Inspection of Stockport local authority children's services

Inspection dates: 12 to 23 May 2025

Lead inspector: Lisa Summers, His Majesty's Inspector

Judgement	**Grade**
The impact of leaders on social work practice with children and families	Requires improvement to be good
The experiences and progress of children who need help and protection	Requires improvement to be good
The experiences and progress of children in care	Requires improvement to be good
The experiences and progress of care leavers	Good
Overall effectiveness	Requires improvement to be good

Since the last inspection in March 2022, when services for children were judged to be good, there has been a continued rise in the demand for children's services, including an increase in complexity. Leaders were not sufficiently sighted on the impact this was having, leading to a deterioration in the quality and impact of support both for children who need help and protection and for those in care. For some children, there are delays in the screening of concerns in the multi-agency safeguarding and support hub (MASSH) and, for some children, there are delays in holding strategy discussions. Most child in need and child protection plans are not sufficiently targeted on the underlying causes of parental behaviours that adversely affect children. Although plans are regularly reviewed, there is insufficient focus on the impact of interventions for children. This means that there are delays in taking more assertive action for some children, including bringing children into care at the right time. Permanence is not secured soon enough for some children because of ineffective management direction and independent reviewing officer (IRO) challenge to help social workers drive planning for children in care.

It became clear across the course of the inspection that leaders were aware of the areas for improvement prior to the inspection. Plans to address several of these areas were appropriately focused to address the deterioration in practice but were

not sufficiently progressed to bring about the necessary change in a timely way. Practice weaknesses identified at a focused visit in February 2024 and two internal reviews this year have not been addressed effectively.

Despite these challenges, targeted and focused work in specific areas has led to several aspects of strong practice for some children and young people. Financial investment has preserved and expanded an array of early help and targeted support services for children, including those experiencing domestic abuse or exploitation. Leaders have ensured strong and effective support for foster carers and adopters and have developed a responsive and effective service for care leavers.

What needs to improve?

- The timeliness and monitoring of management decision-making in the MASSH, for strategy discussions, in decisions for children to come into care and securing permanence for children in care. (Outcome one, National Framework)
- The quality of planning to address risk and need for children. (Outcome one, National Framework)
- The effectiveness of practitioners' responses to neglect, domestic abuse, children living in private fostering arrangements and 16- and 17-year-olds who present as homeless. (Outcome three, National Framework)
- The quality of visits and direct work with children, including completing life-story work for children in care. (Outcome two, National Framework)
- The quality of supervision for social workers and personal advisors so that it is reflective and challenging, considers children and care leavers' circumstances and provides appropriate direction. (Enabler two, National Framework)
- The quality of management oversight to ensure that frontline practice is robustly scrutinised in a timely manner. (Enabler two, National Framework)

The experiences and progress of children who need help and protection: requires improvement to be good

1. Children and families benefit from a range of early help support. Skilled early help workers engage well with children to understand their experiences, mostly through the use of creative direct work. Assessments are thorough and detailed, consider children's histories and are informed by multi-agency information. Subsequent plans are targeted to help meet the diverse needs of families. This is helping to prevent concerns from escalating for many children.

2. There are delays in the screening of concerns for some children in the MASSH. Once decisions are made, they are usually well informed and proportionate to support the application of thresholds. Although managers oversee all referrals, providing social workers with guidance to inform screening, there are delays in processing contacts, in gathering additional information or in managers' final

decision-making for some children. There is insufficient management oversight during these periods. This is leaving some children without the necessary support they may need during these critical times. Leaders took immediate action to address these shortfalls during the inspection.

3. There is a robust response to concerns for children outside of normal office hours. The service swiftly responds to concerns and appropriate protective action is taken, with prompt sharing of information to daytime services to follow up concerns.

4. Strategy discussions are not always timely. This is sometimes because of insufficient police availability. When strategy discussions are delayed, there are usually agreed plans to manage the child's immediate safety, but this is without the benefit of all risks being explored. When discussions take place, meetings are well attended, supporting multi-agency information-sharing to inform decisions to progress to child protection enquiries. Most meetings do not conclude with an agreement about what multi-agency actions are needed to protect children during the enquiry period. This means that children do not always benefit from robust, multi-agency plans to keep them safe during this time.

