privately fostered children result in a poor service to this small but highly vulnerable group. Services offered to homeless young people do not always result in them receiving the right level of support quickly. While decision-making is appropriate in cases referred to the local authority designated officer, current arrangements do not help to raise awareness of the role.

Multi-agency responses to young people who go missing from home, care or education, and to protect those at risk or victims of child sexual exploitation are robust. A well-organised multi-agency approach is helping to raise awareness among professionals of female genital mutilation.

Inspection findings

15. The volume of contacts made by other agencies to children's social care that do not require a social work service remains high despite a wide range of effective early help services being available. The advice and referral team (ART) signposts to early help those contacts that do not meet the threshold for a social care assessment. This ensures that delay for children in being referred to the right service is minimal but significantly increases the workload of the team. Good management information systems enable ART managers to track the progress of contacts accepted as referrals and ensure work is completed within one working day in almost all cases. Previous history and information gathered are used to make clear, balanced recommendations for the referral outcome. Decision-making is undertaken by suitably qualified social work managers. Decisions to progress to an assessment or to pass to early help are supported by advice on what action is required next.

16. The ART is co-located with the MASH, enabling good communication at strategic and operational levels and close, trusting working relationships. The MASH has strengthened understanding between the participating agencies, currently the police, health services, probation, adult social care and children's social care. It is an effective information-sharing hub providing prompt and detailed information to aid decision-making, primarily in domestic abuse, child protection and missing children cases.

17. The early help strategy is comprehensive, well informed by a thorough analysis of local needs and supports a well-integrated offer across the city through good multi-agency partnership working.

18. There is a single point of contact for all early help services, which is now in place with one city-wide phone number and direct links to the ART team. Trained staff take and direct calls to appropriate services, including to the early help team. Careful monitoring of early help activity, well informed by data, is ensuring managers can now regularly check that referrals are being made at the right level to the right services at the right time. However, this new service is yet to make an impact on the numbers of contacts the ART receives.

19. The new early help assessment tool is an improvement on the common assessment framework (CAF) and ensures that all intervention and work with families with complex needs is effectively captured. Interventions are well supported by timely multi-agency meetings, where detailed action plans are regularly reviewed. This enables progress to be monitored and measured with evidence in cases seen by inspectors of families and children building resilience and developing additional coping strategies.

20. Inspectors' reviews of early help cases indicate many positive features including effective multi-agency working and thorough and comprehensive early help assessments. Early help workers demonstrate a good understanding of risks, including child sexual exploitation, domestic abuse, mental health problems,

drug misuse, debt, housing problems, anti-social behaviour and criminality. All cases reviewed were at the appropriate level of need for early help interventions.

21. Professionals from other agencies have good access to well informed advice from locality social workers based in early help settings, who provide additional guidance if they become concerned about cases. This is yet to make a difference in the number of contacts to the social care front-line. Social work managers provide thorough and regular supervision and consequently social workers feel well supported and confident in their role.

22. Schools across the city are making a significant contribution to early help through a range of interventions including use of education welfare officers to reduce persistent absences. Community police officers work in schools to support young people in relation to risks associated with drugs, alcohol, gangs, radicalisation, child sexual exploitation and domestic abuse. A number of schools are involved in 'edge of care' projects that provide additional local support to families.

23. The local authority is good at helping schools deal with bullying. A number of good initiatives are used in primary schools. For example, peer mediators are being trained and used to help younger children manage their own behaviour, and sort out problems between themselves as they arise. A further initiative in restorative justice is being used successfully in secondary schools to resolve issues.

24. New arrangements are helping to ensure partners take lead roles in early help assessments where this is appropriate. Early help cases are open for an average of 120 days. Closures are closely monitored to ensure that needs have been met or there has been appropriate escalation to social care services. An early help evaluation tool, 'Family Life Outcomes', is being piloted. This tool, alongside regular parent evaluations of the service, helps managers evaluate the difference they are making to children and families.

25. The system to manage domestic abuse referrals is robust. The ART analyses risks and strengths from the information available to complement the police risk assessment, known as 'DIAL'. In all cases seen, the judgements about whether the incident should lead to a social care assessment were appropriate. All DIAL referrals are discussed in the MASH and a record of the discussion is stored on each child's case record. The information provided to the multi-agency risk assessment conference (MARAC) on the cases that meet this threshold is of high quality, enabling the MARAC to consider and recommend actions to reduce risks to victims and children including perpetrators.

26. Strategy meetings held in the ART demonstrate good, timely information-sharing with appropriate decisions made about whether to proceed with child protection enquiries. Information-sharing in the MASH about missing children was timely. All such children were offered interviews upon their return.

27. The ART passes referrals that need a social care assessment to the safeguarding and support teams (S&S). The social work teams (pods) on duty generally take on all the work received from the ART, which means that pod caseloads are at their highest after the duty week and reduce over the following weeks. Senior managers maintain a good overview of high workloads in pods and take action to equalise work where necessary. However, in some instances high caseloads have had an impact on the quality of work.

28. The local authority's data indicates that less than 40% of children and family assessments lead to a social care service being provided. This is low compared with the England average percentage and may mean that resources are not targeted effectively. It also places unnecessary pressure on social workers in the S&S teams. The local authority is aware of the need to understand how the threshold for referral and assessment is applied but does not yet understand the reasons for this low figure. The comparatively low re-referral rate (21% against an England average of 24%) is an indicator that decisions to take no further action are appropriate. Apart from two cases that were referred back to the local authority, inspectors agreed with the decisions to take no further action. In neither of these cases were young people at continued risk. Case supervision takes place in the weekly pod meetings. Not all cases are discussed each week, but examples seen meet the local authority's expectation that each case is discussed at least once every six weeks.

29. The record of discussion and the degree of management direction are variable and a small proportion of the cases sampled lacked clarity about what should be done or why. In most cases actions don't have timescales, which can lead to delays. Some supervision records are a snapshot of the case at the point in time rather than an appraisal of progress with the overall plan, which can lead to some drift as seen in a small number of cases sampled. Some of the better supervision records set out the dates of the last and the next child in need meetings, the date the child was last seen, analysis and actions. Workers are positive about the support they receive from their managers and from colleagues in the pods and describe good lines of communication with senior managers.

30. In most child protection cases risk is managed appropriately. In a small number of cases sampled by inspectors, assessments were completed without seeing the children who were at the centre of the enquiries, or not seeing all of the children in the household. In one case the child protection enquiry was concluded without speaking to the parent who had allegedly hit the child. In a case involving domestic abuse, the social work assessment was over-optimistic about the prospect of the parents separating permanently and was closed too early. In some cases assessments were not as comprehensive as they could have been because of pressure on the social worker to complete them in time for the child protection conference. The authority is aware that a high proportion of cases assessed as meeting the threshold for a child protection investigation do not proceed to a child protection conference. Inspectors noted that many of these cases were being supported by comprehensive children in

need plans, thus keeping children safe. In two cases referred back to the authority, senior managers were able to demonstrate that children had been kept safe and a child protection conference was unnecessary.

31. The majority of child in need assessments are completed within the appropriate timescale based on the child's needs, but more than a quarter (27%) take too long. Most assessments sampled include information from discussions with relevant partner agencies and parents, the views of children or observations of their presentation and some consideration of previous history. The quality and use of chronologies is variable with some missing significant historical information. In many cases information was well analysed and informed both assessments and planning.

32. The quality of children's plans varies considerably. Some set out clearly what needs to be done and the measures for recording progress. Others lack specific, measurable actions and timescales. In a few cases there has been significant drift and delay affecting children. Two tracked cases were referred back to the local authority because children had been left at home in neglectful conditions for too long. In these cases there was an element of over-optimism in plans made and a lack of management direction.

33. The quality of case recording is too variable. In most examples seen recording is up to date but in a few this was not the case. Management directions outside the pod meetings are not consistently well recorded. This is even more important when several members of the pod may have a role in the plan. In the majority of cases looked at in detail by inspectors, social workers know the children well, see them regularly and speak to them alone. In many cases there was evidence of direct work being completed with the children using age appropriate tools, although the children's responses to the activity were not necessarily fully analysed and interpreted.

34. Child protection conferences, core groups and child in need meetings are well attended by partner agencies and meet statutory timescales. GPs do not always provide reports to conferences when they have relevant information, and while schools almost always attend they do not consistently provide written reports so the opportunity is missed to share their information with families in advance of the meeting. All child protection conferences are chaired by one of the three experienced conference and review managers (CRMs). A child protection conference seen by inspectors was well chaired, with suitable challenge to professional views. The chair made sure family members understood the process. CRMs meet informally with new social workers to set out their expectations and encourage good practice. They challenge social workers when practice is not good enough, use informal measures to raise issues on a case-by-case basis and hold quarterly meetings with SST managers to raise more general issues.

