

Stoke-on-Trent City Council

Inspection of children’s social care services

Inspection dates: 4 to 15 February 2019

Lead inspector: Neil Penswick HMI

Judgement	Grade
The impact of leaders on social work practice with children and families	Inadequate
The experiences and progress of children who need help and protection	Inadequate
The experiences and progress of children in care and care leavers	Inadequate
Overall effectiveness	Inadequate

Children are not being protected, and they experience serious and widespread delays in having their needs met across children’s services. Leaders have not sufficiently understood the extent and impact of the failures and have been ineffective in prioritising, challenging and making improvements. As a result of poor leadership, management oversight and an absence of clearly evaluated performance information, services for children have seriously declined since the last full Ofsted inspection in 2015, and the majority of recommendations made at that inspection and at a focused visit in 2018 have not been actioned.

Vulnerable children are not safeguarded in Stoke-on-Trent. A coherent framework to support the delivery of social work to children and families has not been implemented. Inspectors did meet a considerable number of dedicated and committed social workers. However, they are not being supported to practise safely. No social worker is receiving one-to-one case supervision, and this means that there is little management direction and challenge to their work. Thresholds are not consistently applied by both partner agencies and social work staff. Risk is not robustly managed. Children’s experiences and their views are not at the centre of social work practice. The local authority is not routinely working in partnership with families in securing parental consent to undertake enquiries and assessment and to voluntarily accommodate children.

Permanence planning is absent for many children. Too many children come into care in a crisis or wait too long to be reunited with their families. There are insufficient fostering placements to meet local need and many children are placed in unregulated placements. The local authority knows that some of these placements are unsafe. Support for care leavers is variable, with children reporting positively about their social workers. However, education support is limited, which results in far too many care leavers not being in employment, education and training.

What needs to improve:

- The development and implementation of a coherent framework to support the delivery of social work to children and families.
- Management oversight, direction and challenge, and the holding of regular case supervision.
- The urgency and robustness of the child protection response, including multi-agency attendance at strategy meetings, and child protection conferences, and ensuring contingency in pre-proceedings work.
- The response to risk and application of thresholds to services to help and protect children, including when to seek consent from parents.
- Staffing capacity, including for social workers, IROs, local authority designated officer arrangements and fostering support workers.
- The consideration of children's experiences and views in assessments, planning and complaints.
- The quality of assessments and specific measurable and timely plans, reviewed and enhanced on a regular basis or when circumstances change.
- Learning from complaints, quality assurance, auditing and performance data, including the analysis and distribution of the key lessons to stakeholders in and outside children's services.
- The quality of case recording so that children's progress can be properly tracked.
- The system for tracking children who are missing education.
- Support for vulnerable children, including those at risk from child sexual exploitation, going missing, being homeless, private fostering and extremist ideologies.
- Permanence planning at every point of the child's journey, including the availability of life-story work.
- The implementation of the legal framework in relation to working in partnership with parents. In particular, securing parental consent to undertake enquiries, assessment and to voluntarily accommodate children.
- Sufficiency of placements to meet the needs of all children and care leavers to ensure that unregulated placements are not being used.

- Support for care leavers, including in relation to health histories, personal education plans (PEPS), not in employment, education and training (NEET) and apprenticeships.

The experiences and progress of children who need help and protection is: inadequate

1. Local authority responses for children in need of help and protection in Stoke-on-Trent are inadequate because there are widespread and serious failures which leave children at risk of significant harm.
2. Thresholds for access to children's social care services are not well understood by partner agencies or by local authority staff. In the last three months, local data shows that there have been over 4,500 repeat contacts and re-referrals, which is exceptionally high. Many of these referrals do not meet the thresholds for children's services, and this results in social workers spending too long unnecessarily evaluating information when families could have been better supported by early help services. Where there are no safeguarding concerns, consent for early intervention and for children's social care to gather information is not routinely sought by partner agencies and social workers. This means that contacts and referrals are made to children's social care and then inappropriately actioned without families' knowledge. This limits a full understanding of children's situations and undermines partnership work with families.
3. In other cases, contacts and referrals are being closed inappropriately without full consideration of risk. Where there are clear presenting issues of children being injured and at risk of significant harm, inspectors saw cases which were closed without actions being taken to protect the children. Staff and managers are not appropriately considering previous historical concerns when making decisions about risk. Despite extensive co-locality arrangements with agencies including Staffordshire Police and health services, staff from children's social care do not make best use of the opportunities provided to share information knowledge to inform decision-making. Children's social care staff are working too much in isolation from these other agencies, and this dilutes their ability to fully comprehend the issues and take effective actions to identify children's needs and protect those at risk of harm.
4. Strategy discussions are not effective in coordinating the immediate response to concerns about children who have been identified as being at risk of significant harm. Most strategy discussion records do not include sufficient information from the partner agencies that know the children. The investigating social worker and manager are not routinely at those meetings, resulting in workers being ill prepared when they see children and families, and not knowing all the concerns. In too many cases, this results in children being poorly protected and left in unsafe situations. The vast majority of initial child protection conferences are not attended well enough by partner agencies