5. Most assessments of children's needs are strong. These are thorough, evaluate children's histories well and are informed by multi-agency partner information. Children's voices are captured effectively, and assessments consider children's identity and cultural needs. In a small number of weaker assessments, there is too much focus on the presenting concerns, impairing social workers' ability to understand both cumulative harm and children's broader needs. As a result, some children experience repeated concerns and further assessments as their needs have not been met at the earliest opportunity.

6. Leaders have taken recent action to understand and address the increase in children experiencing delays to progress to initial child protection conferences (ICPCs), and this is very recently starting to show some improvement. They have acknowledged that there is insufficient management oversight during this critical period, which means that for some children, their safety and well-being are not clearly planned for.

7. Most plans are weak despite an understanding of children's needs through assessments. Some plans are too adult focused or do not reflect the breadth of work being delivered that is improving children's circumstances. Plans are often a list of tasks, such as referrals to be made or appointments to be attended by parents. Plans are regularly reviewed through well-attended multi-agency core groups and team around the child meetings. This has led to some children benefiting from tailored support through a range of resources and diverse expertise. The progress of plans is mostly tracked for compliance or parental engagement, with insufficient focus on the impact of the plan on children's lives. As a result, timely assertive action is not always taken when children's

circumstances do not improve, and some children step down from child protection planning too soon.

8. Some children experience episodic social care interventions that span significant periods of their life without change being sustained or decisive action being taken. This is because planning is not always effective in sustaining parental change as underlying issues are not always addressed.

9. Leaders recognised that the number of children who are experiencing repeated periods of child protection planning is high, and they have recently implemented multi-agency reflective discussions to help practitioners think about how to develop more effective plans and better support families to reduce risk in the longer term. It is too soon to see the impact of this for children.

10. The response to domestic abuse is inconsistent. Some social workers do not understand the complexities relating to coercive control and fear. As a result, safety planning sometimes relies on victims to protect their children from the people who have abused them. Where the specialist domestic abuse team is co-working with vulnerable families, the response to risk and safety planning is stronger.

11. Children continue to receive an inconsistent approach to neglect. Stockport has refreshed its neglect strategy to include a range of tools to help professionals to understand neglect and the impact it has on children. These tools are not consistently used, making it difficult to understand the impact or to measure improvements in children's lives.

12. The quality and impact of social work practice are stronger for disabled children. Safeguarding is considered well in most assessments and plans. Knowledgeable social workers build strong relationships with children through creative approaches that support an understanding of their experiences.

13. There is an impressive range of services that deliver targeted support to families, including a dedicated family group conferencing team, a specialist domestic abuse team, edge of care provision and trauma-informed parenting support. Interventions are targeted to individual needs. Most children are receiving the right help to improve family relationships, and if it is safe to do so, remain living within their family networks. These services are delivering some impactful work, which is improving children's experiences.

14. Many children benefit from long-standing relationships with social workers. Although most children are seen regularly, direct work is inconsistent. When this is stronger, work is purposeful and creative, enabling children to share their worries, fears, wishes and feelings. In weaker work, visits lack purpose and are not used to test the impact of the child's plan.

15. Stockport has a robust, well-coordinated multi-agency approach to help children at risk of sexual and criminal exploitation through the Aspire service.

This service provides strong and effective support to children who are at risk due to exploitation. Assessments are comprehensive, regularly updated and include safety planning that is completed alongside parents and children. Skilled workers work with the locality teams to support, prevent and disrupt exploitation, and their involvement is making a difference. This is helping children understand the risks of exploitation and supports them to move away from harmful situations.

16. Most children who go missing from home and care receive an appropriate response. Missing-from-home officers engage with children well and understand children's circumstances and what actions are needed to reduce incidents of them going missing in the future.

17. Some children with specific vulnerabilities receive a poor service. Children aged 16 and 17 who present as homeless are not having their needs assessed through a joint housing and social care assessment. For children living in private fostering arrangements, police and Disclosure and Barring Service checks are not always completed to understand if homes are safe for children. These children's needs are assessed, supported and visited frequently.

18. When children escalate into pre-proceedings, effective senior management oversight ensures that there is little drift and delay for them and that appropriate decisions are made to protect them from harm. Regular meetings chaired by service leads ensure that progress is measured and plans progress. Impactful work is enabling some children to step out of pre-proceedings appropriately and successfully. When concerns about children are not reducing during a period of pre-proceedings intervention, children's cases are stepped up into care proceedings at an appropriate time.

19. There are appropriate mechanisms to track children who are missing from education and to check on their welfare.

20. Allegations of harm against people who work with children are robustly responded to. Action is swift and proportionate, and this is helping children to receive appropriate help and protection.