35. At 31 March 2015, 261 children had a child protection plan. Of these, 131 were under the category of neglect, 114 emotional abuse, nine sexual abuse and

seven physical abuse. The local authority has carried out an analysis of need arising from domestic abuse, parental mental health and drug and alcohol misuse – the 'toxic trio' – to inform its strategic needs assessment. During 2014, almost 25% of children assessed as a requiring a child protection plan lived in a household where all three of these elements were a feature, compared with 10% for those requiring a child in need plan. Of the assessments that resulted in a child protection plan during 2014, domestic abuse was the most common factor identified (in 59% of assessments), higher than mental health problems (51%) and substance misuse (52%). As a result there has been a range of training for staff including a focus on disguised compliance and work with young people in schools in relation to alcohol and drugs.

36. In the majority of child in need cases, regular multi-agency meetings consider children's needs well. These give appropriate consideration to the need to continue with service provision and cases are 'stepped up' to child protection or legal processes or 'stepped down' to early help appropriately. However, a small number of older young people were stepped down to child-in-need-level support after a period in care without clear plans. All children who have been subject to a child in need plan for more than 200 days are reviewed by practice managers to ensure that interventions remain appropriate or further action is required. This helps ensure drift and delay is avoided.

37. A good range of services are commissioned to tackle domestic abuse. These include: a victim helpline; the Freedom Programme, which helps victims regain confidence and self-esteem; a perpetrator programme that seeks to help abusers change their behaviours; and a schools' programme to educate children about positive relationships and raise awareness of domestic abuse and how to report it. The numbers of domestic abuse incidents reported to the MASH are increasing, which may indicate that awareness-raising is successful.

38. There is a good multi-agency approach to safeguarding young people who are victims or at risk of child sexual exploitation. New referrals involving child sexual exploitation are discussed in the daily meetings held in the MASH. The dedicated child sexual exploitation social worker maintains a list of all such young people. The monthly multi-agency child sexual exploitation panel considers all the cases, shares intelligence and provides advice to those working directly with the young people. All cases are allocated to a qualified social worker. Currently the panel is monitoring 39 young people. Risks are categorised using a risk matrix and updated monthly by the panel. Cases are escalated if risk increases, and stepped down following successful intervention to reduce risk.

39. Cases sampled demonstrate that risks of child sexual exploitation are understood and effective action is taken by agencies working collaboratively to tackle them. This includes disruption activity by the police, the use of child abduction notices (41 since 2014) and intelligence-sharing with other police forces. Interventions by managers, social workers and commissioned third

sector services are making a difference. For example, the commissioned service provides support to individual young people to reduce risk-taking behaviours. Examples of good work have been seen where effective intervention has reduced risk to young people including one case where direct work on relationships and using the 'Say it your own way' pack helped keep an 11-year-old girl safe. Young people have been accommodated when risks cannot be managed at home and senior managers have considered secure accommodation where risks have increased.

40. The approach to safeguarding young people who go missing from home or care is robust. Two missing persons coordinators are based within the MASH. All referrals from the police are entered on the social care computer system, including any for children in care placed in Stoke-on-Trent by other local authorities, who are also alerted. An independent organisation commissioned by Stoke-on-Trent also receives the referral from the police and offers return interviews to assess risk including advice and guidance on risks and keeping safe. There has been a year-on-year reduction in missing episodes for the past three years. Cases sampled demonstrate effective joint work with the police and the child sexual exploitation social worker to assess and reduce risks including the risk of sexual exploitation.

41. The local authority reports that in the year 2014–15 there was a total of 446 missing episodes relating to 127 young people. Eighty-eight young people who went missing had three or fewer missing episodes. Nine young people missing accounted for 239 of the 446 episodes and 38 of the 127 young people who went missing were vulnerable to risk of child sexual exploitation.

42. Thorough and effective procedures are in place to ensure that any child missing from education (CME) is identified quickly and appropriate action taken to establish their whereabouts. The CME team swiftly follows up the fortnightly school returns of children missing education, ensuring wide-ranging enquiries are made including appropriate searches. Good and effective liaison with a neighbouring authority means that young people are often located within the wider region.

43. Currently 124 referrals are being investigated by the CME team. Of these, 54 are awaiting a school place and 28 remain unknown. The authority is actively involved and doing all it can to track these children including making all the necessary checks with children's social care, benefit providers, housing department, health visitors, police, Border Agency and notification to the national CME database. The 28 children whose whereabouts are unknown, and are therefore a concern, remain the local authority's highest priority.

44. Alternative education provision is effectively coordinated by the Alternative Provision Commissioning Board. This provides a single point of access for all requests from schools for alternative provision. Thorough quality assurance arrangements mean that these young people attend only registered and good provision. For the 68 who are currently accessing alternative provision, there

has been a significant reduction in the incidence of fixed term exclusions from 80 during 2013/14 to 10 in 2014/15.

45. The local authority has registered 151 children as electively home educated. Education support staff are proactive in encouraging families to register when they choose to educate their children at home. A small number of children are home educated while also accessing alternative provision. When parents register, the authority provides good guidance and support.

46. Good partnership work is helping to raise awareness and prevent female genital mutilation. A clear, informative multi-agency procedure has been published and good practice in Stoke-on-Trent has been highlighted by the Local Government Association. The local authority has been collecting data on contacts received about female genital mutilation since August 2014. Since that time there have been 27 contacts about 24 children. Two early help plans have ensued and six referrals have progressed to a child and family assessment, with one young person on a child protection plan. The strategic manager for vulnerable children has given a strong lead by chairing strategy meetings and maintaining close oversight of these cases.

47. Arrangements to safeguard homeless young people aged over 16 are not always robust enough. In one case sampled there were delays in commissioned housing providers referring a young person to social care for a full assessment of need when possible homelessness was identified. As a result, this young person's circumstances deteriorated and he subsequently became looked after. An earlier referral may have avoided this outcome. Contract specifications have been tightened since April 2015 in order to avoid this being repeated. In another case a young person who was assessed as homeless was not informed of his entitlement to come into care and was not made aware of the rights this status would confer.

48. Arrangements to safeguard privately fostered children are poor. The small number of cases is allocated on a general basis, meaning the social workers involved do not develop the knowledge that comes with experience. In cases seen, children's views had been recorded and children in need plans were in place following assessment. However, statutory visits were out of timescale in two of the four cases sampled. In one case the local authority was planning to close the case of a young person in a stable suitable placement as they had reached age 16. This young person has a disability and the local authority was unaware that the regulations apply to age 18 in such cases.

49. The local authority designated officer service lacks dedicated capacity. Although the strategic manager for safeguarding is the named designated officer, the role is actually undertaken by any one of the three conference and review managers, who have significant other responsibilities. While individual cases are appropriately managed this has affected the level of priority and time this work is given, particularly for training and awareness-raising activity.

50. Cases sampled demonstrate a consistently good response by the emergency duty team. There are suitable staffing arrangements with additional resources available at busy times. The service has responded to feedback and has set up a dedicated telephone line for foster carers enabling them to receive prompt advice and assistance when needed.

51. There is a commissioned advocacy service providing support to a minimum of 80 young people per year. The service produces quarterly monitoring reports, providing evidence that it is valued by young people. However, these do not distinguish between children in need and children looked after, so it is not possible to monitor the extent to which advocacy is offered to each group.

The experiences and progress of children looked after and achieving permanence	Requires improvement

Summary

In Stoke-on-Trent children are not looked after unnecessarily and concerted efforts are made to ensure that children remain with their families. The quality of practice is variable. Most decision-making is sound, but in a small number of cases children have not become looked after soon enough. Some older children have returned home with plans that lacked rigour and effective contingency arrangements. Social workers know their children well. Children looked after are seen and seen alone, with some good examples of direct work. However, children's identity needs are not always fully considered or addressed in assessments and plans. Children benefit from timely looked after reviews and careful attention to their care needs. Independent reviewing officers' (IRO) caseloads are too high. IROs' quality assurance activity is limited, but there is effective challenge in individual cases.

The local authority is not yet effective in helping enough looked after children achieve their educational potential. Outcomes are low at all key stages. A new system of electronic personal education plans (e-PEPs) has great potential, but the quality of e-PEPs is not yet consistently good enough.

The majority of children in foster care live in good quality stable placements with their brothers and sisters unless this is not in their best interests. Some of these are not yet permanent and need to be formalised by the local authority. High numbers of children are placed out of area due to a shortage of suitable placements. Many are placed nearby and receive the same level of health and education services as children placed in Stoke-on-Trent. Children placed further afield are visited regularly and receive high quality specialist therapeutic support when needed. In a minority of cases children's education was disrupted due to delays in appropriate schools being identified. There are thorough and effective procedures for children missing from care and at risk of child sexual exploitation, with well-coordinated multi-agency responses to reduce risk, including for children placed out of area.