to support good-quality decision-making. For instance, the most recent local authority data indicates that less than a quarter of these meetings have been attended by the Staffordshire Police, even when they have had significant previous and current involvement.

5. In the main, the safeguarding locality team social workers have caseloads that are too high, the average being over 25 children. This compromises the ability of social workers to fully carry out their responsibilities. Too many children's assessments do not gather sufficient information and evaluate all of the concerns. They are overly focused on the parents rather than on the impact of their behaviour on the children. This includes when there are concerns about parental domestic abuse, drug and alcohol misuse and mental health issues. Workers are over-optimistic about the ability of parents to change based on limited information. Assessments are not routinely updated when the circumstances alter and plans are ineffective in ensuring that children are protected. Most children's plans are not sufficiently specific about what needs to happen and they lack clarity about the expectations of parents. Core groups and children in need meetings often share information well, but do not effectively challenge the lack of progress. As a result, inspectors saw widespread delays in some children having their needs met. At other times, children's cases were closed too soon without there being improvements in children's situations.
6. When risks to children increase, the public law outline (PLO) pre-proceedings process is not timely or used effectively. When decisions are made to escalate to PLO, all work that could have been done to support children and their families prior to attending a legal gateway meeting has rarely been completed in advance. This work includes, for example, updating assessments or convening family group conferences to explore support and make clear contingency plans. This results in some children remaining in high levels of risk when they should have been removed urgently for their own safety.
7. The response to child sexual exploitation is not sufficiently thorough and coordinated. When there is concern about children at risk of child sexual exploitation, a risk factor matrix is completed that provides a platform for information-sharing at a local authority panel. However, there is a sole focus on the current risk to children and not the wider or historical issues. This results in some children not having all the risks and their needs identified and actioned.
8. There is insufficient capacity to manage the arrangements for responding to allegations about adults in a position of trust or working with children. Up until recently, there was a large backlog of cases (89), and concerted efforts were made to reduce these numbers, although the review has not been sufficiently robust. Immediate actions taken to protect children have been appropriate, although records do not demonstrate sufficient detail about the decision-making. There remain significant deficits in monitoring the progress of

referrals as well as delays in ensuring that other agencies have carried out the agreed tasks to reduce the identified risks.

9. The system for tracking children missing education is inadequate. Checks on children missing education have not been sufficiently thorough and have not been completed in a timely way to ensure that children are safe.
10. Risks to some children who have heightened vulnerabilities are not effectively managed. Children living in private fostering arrangements are not effectively supported. When private fostering situations are identified, children are visited by a social worker and given the opportunity to express their views about where they want to live. However, not all of the appropriate checks are undertaken, and ongoing support is not always provided. Vulnerable 16- to 17-year-old young people who are homeless do not always receive a timely or thorough response to meet their needs. They are not consistently advised of their rights and entitlements, thus their ability to make informed choices about their lives is limited. The response to children and young people who may be at increased risk due to contact with extremist ideology is not robust, and this leads to a failure to identify risks in some highly concerning cases.
11. Some disabled children in need of help and protection support receive a better service and this is supported by the co-location of social care, educational and health professionals.