The experiences and progress of children in care: requires improvement to be good

21. Some children do not enter care at a time that is right for them. For these children, decision-making is incident led, leading to unplanned emergency admissions, as timely action has not been taken to address cumulative harm. This is leaving some children in harmful situations for too long.

22. The quality of social work practice with children who are the subject of ongoing family court proceedings is strong and timely. The work of the Family Drug and Alcohol Court is particularly impactful for children. This means children do not

experience unnecessary delays in their plans progressing while there is court oversight and involvement in their lives.

23. Social workers routinely consider placing children with kinship carers, and as a result, many children continue to live successfully within their friends and family network when they come into care. Sibling assessments are routinely completed and give careful consideration to children living with their brothers and sisters when it is in children's best interests to do so.

24. Social workers know their children well, visiting them regularly, and they build enduring and trusted relationships with the children they work with. Children told inspectors how important these relationships are to them. Social work visits vary in quality. Some are detailed, and social workers hold sensitive conversations with children about their feelings, while others are brief and perfunctory to ensure that children are seen in the required timescales. Not all children benefit from life-story work. When this is completed, this is of a high quality.

25. The quality of children's care plans is inconsistent. Some written plans are appropriately detailed and clear about how children's needs will be met. This includes the necessary support to ensure that children's well-being and ongoing development are responded to effectively. Weaker plans are not specific enough about who needs to complete what actions and by when. There is insufficient focus on planning for children's futures, including securing permanence.

26. Some children experience delays in achieving long-term permanence. This includes some children who are placed with their parents and continue to be the subject of care orders longer than is necessary. It also includes children who are living with kinship carers who could be the subject of special guardianship orders and children who are living in Section 20 arrangements who could return to their parents. This delay leaves children subject to unnecessary and intrusive statutory interventions. For other children, the long-term matching of children in long-term foster care is not consistently prioritised.

27. Review meetings do not sufficiently focus on progressing children's plans. Most meetings are regular and usually well attended, and children are encouraged to attend and contribute to their planning. However, longer term plans for permanence for children are not always clearly set out in meetings and plans. The lack of effective and supportive challenge from IROs and managers means that delays in progressing children's plans are not addressed and resolved effectively. As a result, some children become unsettled in their placements because they are unsure where their future lies.

28. Family time is carefully considered and reviewed in line with children's assessed needs. This includes any risks that time with family members may pose. Children's wishes and feelings are carefully considered when decisions are made about the time they spend with their family members. Relevant family

members are not routinely involved in devising care plans for children who are not living in kinship arrangements.

29. Children have their health needs well met. Children are routinely registered with GPs, dentists and opticians and have regular health assessments and dental check-ups. Any needs arising from children's emotional well-being or trauma they have experienced are quickly identified, and prompt support is delivered through the co-located emotional well-being team.

30. The virtual school has a detailed oversight of the educational progress of children in care. The quality of personal education plans (PEPs) has improved since the last inspection. Quality assurance mechanisms identify weaker plans, and action is taken to improve these. Children who are not accessing full-time education are tracked and supported so that the education delivered is as suitable as possible.

31. Leaders recognise the importance of children continuing to live near their communities. An impressive and effective sufficiency strategy has led to the creation of a range and breadth of available local placements. At the time of this inspection, no children were living in unregistered children's homes. Most children in care live in homes that meet their needs and provide the love and stability children need as they grow up. Children enjoy all the aspects of family life and are supported to take part in a range of activities that help them to build their confidence and skills and enable them to connect with peers and the wider community.

32. If placements become fragile, there is a prompt and well-coordinated response from the child's social worker and the fostering team. There is an array of resources that are used in supporting children and their foster placements, including the emotional well-being team and the carers within the extended family hub model. This is helping to prevent some placements from breaking down.

33. Since the last inspection, scrutiny and oversight of the fostering service has improved. The fostering panel has high expectations, which has helped to improve standards. The addition of an IRO has enabled an additional layer of scrutiny and accountability. Foster carer assessments are robust. Carers told inspectors how much they enjoyed the assessment process and the training they received, which helps to prepare them for their initial year as carers. A significant number of fostering households benefit from the well-established family hub model, and the skilled fostering team offers 'excellent' support to foster carers.