Too many care leavers are not engaged in education, employment or training. This limits their career prospects and life chances. Most care leavers are in suitable accommodation and some are at university and well supported by the local authority.

Children placed for adoption are appropriately matched to adopters who are well supported. While some sibling groups and those with complex needs wait longer than the national thresholds, this is improving. Children in care are well represented by the Children in Care Council and have made a positive impact on services.

Inspection findings

52. The local authority makes concerted efforts to ensure children remain with their families. Effective direct work and family programmes for children at risk of becoming looked after result in some families making the required changes to enable them to remain together.

53. Inspectors saw no cases where children were looked after unnecessarily and in the majority of cases decisions that children should become looked after were made within a timescale that met the child's needs. However, in a minority of cases an over-optimistic determination to help children remain with their families meant that children did not become looked after quickly enough.

54. Social workers spoken to by inspectors knew the children and young people they were working with well, and saw them regularly and alone. They paid careful attention to the children and young people's wishes and feelings, including through observations of younger children. Inspectors saw examples of direct work with children and careful analysis of their attachments. This work was then used to inform planning. As a result, involvement of children in decision-making is mostly good, although this is not always reflected in written records. In stronger cases children are fully involved in assessments and plans which are updated regularly. However, a small number of assessments did not consider the views and abilities of wider family members sufficiently. In other cases care plans did not reflect recent significant changes in children's circumstances, lacked timescales for actions and did not have clear contingency arrangements.

55. Consideration of children's identity needs in assessments and plans is too often superficial and limited to a record of their ethnicity unless the child's identity needs are a central feature of the case. Inspectors did see some very good examples of sensitive analysis, such as the consideration of the emotional impact on a child of the onset of puberty, but these were a minority.

56. Overall the quality of case recording varies from comprehensive and up to date to a minority with gaps and key documents missing from files. This makes it difficult to follow the child's story.

57. Requests for children to become looked after are given detailed consideration at case directions meetings, which are chaired by senior managers and supported by good quality legal advice. Case directions meetings identify cases requiring court proceedings to secure appropriate plans for children and ensure they are progressed swiftly.

58. The progress of plans for children subject to pre-proceedings agreements is variable. When parents are unable to meet children's needs the local authority does not always identify and assess family members who could care for them before entering court proceedings. The local authority recognises it is not yet effective enough in this area and in some cases court proceedings could have

been avoided altogether by more rigorous exploration of alternatives. It has recently introduced processes for identifying alternative family members at an early stage in involvement with families but this is not yet having a significant impact.

59. The Children and Family Court Advisory and Support Service (Cafcass) and the judiciary report that the majority of social workers come to court well prepared and supported by managers. The quality of reports remains variable, with some reports overlong and some lacking analysis. The local authority recognises greater consistency is needed and has recently decided to adopt nationally recommended formats with a view to improving overall quality.

60. Timeliness of cases within the court arena is consistently good, meeting or falling within the expected timescale of 26 weeks. However, this is not yet resulting in timely decisions about permanence for some children. The local authority's limited success in completing assessments pre-proceedings, combined with a strong focus on achieving timescale targets, results in high numbers of children placed at home under placement with parent regulations. While in many cases this is to test out the sustainability of arrangements not fully tested prior to making the order, in some cases court timescales are being given inappropriate priority. In these cases decisions about permanence are delayed and parents and children remain in a position of uncertainty without the benefit of independent legal advice or the scrutiny of the court.

61. At the time of the inspection, 68 children were placed at home on a care order – 11% of all looked after children. This is a slight decrease from 2013–14 (12%), which was significantly higher than the average for all England (5%) and statistical neighbours (6%). At the time of the inspection 23 children had been at home on a care order for over a year and 10 for over two years. Until recently, discharge of care orders was not prioritised due to legal capacity and some children and parents have remained subject to intrusive statutory intervention for too long.

62. When children return home following court proceedings, careful planning and comprehensive multi-agency support packages reduce the risk of breakdown. Any deterioration is recognised and responded to quickly as a result of effective partnership working. As a result most children achieve stability within their families.

63. When children return home following a period of voluntary accommodation under section 20 of the Children Act 1989 the quality of preparation, support and contingency planning is more variable. Although in the majority of cases robust multi-agency support was given, inspectors saw a small number of older children returning home with plans that were not rigorous enough and contingencies that were unclear. This can give the wrong message to young people about the level of concern agencies have about their risk-taking behaviour and its consequences.

64. Children benefit from timely looked after children reviews that are well attended by relevant partner agencies and competently chaired by suitably experienced and committed chairs. Careful attention is paid to ensuring children's care needs are met and that they have appropriate contact with people who are important to them. Nearly all looked after children reviews are completed within timescales and the vast majority of children participate in their review either through filling in consultation documents or attending the meeting.

65. Current caseloads of IROs remain significantly higher than recommended in statutory guidance despite an increase in staffing. Workloads impact adversely on the contact IROs can have with children, the timing of reviews, the recording of IRO activity and their quality assurance work. A few reviews take place during lesson time, disrupting young people's schooling and potentially stigmatising them. IROs do not have contact with all young people before their review. This means that these young people may not be given sufficient opportunity to express their views and have them heard. At the time of the inspection, the local authority did not have a clear enough picture of whether IROs had enough contact with children. The local authority had appropriately identified as priorities young people placed at a distance and children who choose not to participate in reviews.

66. IROs effectively challenge poor practice in individual cases, leading to improvements and better decision-making for children, though this is not strongly reflected in written records. Overall themes are known from these cases and are discussed in regular meetings with practice managers but they are not collated, impact is not currently evaluated and the quality assurance activity of this group is too limited.

67. Looked after children have access to good advocacy services from a commissioned provider. The same organisation provides an independent visitor service for children who have limited family contact and need a befriender. Take-up for both services is good, with over 80 children a year receiving advocacy support and 50 to 70 children receiving a service from independent visitors each quarter. There is no waiting list for these services. This ensures that these groups of young people have timely access to an adult who is independent of the local authority and the placement and who can take up any issues or concerns on their behalf.

68. The local authority uses strengths and difficulties questionnaires well to identify children who may need additional emotional support. All children whose score indicates a cause for concern are referred to child and adolescent mental health services (CAMHS) for assessment and help.

69. The small dedicated looked after children CAMHS service struggles to meet demand, and the local authority and health partners recognise that historically too many children have not received help that was effective or timely. The service has recently been reintegrated within wider CAMHS provision with a view to providing children with a more flexible and responsive service. It is too

soon to measure the effectiveness of these changes and during this period of transition some children continue to wait too long for a service. Children who are placed outside Stoke-on-Trent receive CAMHS services that are local to the area of placement. In cases seen this did not disadvantage them and they received good quality effective therapeutic support often provided in-house by specialist placements.

70. The current percentage of looked after children who misuse drugs and alcohol in Stoke-on-Trent is almost double the England average for 2014. Although a good range of services is available to provide help, take-up is low with more than 60% of young people refusing the intervention that was offered. Reasons for this poor take-up have not been fully analysed or understood. However, when young people do accept help, services are effective in educating them to take fewer risks and reduce their substance misuse.

71. The local authority's data performance for children's immunisations, dental checks and initial health assessments conflicts with figures provided by health partners. As a result the local authority cannot be confident that it has an accurate overview of children who have outstanding checks or the reasons for delay. This does not help them prioritise completion or analyse and address issues. The current agreement with the clinical commissioning group (CCG) requires 80% of initial health assessments to have been completed by the end of March 2015 but the local authority during this inspection was unable to provide agreed data on performance in these areas.

72. In cases tracked and sampled by inspectors, children placed at a distance from Stoke-on-Trent were seen regularly by social workers. Placement providers reported regular and effective liaison with a swift response to any emerging concerns. Generally children's health and educational needs were well met and placements were effective in meeting children's often complex needs. In a minority of cases there was delay in identifying suitable educational provision for the young person, leading to disruption to their education. This includes one case where the young person had been in placement for two months and educational attendance had still not been resolved.

73. Sixty-eight percent of children in care attend good or better schools. The Virtual Head ensures that those who do not are supported by a commissioned service that provides mentoring and additional one-to-one support.

74. The proportion of looked after children who have had at least one fixed term exclusion has, for the last three years, been lower than for similar groups nationally. No looked after child has been permanently excluded for the last six years.

75. A new system of e-PEPs (electronic personal education plans) has great potential, but the quality of e-PEPs is not yet consistently good enough. In those that are of poor quality, target setting is insufficiently clear to drive progress effectively. Targets are not specific or measureable and so do not

enable progress through monitoring and review. Important key information is sometimes missing and young people's views are not always recorded well.