The experiences and progress of children in care and care leavers is: inadequate

12. There are widespread and serious failures, including unnecessary delays in achieving permanence, which result in the welfare of children in care not being safeguarded and promoted.
13. There has been an increase in the numbers of children in care, from approximately 600 at the time of the last inspection to 850 at the time of this inspection. This has had a seriously negative impact on the capacity of social workers and the sufficiency of placements to ensure that children in care receive a service that meets their needs.
14. Reactive and crisis-driven social work practice results in too many children being placed in care in an unplanned way through urgent actions being taken to protect them by the police and social care. Too many children move placements in a crisis, which is frightening and unsettling for them and not good for their emotional health and well-being.
15. Assessments are generally poor, and rarely updated when children's circumstances or needs change. Plans for children in care and pathway plans for care leavers are also mostly poor. This means that relevant information is

not regularly being analysed to ensure that plans can effectively meet the needs of children and help improve their outcomes.

16. Children are seen regularly, but social workers do not have time to do direct work with children due to having very high caseloads. This includes important life-story work which children need in order to be able to understand their experiences and move on to the next stage of their life.
17. There are serious delays in achieving permanence for many children. There is drift at every step of their journey, both in the pre-proceedings stage and following court proceedings. Permanence in its broadest sense is not secured, for example in relation to placement with parents arrangements, special guardianship orders, long term fostering and adoptions. This means that children live in uncertain and insecure situations for far too long and far too many children remain in care when they do not need to be. The local authority reports that a high number of children do not need to be still in care and that there has been drift in resolving permanence arrangements.
18. There is a widespread lack of understanding and use of s20 of the Children Act 1989 in relation to working in partnership with parents. Only 8% of children in care are accommodated through these arrangements, which is significantly less than the performance of national and similar authorities. Inspectors found children who appeared to have been accommodated without any legal basis, with no documentation and no apparent explanation to their parents of their rights. Some children had been identified as having no one with parental responsibility, and there were decisions taken for this to be resolved to protect the children. However, no further actions had then been taken.
19. For too many children, their journey to adoption is subject to drift and delay. There is no evidence of parallel planning, and permanency workers do not become involved until after a placement order has been granted, resulting in no early family finding. Fostering to adopt is extremely rare, which means that very young children miss out on the opportunity for very early permanence. Poor management oversight and the lack of an effective system that tracks children's journey to permanence contribute to drift and delay.
20. There are not enough foster carers to meet demand. Children are not always placed where their needs can be met due to insufficient choice, and this results in poor matching and children living in placements that are not meeting their needs. Inspectors saw examples of some children who had been in a high number of placements over a short period due to poor planning, and this had impacted negatively on them.
21. Deficits in the fostering service have resulted in a significant number of foster carers and connected carers not having an allocated supervising social worker, and this has led to considerable gaps in supervision and support. There were

too many carers who had not received unannounced visits, which are essential for monitoring safeguarding in placements. Assessments of prospective foster carers and adopters are comprehensive, facilitating the right approvals for children.

22. Too many children in care are placed in unregulated placements, where the suitability of carers has not been fully assessed and approved, or when it is known that they are living in unsafe environments. At the time of the inspection, there were 56 children placed in unregulated settings. Management decisions, oversight and rationale about why these unregulated placements are appropriate and how children's safety will be ensured are missing from all children's case records.
23. Independent reviewing officers are stretched, with very high caseloads. This prevents them from monitoring children's welfare and progressing their plans. Many review records on children's files were either empty or incomplete. There is not currently a formal process for raising concerns about practice. When issues are being raised, these do not always result in a response from managers or improvements being made.
24. When children in care go missing, they receive an inconsistent response to protect them. Records of incidents and return home interviews are not fully evidenced on children's case files. This means activity and intelligence from return home interviews are not always utilised to improve interventions with highly vulnerable children and young people.
25. Social work assistants work with care leavers in Stoke-on-Trent and are valued by them. They demonstrate commitment and understanding of the needs of young people and try hard to stay in touch with all of them. The vast majority of care leavers live in suitable accommodation and those spoken to report feeling safe where they live.
26. Not enough children have their health assessments completed in a timely way. Care leavers are not provided with their health histories, meaning that they will not have the essential information that they will need as they transition into adulthood.
27. Education outcomes for children in care, given their starting points and complex needs, have been mostly positive in comparison to national performance data of children looked after. The quality of personal education plans is variable, though, with a small but significant number of children never having had a plan to steer their education progress. At the age of 17, the rate of those who are NEET is equivalent to the national average. However, for the 19–21 group, this rises, with the result of Stoke-on-Trent having the second highest proportion of NEET in England for this age group. Apprenticeships are low, with only one care leaver currently employed by the council on this basis.