34. Adoption work is mostly strong, and the right decisions are being made for children without unnecessary delay. The adoption service is managed through the well-established regional adoption agency (Adoption Counts). The service continues to innovate and explore different ways to ensure that adopters can meet the needs of children who require adoptive families. Adopters have

positive experiences of the assessment process, and reports are thorough. Most children are swiftly matched with their new families. Adoption support services are robust, with dedicated multi-disciplinary professionals available to support the stability of children's families.

The experiences and progress of care leavers: good

35. Most care leavers live in homes that are safe and suitable, with transitions into independent tenancies completed at a pace that is right for them. They are offered a range of support in line with the local authority's 'staying close' arrangements. This is providing an additional layer of support for care leavers. Young people are encouraged to remain with their foster carers in 'staying put' arrangements.

36. The quality of transition planning for children as they approach adulthood is inconsistent. Pathway plans for children are not always up to date, and plans do not outline what is needed to support children as they move into adulthood. Personal advisors (PAs) are not always introduced to children as soon as the local authority would like. This means that planning for some children is not always robust or challenged, and this leaves some children uncertain about what will happen to them once they turn 18. Leaders have recognised this and have recently increased the number of PAs.

37. Once PAs are allocated, they are tenacious in building relationships with young people, and there is regular contact. They take time to understand young people's history and the impact of the trauma they have experienced as children. They demonstrate care and compassion in the support they offer. Advisers are responsive to the changing needs of young people, increasing visiting frequency when needed.

38. Most pathways plans are thorough, detailed and completed collaboratively with young people. Their wishes and ambitions are clear, and young people are helped to achieve these. Plans are independently reviewed through multi-agency review meetings, chaired by a dedicated IRO. The IRO is supporting information-sharing between all relevant parties, including young people, and additional actions are identified appropriately. This process ensures that planning is responsive to the changing needs of care leavers.

39. PAs help young people to maintain relationships with their families, and 'lifelong links' work is building long-term networks of support for young people. Advisers help young people to develop appropriate and supportive relationships with their peers and nurture developing friendships. Young people have helped to design the recently opened care leavers hub that provides a focal point to deliver support and social opportunities.

40. Risks that young people face are usually recognised, and the response is mostly prompt and effective. This includes risks from domestic abuse, exploitation and social isolation. If young people go into custody, they continue to receive

regular visits from their PAs, who make appropriate plans in preparation for their release. A very small number of young parents do not always get the help they need to develop their parenting skills safely.

41. Young people are well supported with their physical, emotional and mental health needs. PAs ensure that young people are registered with a GP and support them to access dental care. In addition, young people benefit from a breadth of additional services, including an alcohol support service and a dedicated health and well-being team. This means that there are no delays in young people receiving the help they need.

42. Young people benefit from effective support to access education, employment and training (EET). Leaders have responded to the recent reduction in the number of 17- and 18-year-olds who are in EET, and the virtual school has developed new pathways to match young people's interests. The council has secured access to local apprenticeships and employment opportunities, capitalising on their strong relationships with local businesses. Advisers are skilled at understanding young people's aspirations and are systematically helping them to achieve these.

43. Stockport has developed a comprehensive and accessible local offer. Young people are aware of this and understand their entitlements. Even when they have accessed their full entitlements, young people still receive additional financial support, when necessary, in accordance with their needs.

44. There are a significant number of care leavers aged 21 and above who continue to receive strong and effective support. During difficult periods, older care leavers reach out and get the help they need. For those care leavers wanting this ongoing support, the leaving care team regularly reminds them that they can access support if needed.

The impact of leaders on social work practice with children and families: requires improvement to be good

45. Leaders have a broad understanding of the quality and impact of practice for children and young people in Stockport. Although associated plans have been created to improve services for children, it is too soon to see the impact of this work in some areas.

46. Management oversight and challenge is weak in some key areas of front-line practice. The tracking of permanence for children in care is under-developed. Children living in private fostering arrangements and those aged 16 and 17 years old who present as homeless are not monitored by senior managers. There is an over-optimism from many managers and leaders that work with children is progressing, without sufficient evidence, which is too often regarded as a recording issue.

47. There has been a lack of pace in addressing some known practice shortfalls effectively. A focused visit in February 2024 identified inconsistencies in core elements of social work practice for children in need of help and protection and those at risk of neglect. Recent targeted activity by the improvement team also identified delays in the MASSH, in strategy discussions and in achieving permanence for some children. Appropriate plans are in place, but these are not swiftly progressed or monitored for effectiveness. For example, leaders increased staffing in the MASSH prior to this inspection, but the impact has not been tested. In response to the findings of this inspection, leaders took immediate actions to further strengthen management oversight of the MASSH, and more timely remedial activity is now planned to address the remaining shortfalls. A neglect strategy will be launched imminently, but leaders acknowledge that this has taken too long to progress.