76. The use of the pupil premium is well monitored by the Virtual School team. The premium is used in a wide variety of ways based on an up-to-date assessment of need to support children's academic, social and emotional development. Although outcomes are low at all key stages, they compare favourably with their comparators for other looked after children except at Key Stage 2. However, the attainment gap in relation to all children in Stoke remains too wide.

77. At Key Stage 2, mathematics is the only subject where Stoke-on-Trent is performing better than comparable authorities. Writing, grammar and reading are all below comparators. The Virtual School recognises the progress of pupils at Key Stage 2 is not as positive as it could be. As a result, they have commissioned services that focus on improving progress for these children and this is beginning to have an impact on results.

78. Although work is underway, the rate of progress is not yet rapid enough to close the attainment gap. The better progress made at Key Stage 1 for some children is not sustained through the remaining key stages. Performance in achieving at least five A* to C grades at GCSE in all subjects shows a decline from 35% in 2013 to 27% in 2014. This mirrors the decline across the city for all children. Attainment of A* to C GCSE grades including English and mathematics at 17.6% was an improvement from the previous year and is above the children in care rate for England but well below all children in Stoke.

79. Alternative education provision is effectively coordinated by the Alternative Provision Commissioning Board, which provides a single point of access for all school requests for alternative provision. Seven looked after children are currently accessing this provision. Thorough quality assurance arrangements mean that young people attend only registered and good provision.

80. Arrangements for the transition of young people into post-16 education are thorough and well defined. Virtual School staff now track the progress of all young people up to the age of 18 to help them explore sufficiently the whole range of post-16 options.

81. Children who go missing from care benefit from the same robust multi-agency response to assess and reduce risk as children who go missing from education or from home. Unpublished data provided by the local authority indicates that 55 looked after children went missing from their placements in 2014–15 for a total of 307 episodes. The vast majority of children who are placed in Stoke and have gone missing are offered a return interview within 72 hours undertaken by an effective commissioned provider. In cases seen by inspectors, young people were helped to reduce risk-taking behaviour. One previously prolific absentee has, with help and support, not gone missing for over nine months. The overall trend for looked after children who have experienced two or more repeat

missing episodes is improving (65 in 2013–14 reduced to 55 in 2014–15). For children placed out of area, return interviews are offered as a bespoke service. The local authority has identified that its response to looked after children placed outside Stoke-on-Trent is less well coordinated than its response to those within Stoke. It is exploring ways of strengthening these arrangements.

82. At the time of the inspection 25 looked after children were assessed to be at risk of child sexual exploitation. They receive a well-coordinated multi-agency response to reduce risk, irrespective of geography. In cases seen by inspectors, detailed plans and clearly identified triggers were used well to identify escalating risk. These cases were all referred to the child sexual exploitation panel. Some children placed out of area have clearly benefited by being distanced from harmful influences, and the risk of exploitation was reduced as a result.

83. The local authority's efforts to increase its establishment of in-house foster carers have had limited impact. In 2014–15, although 40 carers in 22 households were recruited to the service, this represented a net gain of just six placements, as during the same period 17 households left the service. Of these, five households left due to adoption or special guardianship arrangements for the children in their care which, while impacting on overall sufficiency, was a highly positive outcome for those children. A further seven households left the service.

84. The local authority, like many others, struggles to recruit sufficient foster carers to meet the needs of large sibling groups and older children with complex needs. The local authority makes good use of independent fostering agencies and its own residential provision of one- or two-bedded homes for young people with very challenging behaviours. As a result there are no young people separated from their brothers and sisters unless it is in their best interests. No young people currently assessed by the local authority as requiring foster care are placed in residential provision.

85. Foster carers receive core training that covers generic skills including life story work. As a result they are able to help children and young people understand their history. Foster carers capture experiences through photographs to contribute to memory boxes and life story books. Examples seen contained information appropriate to the child's history and understanding. One example helped a child who had remained at home to understand her relationship with her younger brother who had been adopted.

86. The independent fostering panel chair is suitably experienced for the role. Independent panel members are all foster carers and provide a useful carer perspective. The chair reports that the quality of reports is improving and they are generally good. Stronger applications demonstrate the voice of the child, use direct quotes and have a clear safeguarding focus.

87. Long-term placement stability is improving overall. The provisional data for 2014–15 shows an improvement of nine percentage points from the previous year was, at 70%, the local authority's best performance in the past 10 years. Short-term stability has also improved. This means that increasing numbers of children are benefiting from living in stable placements with carers who develop positive and supportive relationships with them.

88. The local authority tracks thoroughly progress in achieving permanence for children. This is resulting in an increased focus on achieving permanence in all its forms for children who are looked after.

89. Special guardianship is promoted and supported effectively. In 2014–15, 26 children were made subject to special guardianship orders which, while fewer than the 35 children in 2013–14, still represents strong performance. At the time of the inspection a dedicated resource in the adoption support service was supporting 10 families with children who are subject to special guardianship orders.

90. At the time of the inspection 108 children had a plan for long-term fostering. The local authority has recently identified that 70 of them could be permanently matched with their current carers. The local authority recognises the uncertainty that lack of permanence can cause for children and is taking the necessary steps to formalise these arrangements. If concluded this activity will represent a considerable improvement in performance on previous years (10 matches approved in year 2014–15, and 13 in 2013–14). Social workers pay good attention to broadening young people's experiences and promoting their talents and interests. Young people spoken to by inspectors were involved in a wide range of social activities that were age appropriate and fun. Foster carers have delegated authority specific to the needs of individual children, which is clearly agreed at the start of placement. As a result young people's experiences are normalised and they are encouraged to make positive choices in their leisure activities and friendships.

91. Young people spoken to are very positive about the support they receive from foster carers. They appreciate their carers' tenacity in helping them to thrive. One young person who is thriving said 'I wouldn't be where I am today if it wasn't for my carer.'

92. Children in care are well represented by the Children in Care Council, which runs two groups: 'Out Loud' for children aged 11-16 and 'Tune In' for older young people and care leavers. The groups have a well-established core membership. They meet regularly and are well supported by an enthusiastic and skilled participation officer. This was greatly valued by the young people as he has added insight to their experiences. As a result of the positive working relationships developed, the group is highly motivated and is helping to improve the experience of all young people in care. They have contributed to the 'Pledge' for looked after children and care leavers and the current corporate

parenting strategy is headlined by a powerful statement from the group of what it means to be a good corporate parent.

The graded judgement for adoption performance is that it is good

93. The local authority appropriately considers adoption for all children who become looked after. There has been an increase of 11 additional children being adopted in the last 12 months. Over the last three years Stoke-on-Trent has been able to achieve the adoption of children who have complex needs or are over the age of five (8% of all children in care) better than the England average (5%) and just above comparable authorities.

94. The number of days children wait from becoming looked after to being adopted is reducing. In the last 12 months the average number of days from becoming looked after to being placed for adoption is 536 days. Although this is 49 days more than the national threshold of 487 days, the most recent data shows that timeliness in the last 12 months has improved by 24 days and is now 25 days more than the threshold. Of the children who exceeded the national threshold, the majority had severe disabilities, behavioural difficulties such as attention deficit hyperactivity disorder, autism or were older children. In all these cases successful matches were made.

95. The three-year adoption scorecard data does not reflect the good practice seen by inspectors, which over the last year has achieved significantly better outcomes for children. The data reflects the experience of a small number of children (five) who are now placed for adoption or adopted, but who waited over 1,000 days. In four of these five cases delays were caused by the volume of work required to secure the right placement. This included a thorough exploration of wider family members abroad, consideration of current foster carers to adopt, sibling 'together or apart' assessments and contested placement order hearings. In only one case was there significant avoidable delay.

96. The local authority maintains good oversight of progress in individual cases. Managers' report progress on timescales through the monthly business performance report. The corporate parenting panel provides challenge and scrutiny. In the last 12 months more robust management oversight using a permanence tracker provides middle managers with data, and robust challenge is beginning to significantly improve performance.

97. An assistant director, as agency decision-maker, is involved in cases as early as possible, and ensures all alternatives to adoption have been thoroughly explored before agreeing to a plan for adoption. Social workers present their cases directly to the agency decision-maker. They explain their analysis and receive appropriate challenge, particularly in relation to consideration of wider family members. In the last 12 months there have been seven challenges by the agency decision-maker to the proposed plan for adoption. In cases sampled

by inspectors, changed circumstances for the child meant that after further assessment the decision to rescind the adoption plan was appropriate.

98. In all examples seen, child permanence reports are of good quality with clear chronologies and assessment of risks. They contain detailed exploration of wider family members' circumstances and strong analysis supporting the plan for permanence through adoption. The quality assurance by managers of all adoption plans is robust. The record of the agency decision-maker's decision is comprehensive and identifies areas for improved practice and recording, and this is driving up standards.