The impact of leaders on social work practice with children and families is: inadequate

28. Leaders and managers in Stoke-on-Trent have failed on the most basic of levels to ensure that children are safeguarded, protected and that their permanence is secured. A framework for supporting the delivery of social work is largely absent and statutory responsibilities are not met. There has been a corporate failure to address the serious and widespread failures identified during this inspection and to prioritise, challenge and make the improvements identified previously.
29. A new interim Director of Children's Services started on the first day of this inspection. He agreed with the findings of the inspectors and committed, with the City Director (chief executive of the council), to address the issues with urgency. As a result of the inspection findings, he has been in conversation with council members and other local authorities to assist in the extensive work needed for a wholesale review of service provision. An existing action plan failed to cover the majority of issues identified at this inspection, did not prioritise issues and did not place the experience of children at the centre of the necessary improvements.
30. The last full inspection was in August 2015. All of the judgements were requires improvements to be good, with adoption judged to be good. Since then, there has been a serious decline in all of the services. Most of the recommendations made at the previous full inspection in 2015 and the majority of areas for improvement identified in a focused visit in April 2018 have not been actioned.
31. Prior to this inspection, leaders and managers had failed to recognise and manage risk at every level of the organisation. They have had an over-optimistic view of their services, which was not supported by the evidence of poor and deteriorating services at all stages of the child's journey. Decision-making has been inconsistent and ineffective, resulting in widespread drift and delay and children remaining in situations of serious harm and staying in care unnecessarily.
32. Children's services managers have shown some recent understanding of some of the deficits of the services, but have not evaluated what this means for children and families. Inspectors found that children's experiences are not at the forefront of planning individually, operationally and strategically. There is little knowledge and understanding of what the daily lives are like for the most vulnerable children and young people in Stoke-on Trent. Their views are also not well considered. This is a serious gap for an organisation aiming to focus on promoting the welfare and safety of children.
33. The managers have been too slow to share their findings and concerns, and have not been sufficiently transparent about the issues, with the council

members and with partner agencies, to enable them to address immediate and longer-term issues. There was no evidence that the significant concerns about practice were being shared with the Safeguarding Children Board and Corporate Parenting Board or evidence of any challenge provided by board members to the widespread and serious failures.

34. Two models of social work practice have been introduced, but neither are fully embedded. No social worker is receiving one-to-one case supervision from a manager, with the result that there has been little case direction, prioritisation and challenge across children's services. Social workers identify the actions they need to take and prioritise their own work. For some, this results in appropriate actions being taken, but for many this results in significant issues not being addressed. This results in a lack of progress of plans, and in children remaining in unsafe environments. Inspectors did meet a considerable number of dedicated and committed social workers. However, they were not being supported to practise safely within a framework that supports good social work.
35. There are significant capacity issues. Social work staff, including social workers, newly qualified workers and IROs, have too high caseloads. This impacts negatively on their ability to carry out core social work tasks. Children who met with inspectors commented negatively about their experience of seeing many different social workers, which prevents them from building a relationship with someone they can trust.
36. Recording is very poor, with key documents missing on some children's electronic files, including children in care reviews. This does not facilitate management oversight or quality assurance effectively. Children and young people who request to see their records will not be able to read about their experiences or understand the reasons for decisions being made about their lives.
37. Auditing has recently been introduced, but not enough has been done to enable the authority to understand the quality of frontline practice. The vast majority of audits seen by inspectors were very poor, lacking an understanding of risk and failing to identify learning to improve practice.
38. Performance data is not comprehensive and does not provide sufficient information to aid managers in carrying out their daily tasks. The analysis and scrutiny of the data is limited and that which is provided to council members is insufficient in allowing an understanding of performance and the impact of practice on children.
39. The annual complaints report is part of a corporate document and does not meet the national guidance for children's services or identify themes and learning. The complaints process does not sufficiently support children and young people to raise issues about their care.



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