48. Recently strengthened governance arrangements are bringing together leaders across the council and partners. This has led to some improving oversight and challenge at a strategic level, and action has been taken to address some areas of concern, for example in tackling the delays for children in advancing to ICPCs and addressing the high numbers of children subjected to repeated child protection planning. The recently strengthened governance arrangements are not fully embedded across front-line management practice, and as a result, some areas of weaker practice remain.

49. Leaders have recognised that the current service structure of end-to-end social work is no longer working well enough to deliver good practice and outcomes for children and is creating inconsistencies. Although many children and young people benefit from enduring and trusting relationships with their workers, high workloads bring significant difficulty for social workers in balancing competing demands. Leaders have plans to restructure services to better support more consistency in social work practice.

50. There is significant council support, including financial investment, that has both preserved and expanded a wealth of dedicated services that are helping many children remain in their home safely and get the help they need from skilled professionals. Leaders ensure that there is strong and effective support for foster carers and adopters, and they have cultivated a good service for care leavers.

51. 'Stockport Family' benefits from stable, well-respected and established leaders. They invest in building and retaining strong and respectful relationships with external partners. Cafcass and the judiciary are highly complimentary of the good-quality work for children in court proceedings, and of leaders, who are proactive in addressing any issues as they arise. Challenge to partners has led to improvements in health attendance at strategy meetings. Previous leadership escalations have resulted in additional police capacity for strategy meetings within the MASSH, and when delays were identified during the inspection, capacity was further increased.

52. Since the last inspection, there has been significant work in forecasting and understanding sufficiency of placements to build services that meet children's needs more effectively. Leaders maximise regional relationships, and Stockport has expanded the breadth and range of placements available for children in care and care leavers effectively. As a result, most children live in placements according to their assessed needs, and no children were placed in unregistered children's homes or supported accommodation at the time of this inspection.

53. Significant work has stabilised the workforce. Leaders have taken effective action to address the increasing social work turnover seen at the focused visit in 2024. More recently, social work turnover rates have reduced, and the use of agency workers has decreased, with many being in post for significant periods of time or being supported to convert into permanent positions. Regional pay discrepancies have been resolved, which is helping to recruit and retain social workers.

54. The local authority has invested in creating a culture that supports workforce development through its newly launched strategy. This is enabling training to be flexible and adapt in line with the learning from quality assurance mechanisms and safeguarding practice reviews. This is providing a multi-faceted approach to support social workers' and managers' professional development. Training is underpinned by the newly launched practice standards, focusing on the key pillars of social work practice. Social workers value the training afforded them, describing impactful sessions that have helped them to develop their practice with children and families. However, some social workers felt unable to access these sessions due to heavy caseload demands. At the time of this inspection, targeted training on assessments had only just been delivered, which is demonstrating some improvements.

55. Social workers told inspectors that they love working in Stockport. They feel valued and appreciated the practice model, working alongside colleagues who share the same ethos and values in their approaches to working with families. Although they described high levels of support they receive from managers across the service, the quality of supervision is not consistently strong. Supervision is sometimes too infrequent to drive and progress children's plans. There is also insufficient challenge from managers and IROs to help social workers think about next steps, including the need for more assertive action or in securing timely permanence.

The Office for Standards in Education, Children's Services and Skills (Ofsted) regulates and inspects to achieve excellence in the care of children and young people, and in education and skills for learners of all ages. It regulates and inspects childcare and children's social care, and inspects the Children and Family Court Advisory and Support Service (Cafcass), schools, colleges, initial teacher training, further education and skills, adult and community learning, and education and training in prisons and other secure establishments. It assesses council children's services, and inspects services for children looked after, safeguarding and child protection.

If you would like a copy of this document in a different format, such as large print or Braille, please telephone 0300 123 1231, or email enquiries@ofsted.gov.uk.

This report is available at https://reports.ofsted.gov.uk/.

Interested in our work? You can subscribe to our monthly newsletter for more information and updates: http://eepurl.com/iTrDn.

Piccadilly Gate
Store Street
Manchester
M1 2WD

T: 0300 123 1231
Textphone: 0161 618 8524
E: enquiries@ofsted.gov.uk
W: www.gov.uk/ofsted