99. Social workers in the adoption team are appropriately qualified and experienced. Recent and ongoing recruitment from safeguarding and children in care teams within the local authority brings additional focus on safety and planning. Co-working by the child's social worker and the adoption worker in most adopter assessments broadens expertise, develops skills knowledge and experience and provides challenge.

100. Assessments completed of prospective adopters are thorough and timely. All adoption social workers have received training in the use of adult attachment interviews, which enables wider consideration of types of applicant to reflect the diversity of the local population. Used as a core part of the prospective adoption assessment this approach challenges applicants to consider their own childhood experiences to identify their strengths and vulnerabilities. This produces good quality assessments. Ongoing training in attachment, Theraplay and story stem techniques has enabled adopters to consider and achieve adoption for children with considerable complex needs and larger sibling groups. A parents' guide for adopters on attachment-based play supports and underpins the training post-adoption order.

101. The adoption panel is well chaired and administrated and panel members are experienced and knowledgeable. Independent members with adoption experience bring credibility and challenge. The panel is effective; there were no deferred cases in the last 18 months and no cases referred to the independent review mechanism.

102. Adopters spoken to reported positive experiences of their assessments, attendance at panel and matching, and all felt that their report accurately reflected their circumstances and motivations. Local authority adopters are actively involved in attracting prospective adopters by presenting at local recruitment workshops. Adopters were recently featured in a TV documentary, demonstrating the local authority's ongoing commitment to creative recruitment.

103. There is careful monitoring of the progress of matching children to adopters. A dedicated family finder coordinator, funded by the adoption reform grant, ensures appropriate referrals are made to the national adoption register after consideration of suitable in-house adopters and within three months of the

placement order. Early discussions about possible matches between the co-located permanence pod and the adoption service are leading to appropriate timely links. Children are profiled in national adoption publications and profiles seen are imaginative, positively presented and capture the essence of the child. At the time of the inspection the authority was engaged in active family finding for 54 children. In the 12 months prior to the inspection 27 adoptive families were approved, 38 children had been placed for adoption and 41 had an adoption order granted.

104. The 2013–14 data shows that a robust adoption support service is providing support to 108 children and adopters. A further 25 requests for assessments were received in 2014-15 resulting in the provision of 20 packages of support. Assessments clearly identify need, and help is directly provided by the local authority or commissioned when specific additional needs are identified. An example seen demonstrated good multi-agency work and creative use of the pupil premium, which enabled a child displaying challenging behaviour to be supported appropriately in the classroom.

105. A dedicated postbox service enables adopted children to maintain links with birth family members and helps them understand more about their background. The service has 600 registered contacts, of which 380 are active arrangements. The coordinator visits all adopters and actively supports them in maintaining their child's contact with birth family members. The coordinator also offers to visit all birth family members, and many are enabled to access the service with this support. In all examples seen there was evidence of creative, imaginative and persistent approaches to ensuring children maintain contact with family members.

The graded judgement about the experience and progress of care leavers is that it requires improvement

106. Too many care leavers are not in education, employment or training (NEET). This limits their present and future life chances. At the time of the inspection more than two out of three care leavers aged 16 to 21 were not engaged in any activity that would assist them to improve their prospects for the future, and 60% of those aged 19 to 21 were also NEET. This is a rise from 51% in 2013–14, which was 8% higher than similar authorities and 13% higher than the national average.

107. The local authority has taken recent action to assist more care leavers to access appropriate further education and training. The Virtual School has extended its remit to care leavers with a separate post-16 education pathway plan (EPP) starting at Year 11 to better support educational transition. A specialist careers advisor is now providing a bespoke service to care leavers, helping them to evaluate job and career opportunities and engage in the range of post-16

education options available to them. However, it is too early to see any significant impact from these initiatives.

108. The EPP has the potential to help young people to consider and make successful choices about their post-16 education options but is not yet used well. Currently EPPs do not have sufficient input from education providers in setting out measurable and attainable learning goals. Targets are often statements of intent rather than real measurable goals for young people which can be tracked and measured for progress. The EPP does contain a useful section highlighting barriers to learning such as medical, social and accommodation problems, and this is often more complete than the actual learning plan.

109. Local education providers are particularly positive about the 'post-16 young people in care and care leavers learning support partnership agreement', which contains a framework to support care leavers during their transition into post-16 education. All partners confirm that the support and challenge from Virtual School staff are assisting them in helping young people stay on track. Schools and colleges participate in EPPs but acknowledge they do not currently have enough input into developing education targets with young people. The local authority has seven young people on apprenticeships, which is helping them develop new skills for future employment.

110. Good arrangements are in place to support care leavers to attend higher education (HE). An enhanced financial package of £5,000 is available in addition to support from local HE providers. Currently nine care leavers are attending higher education and five young people have confirmed places for September.

111. Care leavers prepare for adulthood with support from their workers in the Next Steps team and a range of commissioned services. They use 'getting ready for adult life', a programme that includes access to help with emotional health and well-being. Case files show the support given is helping care leavers with their transition to independent living. Practical support helps young people when moving to new accommodation, arranging benefits, maintaining accommodation, budgeting, accessing counselling services and arranging transport. Care leavers have the opportunity to try independent living by spending a period in a training flat to experience the reality of living on their own.

112. The local authorities' own data shows it is in contact with 93% of its care leavers. The remainder either choose not to have contact or are not contactable. In these situations personal advisors continue to make efforts to re-establish contact through known family members or other professional contacts. Relationships with personal advisors are positive, with care leavers stating they can easily contact them or in their absence another member of the team. The Next Steps team is a stable team, which has allowed workers to establish productive relationships with young people.

113. Care leavers report that their personal advisors know them well. This is not reflected in their pathway plans (PWPs). These are not sufficiently specific about what they are trying to achieve or what needs to happen to result in successful outcomes for care leavers or in what timescale. This makes it difficult to measure the effectiveness of the plan in preparing care leavers for transition to adulthood or to monitor progress of the plan's implementation. PWPs do not pay sufficient attention to care leavers' diversity, their family or their care history. More recent plans (from April 2015) have included a scaling question about the emotional well-being of the young person, which is a positive development, but those seen lacked narrative to explain the score and what actions are required. Records do not show if young people have a copy of their plan. PWPs are not up to date and do not always record care leavers changing circumstances. The local authority is aware of these deficiencies but has not yet made sufficient improvements to ensure that timescales will be met and the quality of plans is improved.

114. PWPs promote health needs by evidencing that care leavers register with a GP and dentist and receive advice on sexual health, drugs and alcohol from their personal advisors and other services. This includes access to counselling to promote their emotional well-being. Not all care leavers currently have a summary of their health histories. Those spoken to could not be certain that they understood all their relevant medical details to enable them to manage their health into adulthood.

115. The local authorities own unpublished data states 89% of care leavers are in suitable accommodation. This is an improvement of 7% on March 2014 and is better than comparable authorities and the England average. There is a well-established young people's housing steering group, which supports integrated working with housing services to address care leavers' accommodation needs. Relationships with the housing department are effective, with two housing officers based in the Next Steps team and appropriate protocols and policies in operation. The young person's housing officer attends looked after reviews for care leavers in advance of them leaving care to ensure effective planning for their accommodation needs and subsequently to maintain their tenancies.

116. Effective links with housing services help to ensure care leavers are not in areas of high crime or anti-social behaviour. No care leavers had been placed in bed and breakfast accommodation in the six months prior to the inspection. It is never used for care leavers under the age of 18 years, and is only used as a temporary last resort for care leavers over 18 years. Where this has occurred support has been provided and appropriate accommodation, including council tenancies, have been made available quickly. There are 15 care leavers continuing to live with their carers under staying put arrangements, which provides stability and enables them to maintain valued relationships. Care leavers spoken to feel safe in their accommodation and have a choice in the areas in which they live.

117. In two cases seen where there are concerns about care leavers who are at risk of sexual exploitation, or have been sexually exploited, the multi-agency child exploitation panel considered the level of presenting risk and set out actions to minimise current and future risk. Personal advisors continue to provide a high level of support in efforts to safeguard the young people.

118. The local authority acknowledges that information required to track the progress of care leavers is difficult to collate, as it is not held in one place. This means that it does not provide an easily accessed effective overview of performance. While the authority collects a significant amount of data, it is not easy to use or extract key information without further analysis. The local authority is now looking to revise its performance reports for care leavers to enable better performance monitoring.

119. The majority of young people spoken to did not have sufficient knowledge or understanding of their entitlements. The local authority has co-produced a leaving care handbook with a previous cohort of care leavers, available on the council's website, but this does not provide easily accessible information. It does not result in young people having all the information they need or give them the confidence to proactively secure all their entitlements. The vast majority of care leavers spoken with stated they are confident that their personal advisor would provide any support needed but this is not the same as assisting them to develop skills for themselves.

