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Dear Mr White

Focused visit to Stoke-on-Trent children's services

This letter summarises the findings of the focused visit to Stoke-on-Trent children's services on 1 and 2 October 2024. His Majesty's Inspectors for this visit were Rebekah Tucker and Margaret Burke.

Inspectors looked at the local authority's arrangements for children in need or subject to a protection plan and the assessment and support of private fostering arrangements.

This visit was carried out in line with the inspection of local authority children's services (ILACS) framework. Inspectors considered a range of evidence, including children's records and discussions with social workers about their work with children. Inspectors also reviewed the local authority's quality assurance and performance management information.

Headline findings

This was the second focused visit since the full inspection of children's services in November 2022, where the quality and effectiveness of child in need and child protection plans, and the assessment of private fostering arrangements, were identified as two of the areas for improvement.

Since the last focused visit in November 2023, a new senior leadership team has been appointed. It has initiated a transformation project that has aligned the front door more closely with the assessment teams, and restructured children's services, to provide opportunity for additional strategic management capacity. It is too soon to see the impact of these changes for children and families. However, some progress has been seen in the quality of child protection and child in need assessments and plans, and private fostering arrangements. Despite these improvements, there is still some variability in the quality of practice. For some children, their needs are well met, risk is recognised and responded to appropriately and they make good

progress. For other children, there is limited management oversight and their plans do not progress in a timely manner, or they end too quickly.

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

- The frequency of visits to children on child protection plans, ensuring that, where appropriate, children are seen alone.
- The quality of management oversight of children on long-term and multiple child protection plans.
- The quality and frequency of supervision.
- The quality and impact of the audit function on practice improvement and the level of quality assurance activity undertaken.

Main findings

Services for children are a high priority for the interim corporate director of children's services and his newly formed permanent senior leadership team. Political support is strong, and significant financial investment has supported a recent transformation of children's services. A clear strategic improvement plan, and ongoing work with an improvement adviser, have galvanised leaders' ambition for children and families. Although the experienced senior leadership team brings a degree of recent stability through ongoing review, oversight and governance of children's services, it is too soon to see the impact of this new strategic alliance.

Most children receive support and protection in accordance with their level of need and risk, with thresholds applied appropriately. When children's needs change, and their cases 'step up' or 'step down' between child protection planning and child in need support, the quality and impact of practice and oversight are variable. For some children, plans have been closed too quickly, without adequate assessment of ongoing risks and appropriate support services being in place, resulting in repeat interventions over sustained periods. For other children, when risks increase, child in need plans are escalated in a timely manner to child protection. They are informed by comprehensive assessments and multi-agency decision-making and capture the voice of children well, to drive their plans forward.

Most assessments are timely and comprehensive, with a clear evaluation of strengths and risk. For the majority of children, the impact of family history is considered, and the views of children and adults are threaded throughout the assessment. The impact of circumstance and risk on siblings living outside of the household is also appropriately appraised. Information gathered from partners contributes to a clear analysis of risk and need. Most outcomes of assessments lead to plans that are child-focused and enable parents to understand what needs to change. For a small number of children, multiple assessments have been completed within a short time frame. Ineffective management of plans and premature closure of their cases, before all needs and associated risks have been met, have resulted in these children and their families having multiple social work interventions.

Children's plans are mostly comprehensive, with clear actions to help parents to meet their children's needs. Most plans consider children's needs well and include wishes and feelings, which bring the child to life. Although plans include contingency arrangements, there is inconsistency in their quality, with some not fully considering the impact of familial history on the effectiveness of any contingency plan. Safety plans are clear in their expectations and are written in a language that is easy for families to understand. For most children, plans result in services and support to families that make a positive difference and improve children's outcomes.

A very small number of children have been subject to four or more child protection plans in their lives. Plans for these children have not been driven forward due to poor social work practice, ineffective planning, an absence of challenge through the child protection procedures and inconsistent management oversight and supervision. This means that a very small number of children and their families have been exposed to continued risk and repeat social work interventions throughout their lives. For some, this has been for all of their lives. This does not align with the local authority's relational practice model. Senior leaders were not aware of these issues, for this very small number of children, at the time of the visit. However, they took immediate remedial action to review all of their records while inspectors were on site.

