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Dear Sarah Parker

Monitoring visit of Stoke-on-Trent children's services

This letter summarises the findings of the monitoring visit to Stoke-on-Trent children's services on 27 February 2020. The visit was the second monitoring visit since the local authority was judged inadequate in March 2019. The inspectors were Peter McEntee, Her Majesty's Inspector, and Andrew Waugh, Her Majesty's Inspector.

Areas covered by the visit

During the course of this visit, inspectors reviewed the progress made in the re-design of service provision, progress of the local authority's improvement plan, whether services and practice quality has improved as a result and whether a trajectory for sustained change is in place.

Inspectors looked at the local authority's practice in assessing the needs of children and families and the quality and effectiveness of practice and planning for children in need.

The visit considered a range of evidence, including electronic case records, supervision files and notes, observation of social workers and senior practitioners undertaking assessments and working with children in need cases, as well as other information provided by staff and managers. In addition, we spoke to a range of staff, including managers, social workers and other practitioners.

Overview

The local authority's lack of progress in improving the quality of social work practice means that local authority leaders cannot be assured that children in Stoke-on-Trent are safe. Risk to children is not consistently identified and acted on. The quality of

social work assessments and children in need planning is poor. This leads to delays in ensuring that children have the right plans to meet their needs and results in plans that are difficult for parents to understand. Casework audits undertaken by managers are overly optimistic in their grading of practice standards, and this does not provide a realistic base to support improvement. In some individual cases, social workers seek and listen to children's views, and their work is making a positive difference to children's experiences. Progress has been made in reducing numbers of unallocated cases, in improving timeliness in completing assessments and in reducing social workers' caseloads.

The local authority's overarching improvement plan does not yet provide clear measures of what progress has been made, and, as a result, its effectiveness is limited.

Findings and evaluation of progress

Social workers and team managers do not consistently identify when children are subject to risk, and, in too many cases, they fail to act to manage or minimise risk when it is identified. This includes failing to recognise that the threshold to convene a strategy meeting and/or to instigate a child protection investigation has been met. In these situations, children are left at risk without the protection of planned multi-agency intervention. After being asked to review these cases, the local authority agreed that in some instances it had not identified these issues. They agreed that strategy meetings and child protection investigations should have been held, and took appropriate remedial action.

The quality of assessments of children's need is too variable. A majority of assessments seen do not fully consider patterns of previous referrals, and information from partner agencies is not always taken into account. These assessments are overly focused on presenting concerns, and, as a result, they fail to provide a complete picture of events and their impact on children. In a number of cases where risk to children is identified, this is not subject to specific assessment activity and is not analysed. Recommendations and plans do not always address children's core needs, and this means that risks to their safety and well-being are not effectively managed or minimised. In better quality assessments, social workers understand the child's history, and their analysis of need evidences an understanding of wider concerns. These assessments are explicit about what needs to change and provide a good rationale for the recommendations made.

Direct work with children is evident in many cases, with social workers clearly striving to understand and hear children's experiences. Some work demonstrates that social work staff are making a positive difference to children's lives, which ensures improved outcomes.

Children in need plans are almost uniformly poor, and there are no timescales for actions to be completed. This makes it extremely difficult to determine the pace of progress. In many cases, plans are overly focused on the needs of parents, and

there is little connection between the actions required of parents and their impact on children. This makes it problematic for parents to see why actions are necessary and how their children will benefit as a result. In some plans, it is difficult to see what a parent needs to do to successfully respond to initial concerns and bring intervention to an end.

Clear 'bottom lines' and contingency plans are identified in case planning, but in some cases when they are breached, this is ignored by social workers and managers. This lack of action means that plans are not fully effective and, in a few cases, it results in an escalation of risk not being addressed. A system of scaling to determine levels of risk is poorly understood by social workers. Similar risks are not being scaled or weighted consistently. Scaling that indicates escalating or high levels of risk does not always result in an appropriate change or an update of a child's plan.

A quality assurance framework is in place, but senior leaders have yet to ensure that team managers undertaking casework audits make consistent and reliable judgements about the quality of practice. Moderation of audits is undertaken by another local authority, and during this visit both senior leaders from Stoke and moderators reviewed audits of cases chosen by inspectors. The vast majority were downgraded and rated as inadequate. This demonstrates that team managers do not yet understand what good social work practice looks like. At present, only half of all audits are subject to external moderation, and this partially accurate view of practice standards seriously limits the ability of senior leaders to understand the depth or scale of poor practice. In an effort to address these issues, the local authority has now begun a programme of back-to-basics training for both social work staff and managers, and this is a positive step.

Management oversight and supervision of cases is weak. Plans are often signed off with little constructive comment or guidance about how to improve quality. Supervision, while regular, is rarely reflective and the way that it is presently recorded does not provide a point of reference or learning for staff.

Following concerns identified at the first monitoring visit, an updated improvement plan is now more clearly focused on the right priorities. It remains the case that it does not support leaders and managers to see clearly what progress has been made. Senior leaders acknowledge this, and further work is to be done to ensure greater transparency and effectiveness.

The joint threshold document between Stoke and Staffordshire has been revised in light of concerns identified at the last monitoring visit. Some concerns have been addressed. However, while the document is clearer about boundaries between levels of need, it still does not focus enough on the needs of Stoke-on-Trent. In particular, there is no recognition that those who are uncertain about responses to risk factors need clear management guidance in order to accurately determine the correct response route for referrals.

Significant financial investment by the council that is used to employ a range of temporary staffing measures has successfully reduced the numbers of unallocated cases and out of time assessments. These arrangements are due to end shortly, meaning that the sustainability of this success is dependent on a current recruitment campaign to appoint permanent senior managers and social workers.

I am copying this letter to the Department for Education. This letter will be published on the Ofsted website.

Yours sincerely

Peter McEntee
Her Majesty's Inspector