120. The local authority has an active care leaver's forum – Tune In. Care leavers are actively encouraged to participate in this and pathway plans explicitly ask if the young person is interested in joining the forum. The Next Steps team has a service user involvement worker who effectively facilitates young people's participation. Young people feel they have influenced the service by contributing to developing the pledge, getting the leaving care allowance increased to £2,000 and being part of the recruitment process for foster carers and staff in the Next Steps team – all of which boosts their confidence and develops valuable broader skills. An annual awards ceremony celebrates looked after children's and care leavers' successes.

121. There is effective transition planning with ASCH (adult social care and health), which is helping to ensure young people with a disability or other additional needs receive a continued service post-18. Workers from ASCH are involved at an early stage with young people in care and attend care planning meetings from age 14.

122. Care leavers are informed of the advocacy service and are aware of how to make a complaint. The service has received one complaint during the last year, which was resolved at stage one.

Leadership, management and governance	Requires improvement

Summary

Since the previous 'adequate' inspection judgement for safeguarding and child protection in 2011, Stoke-on-Trent local authority's senior leaders, in collaboration with partner agencies and staff and service users, have completely redesigned front-line services for vulnerable children and their families. These changes have not yet resulted in services that are uniformly good.

The corporate parenting panel has historically had limited effectiveness in fulfilling its role, exacerbated by a strategy that lacks focus on key priorities and requires updating.

The local authority struggled to provide inspectors with accurate performance management information that was outcome focused. This, combined with a lack of compliance by front-line managers with quality assurance audit processes, limits the ability of senior leaders and elected members to analyse and challenge performance.

The local authority's placement sufficiency strategy does not fully meet requirements of statutory guidance. It lacks a robust evaluation of the range of current services and some targets for improvement are imprecise, making it difficult for leaders to evaluate progress.

Senior managers and leaders are visible and accessible to staff. Social workers and manager's report that senior managers are supportive, actively listen to staff and take decisive action. As a result, children and young people benefit from a stable suitably qualified social care workforce.

Social work caseloads are higher than in comparable authorities. Although staff feel well supported, this affects the quality of work in some cases. The quality of management oversight and supervision is not consistently good, and written records do not always reflect the overall plan for the child or progress.

Due to capacity issues, IROs cannot exercise fully their quality assurance and challenge functions on behalf of children in care.

Partnership working is strong both at strategic and operational levels. Good collaborative work between the local authority and partners has resulted in effective shared initiatives such as responses to children who go missing from home, school and care, and those who are at risk of sexual exploitation.

Early help services are comprehensive with a well-integrated offer across the city. This has not yet resulted in a reduction in inappropriate referrals to children's services. The local authority could not offer an analysis of the underlying causes or demonstrate effective challenge to other agencies.

The local authority is a learning organisation. It actively uses external challenge and scrutiny to good effect to inform service improvements.

Inspection findings

123. Senior leaders and partners in Stoke-on-Trent are highly committed to continuous improvement. They recognise further work is needed to ensure that services for children in need of help and protection and those looked after are consistently good, and that children are offered services at the right level as soon as the need arises. The authority is outward-looking and is good at inviting external scrutiny. For example, an independent evaluation of their redesigned children's services – Making a Difference – confirmed they were making improvements but identified that more work was required.

124. The chief executive, the recently appointed Acting Director for Children's Services (DCS), the Local Safeguarding Children Board (LSCB) chair, and lead member for children's services (LMCS) discharge their individual and collective statutory responsibilities effectively. Effective lines of communication, which include regular meetings between key personnel, safeguarding visits to front-line social work teams, and regular contact with the Children in Care Council ensure officers are held to account. As a result leaders have a good grip on the challenges faced by front-line teams and have detailed relevant knowledge of the diverse needs of their local communities. Staff and young people told inspectors that leaders and managers are visible and accessible and that they feel listened to and respected.

125. A test of assurance has been undertaken in respect of the multiple responsibilities of the DCS together with a risk assessment. The DCS arrangements received political approval but minutes of the meeting indicate it did not sufficiently clarify the risks associated with the post to fully inform the local authority and elected members. However no deficits were identified during the inspection as a result of the acting DCS's large span of control.

126. Routine scrutiny of performance data and exception reporting by leaders and front-line managers are well embedded.The performance management reporting system aggregates activity on front-line practice, with evidence of managers responding quickly to service deficiencies. However, the accuracy of some reports is variable. They are not sufficiently outcome-focused and lack qualitative information on whether outcomes for children have improved. Throughout the inspection the local authority struggled to provide accurate data for some service areas.

127. The local authority's quality assurance audit process is not sufficiently well established or evaluative. At least 40% of managers are not completing audits. The audit tool is supported by a range of grade descriptors but it is not clear how findings are to be measured. The audits undertaken by the local authority for this inspection were variable in quality, with some lacking qualitative analysis. In a number of cases, the local authority judgement was not supported by inspectors. Senior managers accept that currently performance data is insufficiently supported by qualitative analysis.

128. In children's social care the 'new' way of working, branded 'Making a Difference', saw the re-configuration of vulnerable children corporate parenting (VCCP) services in 2012. This created small social work 'pods', in which a group of staff including social workers and practice managers work closely together, sharing responsibility for cases. Staff told inspectors they were positive about the changes as they were able to have more time with children and were supported by the team, who knew their cases.

129. Management oversight of front-line practice is well established, including scrutiny by senior managers. Assessments are routinely signed off by practice managers. Most social workers receive timely reflective supervision as part of the weekly 'pod' session; however, the quality of recording by managers of their decisions varies considerably across the service. As a result, analysis of whether interventions are improving outcomes is insufficiently recorded, in some cases leading to a lack of focus on whether risks are reducing. Supervision records do not routinely record the overall plan for the child or track and measure outcomes. During the inspection the local authority proactively audited supervision records and agrees with inspectors that the quality is inconsistent.

130. Partnership arrangements strategically and operationally are increasingly effective in helping children and their families at an early point. Early help services are comprehensive, with a well-integrated offer across the city through multi-agency partnership working. This cooperative working is sharply focused on meeting the needs of children and families early, characterised by effective multi-agency approaches to problem solving. However, these positive developments have not yet resulted in a decrease in the numbers of inappropriate referrals to children's social care. The local authority has been slow to analyse the reasons for this. While the LSCB has re-launched the multi-agency threshold document there is little evidence of the local authority making an effective challenge to partners through the LSCB or other relevant forums such as the Children and Young People's Strategic Partnership Board.

131. Young people missing from home, care and education or at risk of child sexual exploitation receive comprehensive services. Dedicated missing persons and sexual exploitation coordinators work diligently to identify and respond to those at risk. Effective partnership arrangements are in place to ensure that information on young people at risk, missing episodes and alerts are recorded, analysed and shared on a regular basis, including through daily information meetings. All young people identified as being sexually exploited or at risk of exploitation are considered by a multi-agency child sexual exploitation panel using a robust tracking system that ensures an audit trail is in place. These arrangements provide the local authority and its partners with a comprehensive range of local knowledge about risk in Stoke-on-Trent. As a result the local authority and partners are able to demonstrate a range of effective interventions. These include extensive use of abduction notices and specialist operations by the police, which result in adults being charged with offences

and, for some young people, reductions in risk-taking evidenced by a reduction in the number of missing episodes recorded.

132. The local authority and police commissioned an independent review of their missing children and child sexual exploitation services in 2014. This was recognised as good practice and included in the Local Government Association's 'Tackling child sexual exploitation', a resource pack for local authorities published in January 2015. Findings have been integrated into a wider joint Stoke-on-Trent and Staffordshire child sexual exploitation action plan in liaison with Staffordshire Safeguarding Children Board and Staffordshire Police. Progress is actively monitored at a strategic level by the multi-agency Senior Leadership Sexual Abuse Forum.

133. Stoke-on-Trent is a Home Office Prevent Area; the prevent team has been in place since 2008 and was restructured in 2013. There is evidence of strong partnerships, including a multi-agency prevent board and links with the local authority's community cohesion team. These and comprehensive training arrangements across the city have resulted in raised awareness among agencies and community groups, who share information and intelligence to identify, intervene and help prevent young people at risk from becoming radicalised. As a result there has been an increase in referrals to the prevent team and to Channel meetings, and interventions made to divert young people from radicalisation.

134. A culture of learning and continuous professional development is well established and is an area of strength. Social workers and managers report that senior managers actively listen to staff and take action, for example they agreed to a suggestion that pods can use income generated from student placements for team development. The annual learning offer is effectively informed by outputs from annual appraisals, complaints, case audits and serious case reviews. There is evidence of learning, for example training in female genital mutilation has meant that staff are more aware of issues with increased recognition of risk and interventions as a result.