Social workers mostly understand the needs of their children and have developed positive relationships with them and their carers. Some children, however, on child protection plans are not being seen within statutory time frames and other children are not being seen alone. Direct work is not routinely completed with most children, which means that not all children's lived experiences are captured and fully understood by workers.

Although most core groups are held regularly, there is variability in attendance by partners. For some children, partners review children's needs and ensure that plans are progressed to help to reduce risks. However, for other children, core groups are simply being held with the parent, in the absence of valid participation from other agencies. Most review child protection conferences and child in need meetings are well attended by partners, who contribute to agreed outcomes, with regular review of the plan. While family members are present in most meetings, the attendance of fathers is often less frequent. There is variability in the effectiveness of conference chairs to robustly manage children's plans, and to provide appropriate challenge in review meetings. While the caseloads of the conference chairs have reduced in the last six months, senior leaders have confirmed this remains an area of ongoing service improvement, with more work to do to ensure timely progression of children's plans.

When children's lives are not improving, there is variability in the quality and timeliness of decisions to escalate into pre-proceedings under the Public Law Outline (PLO). While, for some children, PLO is used well and the process rightly focuses on what needs to change and what support is in place, for other children there has been a lack of progress in their plans when in PLO. Outstanding assessments and changes

in social worker and team manager have introduced drift and delay, and for some children it is unclear why PLO has ended, in the absence of sustained change.

Children who live in private fostering arrangements have their needs met. Assessments of the child and of the carers are timely and appropriately detailed, capturing children's wishes. This ensures that children's experiences and carers' capacity to respond to the needs of children are appropriately explored. Children are supported to maintain regular contact with their parents. Child in need meetings include the parents, carers and education staff. Visits by the social worker to children are timely and all necessary safeguarding checks for adults over 16 are undertaken.

There is variability in the frequency and quality of supervision. Although social workers report that supervision supports them to reflect on their practice and offers challenge where appropriate, for some social workers, supervision was seen to be irregular, descriptive and lacking critical reflection. While actions set within supervision are timebound, for most they are process led and do not consider the quality and impact of social work practice for children and families.

Although some social workers' caseloads were high, staff told inspectors their workload was manageable. Senior leaders have a good understanding of caseloads, tracking against projected demands in service throughout the year, and how this may impact on staff. While social workers feel well supported by team managers and have access to a range of training opportunities, not all workers were able to demonstrate they had received regular training.

Senior leaders have acknowledged the high vacancy rates and reliance on agency workers within the service, for case holding social worker posts. This presents a challenge to performance, the quality of practice and outcomes for children. Leaders have plans in place to strengthen ongoing recruitment and retention, including the 'grow your own' social work scheme, the social work degree apprenticeship programme, 'step up to social work' and an increase in the social work remuneration package. It is too soon, however, to see the impact of this, and too late for some children who have had multiple changes in social worker.

The quality assurance framework does not provide managers and senior leaders with a line of sight on practice. The level of audit activity in the service is low and the quality of the audits completed does not consistently deliver improvements in practice. There is an absence of moderation, reflective reviews, consultations with young people or their families and variable collaboration with practitioners. As such, the audit process is not sufficiently effective at closing the loop to evidence practice learning. Senior leaders have acknowledged these shortfalls and have a plan to increase the number of audits being completed and the introduction of moderation, with the new management structure supporting this. The new plans and initiatives have yet to take full hold, and it is too soon to see the impact for children, families, practitioners and the local authority. Senior leaders know the pace of improvement needs to accelerate, with more work to do in this area.

Social workers report that senior managers are visible and accessible. Staff said that they enjoy working for Stoke-on-Trent Council and told inspectors that they have a loyalty to the local authority. They describe the positives of working for the Council and of a supportive service culture and managers. An interim corporate director of children's services has taken up post in the last nine months and has expressed a commitment to ensuring that the necessary improvements are understood and actioned by his new senior leadership team, while his position is permanently recruited to.

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

Yours sincerely

Rebekah Tucker
His Majesty's Inspector