135. The local authority workforce is stable. There are five social work vacancies, but with successful succession planning in place through the council's investment in the Step Up to Social Work initiative, newly qualified social workers currently employed as social work assistants will transfer into these vacancies when their qualifications are confirmed. Seven agency workers are employed over the staffing establishment to cover maternity leave and provide additional capacity in service areas.

136. Social work caseloads are high. This has an impact on the quality of work in some cases. Each pod is responsible for an average of 60 cases. This is approximately 30 children per social worker, with safeguarding pods in their 'duty week' having higher numbers. High caseloads in pods are mitigated by social work assistants who co-work some cases with qualified staff. Workloads are reviewed weekly by strategic managers and fortnightly by the Assistant

Director. Inspectors found that while most social work pods had permanent staff, the practice of frequent secondments had previously meant that some children experienced too many changes of social worker.

137. Although the local authority has increased the establishment of IROs, this has been outstripped by the increase in the looked after children population. Current IRO caseloads are significantly higher than statutory guidance (more than 80 children and more than 20 foster carer reviews). Consequently four of the seven priorities of the 2013–14 IRO action plan, including timely distribution of minutes and dip sampling of reviews to drive up quality, have not been achieved. These issues are long-standing. Stoke-on-Trent was one of the authorities inspected in the Ofsted thematic programme of 2012 that looked at the work of IROs. All of the areas of development identified above were also identified in that inspection. Capacity was identified in 2012 as a barrier to improving IROs' effectiveness. Since then their caseloads have continued to rise as the number of children looked after has risen.

138. The importance of corporate parenting is recognised within the authority. All 44 councillors signed the declaration of corporate parenting following the recent election. While the corporate parenting panel is constituted appropriately, its work and the corporate parenting strategy are underdeveloped. There is a need for a greater focus on care leavers, particularly in relation to their engagement in education, training and employment. The new chair is ambitious for all looked after children and care leavers and is enthusiastic about refocusing and energising the board. The current (2014–16) corporate parenting strategy does not demonstrate the board's priorities and how they will be measured. The accompanying action plan relates to actions largely for completion in March 2014 and needs updating.

139. The local authority's sufficiency strategy for looked after children requires updating in order to be comprehensive. Changes to edge of care arrangements are not reflected and it does not refer to young people in custody, as required by statutory guidance. While the sufficiency strategy is informed by analysis of demographic trends, it under-estimated the continued rise in the numbers of looked after children. It lacks robust evaluation of the range of current services and some targets for improvement in the underpinning action plan are imprecise, making it difficult to measure progress. While changes in the characteristics of the cohort are noted, such as an increase in the number of black and other minority ethnic children placed at home under placement with parent regulations, it does not identify how the needs of these two groups are to be met.

140. Learning from complaints is effective and has resulted in changes in practice and as a result more disputes are being resolved informally without recourse to the complaints procedures. The number of complaints received at Stage 1 has reduced significantly in the last half of 2014–15 when compared with previous quarters. Following targeted intervention in some service areas to improve communication with service users, there has been a dramatic decrease (85 to

58) in the number of complaints received over the past six months. There is a regular presentation at a bi-monthly practice forum to share key messages from complaints.

141. The five key priorities set out by the Children's and Young People's Strategic Partnership are rooted in the joint strategic needs assessment (JSNA) and are closely aligned to the work of the Health and Wellbeing Board and the LSCB, with clear plans and good multi-agency collaboration. The local authority has reviewed the JSNA to ensure greater consistency of approach and to identify gaps.

142. An outcomes-based commissioning framework ensures that commissioners start by asking the question 'what outcome(s) are we trying to achieve?' The JSNA provides a good starting point but commissioners supplement this with specific local research. The views of service users, their families and carers are central to service design. Most recently this has been evidenced through the Commissioning Strategy 2015–18, 'Emotional wellbeing and mental health of children and young people 0–18'. The specialist CAMHS service for looked after children has been decommissioned and the budget has been transferred to mainstream CAMHS from April 2015. Children in care are now prioritised within this mainstream provision, with a target to receive a service within two weeks of referral, although this has not been met in all cases. To supplement this, the local authority is financing additional psychology support and bespoke services commissioned at tier two. Commissioners across health and social care confirmed that joint arrangements between partners are improving. Action is taken by commissioners if providers do not comply with contractual arrangements, for example improving the timeliness of initial health assessments for children in care.

143. Stoke-on-Trent is an active and committed participant in the work of the local Family Justice Board. Relationships with Cafcass and the judiciary are strong and as a result timescales within court proceedings consistently meet or exceed expected targets. There is increasing recognition by members of the Family Justice Board that this does not always lead to achieving permanence for children more quickly. Until recently, due to delays in replacing key members, the board has not met regularly enough to be an effective forum for further improving the quality of work in court proceedings. However, all key personnel are now in post, and the work of the board has been re-energised. As such it is well placed and committed to extend its focus beyond timescales to other areas of improvement.

The Local Safeguarding Children Board

The Local Safeguarding Children Board requires improvement

The arrangements in place to evaluate the effectiveness of what is done by the authority and board partners to safeguard and promote the welfare of children *require improvement*.

An LSCB **requires improvement** if it does not yet demonstrate the characteristics of good.

Executive summary

The Local Safeguarding Children Board (LSCB) is constructed appropriately to deliver its statutory responsibilities. The newly appointed chair has a good knowledge of the local area and a range of partner agencies support the board well. However, a small number of board members do not attend regularly, and there has been little effective challenge to this lack of participation. There are a number of joint working arrangements with Staffordshire LSCB, giving the board a wide strategic overview of services across the two authorities' areas.

The board is active in working across the partnership, as evident through the success of the local early help work. Last year the board's priority areas were domestic abuse, child sexual exploitation and evaluating the impact of services on the outcomes for children and young people.

The board's work in key areas such as partners' understanding of the thresholds for intervention and their application has been more limited. The board has in place guidance on thresholds of need and intervention. Data on contacts and referrals, together with feedback to the board, suggest that thresholds are not consistently understood or applied by all partners, particularly schools and colleges. The board has known of these issues for some time but has not enabled sufficient challenge by them, the local authority or other agencies to gain an understanding of why this may be, in order to support improvement in core services.

The board's business plan for last year and this year's draft plan are not specific or measurable and lack a focus on outcomes. This limits the board's ability to assure itself that services are improving. The annual report does not provide a detailed analysis of the quality of the services for children provided by the partner agencies. A wide range of multi-agency training courses is available. However, it is not subject to a rigorous evaluation of its impact over time in improving services.

Recommendations

144. Ensure that the board's business plan objectives are specific, measurable and linked with identified weaknesses in practice, and that changes made are reviewed to increase the understanding of impact.

145. Review agencies' compliance with the thresholds framework and take steps to improve compliance.

146. Ensure that there is appropriate interrogation of performance data and that this is adequately recorded in the minutes of board and executive meetings so that members have a clear understanding of service weaknesses and strengths.

147. The Board should ensure that its annual reports include a rigorous and transparent analysis of service quality and performance data.

148. Improve the recording and monitoring of challenges made by the board to partner agencies to enable progress to be evaluated.

149. The LSCB should ensure that the effectiveness of training courses in improving practice is evaluated in relation to improving practice and outcomes for children and families.

150. The LSCB chair should challenge those partner agencies that do not regularly attend board meetings to ensure improved engagement with board activity.

Inspection findings

151. The LSCB complies with its statutory responsibilities as defined in Working Together 2015. It is correctly constituted with representation from a range of partner agencies including the voluntary sector. The board lost its one lay member in March 2015 and is now recruiting to this position. Board members are able to commit resources to the work of the board, and to achieving its priorities within their own organisations, due to their senior positions.

152. The new LSCB chair took up post in March 2015 and knows Stoke-on-Trent well as a former senior police commander in the city. He also chairs Staffordshire's LSCB and Adult Safeguarding Partnership Board. The Board benefits from these arrangements through a number of joint working arrangements with Staffordshire such as the Child Sexual Abuse Forum (CSAF) and the child death overview panel (CDOP). This joint working provides a shared understanding and effective use of resources in key areas such as children who go missing and child sexual exploitation. Some of the Board's six sub-committees are jointly arranged with Staffordshire and their chairs come from a range of partner agencies.

153. The independent chair is a member of the Children and Young People's Strategic Partnership Board, the Safer Staffordshire Strategic Board and the

Health and Wellbeing Board. He has well-established links with the chief executive of the council, the chief executive officer, lead members and senior managers. He has a wide brief and will be subject to an annual appraisal completed by the executive director of people.

154. The board has set out a business plan for 2014–15 and a draft plan for 2015–16, both of which include sub-committee business plans and an overarching executive group business plan. These plans are not specific enough, with many objectives lacking clear timescales other than 'ongoing' or 'throughout the year'. Specific reviews of progress are not built into timescales. Impact is often aspirational rather than quantifiable, for example the objective (under the practice sub-committee plan) to bring about positive change to current front-line practice has as its definition of impact 'Children and families will receive a high quality service'. There is no identification in the plans of areas of front-line practice requiring improvement. The business plan does not clearly identify specific issues and weaknesses such as the lack of understanding and application by partners of the thresholds framework and its links to high numbers of social care referrals that lead to no further action. This means that while the board is able to identify major issues such as child sexual exploitation, neglect and the 'toxic trio' as areas for further work, it has not yet ensured that its plans include impact measures.

155. Policies and procedures are up to date and changes are disseminated to staff across all agencies. Practitioners have opportunities to give their views at practice sub-committees and service user feedback is sought. Board minutes demonstrate that policies and procedures are being updated and signed off.

156. The LSCB offers training on 33 topics delivered by over 50 trainers from partner agencies and board members. During 2014–15, 101 training sessions were offered, an increase from the previous year of 89. New courses for this year include safer recruitment, raising awareness in faith groups and working with disguised compliance. There is a broad range of courses relating to the board's priorities in child sexual abuse, neglect and the 'toxic trio'. Overall attendance at LSCB training courses during 2014–15 was similar to the previous year, with 1,949 places taken up and approximately 900 people undertaking e-learning. Some training has been via 'lite bite' three-hour awareness-raising sessions such as those on child sexual exploitation presented to 110 participants. The LSCB monitors attendance at training and takes action where necessary. As a result, attendance by school staff at courses on female genital mutilation has improved significantly, requiring additional courses to meet demand. The Safeguarding Education Development Officer for schools is directly line managed by the LSCB manager, who provides regular supervision and support. This post is funded through the direct schools grant (DSG). In 2014–15 she trained 2,868 school staff in Level 1 safeguarding, provided 'introduction to safeguarding' training to 60 catering staff and 'introduction to safeguarding' training to 52 school governors.

157. While the board offers a wide range of training, it does not always sufficiently consider its impact on practice. Level 1 and 2 safeguarding training is evaluated immediately after delivery and then over time using an online questionnaire. This gives some indication of the effectiveness of training on the levels of skills, knowledge and confidence of practitioners, but does not focus on outcomes. Some courses are not evaluated at all and so their effectiveness cannot be measured. The LSCB has recognised that further work is required to ensure that all courses are evaluated to establish practice impact and change over time.

158. The LSCB has undertaken work in relation to the understanding of thresholds for service among partner agencies. It conducted an online survey in February 2015 on the 'Guide to Levels of Need' threshold document. Responses indicated to the board that a level of uncertainty remains across the partnership about the threshold for children's social care involvement. While the LSCB recognises that more work needs to be done, it has not sufficiently highlighted this area as a significant weakness nor made a clear link with capacity issues in the advice and referral team (ART) in social care. For example, minutes of the performance, monitoring and evaluation sub-committee (February 2015) and the board (March 2015) have noted that there are high contact rates to social care not resulting in a referral. Actions arising as a result (looking at police pathways and referring schools with high referral rates to locality social workers) do not sufficiently address the key issue of whether there is adequate agency understanding of thresholds.

159. The LSCB has been instrumental in improving services for children missing or at risk of child sexual exploitation. The board supported an independent review of child sexual exploitation and missing services in July 2014, helping to develop a joint child sexual exploitation action plan. Stoke-on-Trent and Staffordshire LSCB procedures are available to practitioners and a child sexual exploitation action plan clearly sets out actions for improvement. The Child Sexual Abuse Forum is chaired by the assistant chief constable from Staffordshire police, with membership from the executive group of both Staffordshire and Stoke-on-Trent LSCBs. The scope of this forum covers child sexual exploitation, missing children, trafficking, forced marriage, honour-based violence, intra-familial abuse and youth violence. This work will further enhance the understanding of the board in these key areas. The board receives regular updates regarding the work of the child sexual exploitation panel and work with missing children.

160. The LSCB has been active in raising awareness of child sexual exploitation risks associated with going missing and e-safety. Over 5,000 high school pupils saw a theatre production of Chelsea's Choice in November 2014, and 2,428 primary children saw an ESCAPE theatre production on internet safety. Some child sexual exploitation disclosures ensued, along with a case of online grooming. Briefing sessions on child sexual exploitation (CSE) have been delivered to taxi companies with local authority contracts, CCTV operators and park workers.

161. The LSCB conducts four multi-agency case reviews each year; these identify good practice, learning and poor practice. The performance, monitoring and evaluation sub-committee monitors the resulting action plans. These have included cases where confusion around terminology between 'arranged' and 'forced' marriage resulted in a 15-year-old girl being allowed to leave the country despite a 'marker' being placed against her name. This resulted in clear messages about terminology being disseminated and included in current training. Another case regarding a mother's ability to care for several children highlighted the need for genograms to be used and for weekly updates to health care plans. During the inspection there was evidence that genograms now form an important role in pod case supervision meetings.

162. The LSCB annual report 2014–15 provides an overview of the work of the board. It covers the work of the sub-committees including those for serious case reviews (SCRs) and the child death overview panel (CDOP), and outlines progress against the board's three key strategic priorities of child sexual exploitation, domestic abuse and evaluation of the impact of services on outcomes for children and young people. The report also emphasises work on multi-agency audits and examples of single-agency safeguarding activity.

163. The report does not offer a sufficiently rigorous and transparent assessment of the performance and effectiveness of local services. It does not identify why the positive range of early help services is not reducing the number of referrals to children's social care. Nor does it evaluate the reasons for the rising numbers of children in care, the falling numbers of child protection plans or the effectiveness of private fostering arrangements. While giving a clear picture of partnership working and early help, the report does provide a comprehensive picture of safeguarding in Stoke-on-Trent.

164. There are some examples of partners holding each other to account and challenging practice. A lack of health representation at child protection conferences was taken up with GPs, and challenge about the focus of child protection plans resulted in the form being redesigned and new guidance and training. However, while meeting records show challenge is made, they do not provide the detail of the discussions or what was agreed. The board would benefit from clearer recording of challenge to allow it to track and demonstrate progress over time.

165. The board reports attendance at meetings as high, but a small number of agencies attended only half or fewer meetings during 2014–15 and it is unclear what action the board is taking. Lack of attendance by some partners' means that some agencies are not as engaged as they should be in ensuring that children in Stoke-on-Trent are safeguarded.

166. The work of individual agencies in prioritising safeguarding is monitored through section 11 audits. The joint section 11 audit process was reviewed in 2013–14. Annual audits alternate each year between self-assessment and peer reviews. The audit for 2014–15 identified that more work needs to be done

regarding listening to children and taking account of their wishes and feelings in both assessments and planning. Further work is being undertaken to ensure that staff have appropriate supervision. Individual agency plans set out how improvements are to be made and these are monitored for compliance by the LSCB.

167. The LSCB has a local learning and improvement framework including procedures for SCRs and multi-agency and single-agency learning reviews. Multi-agency review learning meetings are well attended, identifying the purpose of the review, background information, poor practice, where there is good practice and learning arising from the review.

168. Practitioners learn about SCR findings through briefings, the LSCB website and useful documents such as the 'One Minute Guide – learning lessons from SCRs'. Students from a local sixth form college have produced a DVD that captures a child's voice from examples of children's experiences in recent cases subject to SCRs. Practitioners spoken with during the inspection confirmed that they are aware of SCR findings. Two recent SCRs are awaiting publication and lessons have been learnt and action already taken. For example, the CDOP nurse and police have reviewed their rapid response process after delay occurred in offering support to a mother. The learning from recent SCRs and CDOP has informed awareness campaigns about safer sleeping, nappy sacks and blind-cords.

Information about this inspection

Inspectors have looked closely at the experiences of children and young people who have needed or still need help and/or protection. This also includes children and young people who are looked after and young people who are leaving care and starting their lives as young adults.

Inspectors considered the quality of work and the difference adults make to the lives of children, young people and families. They read case files, watched how professional staff work with families and each other and discussed the effectiveness of help and care given to children and young people. Wherever possible, they talked to children, young people and their families. In addition the inspectors have tried to understand what the local authority knows about how well it is performing, how well it is doing and what difference it is making for the people it is trying to help, protect and look after.

The inspection of the local authority was carried out under section 136 of the Education and Inspections Act 2006.

The review of the Local Safeguarding Children Board was carried out under section 15A of the Children Act 2004.

Ofsted produces this report of the inspection of local authority functions and the review of the Local Safeguarding Children Board under its power to combine reports in accordance with section 152 of the Education and Inspections Act 2006.

The inspection team consisted of nine of Her Majesty's Inspectors (HMI) from Ofsted.

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