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Sarah Parker  
Director – Children and Family Services  
City of Stoke-on-Trent  
Civic Centre  
Glebe Street  
Stoke-on-Trent  
ST4 1HH

Dear Ms Parker,

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

Her Majesty's Chief Inspector of Education, Children's Services and Skills is leading Ofsted's work into how England's social care system has delivered child-centred practice and care within the context of the restrictions placed on society during the COVID-19 (Coronavirus) pandemic.

This letter summarises the findings of a focused visit to Stoke-on-Trent children's services on 29 September 2020. The inspectors were Peter McEntee HMI, Alison Smale HMI, Kathryn Grindrod HMI, Andrew Waugh HMI and Tonwen Empson HMI.

The methodology for this visit was in line with the inspection of local authority children's services (ILACS) framework. However, the delivery model was adapted to reflect the COVID-19 context. This visit was carried out fully by remote means. Inspectors used video calls for discussions with local authority social workers, managers and leaders. The lead inspector and the director of children's services agreed arrangements to deliver this visit effectively while working within national and local guidelines for responding to COVID-19 and meeting the needs of the local authority's workforce.

This visit looked at the quality and impact of key decision-making across help and protection, children in care and care leavers' services, together with the impact of leadership on service development.

### **Overview**

Services for children in Stoke-on-Trent continue to be characterised by serious weaknesses in practice as well as significant staffing challenges, with a high ratio and turnover of agency staff. There are too many children remaining in care through

delays in securing permanent homes for those who need them. The quality of management oversight of individual casework and planning is inconsistent. Plans lack focus and actions to improve children's circumstances are not always timely. This has led to delays in bringing plans to fruition and drift in securing the best outcomes for children.

A relatively new group of senior managers is in place and they are beginning to make progress. The extent of poor practice and impact on children described in the last full inspection and in subsequent monitoring visits has now been recognised and understood.

The building blocks of practice improvement are now being put in place. Detailed management information and a more effective quality assurance and audit programme are ensuring a more accurate understanding of the quality and efficiency of services. This is beginning to make a positive difference in service delivery.

The authority has responded positively to the challenges of the COVID-19 pandemic. It has ensured that services to children and families have continued, albeit with reduced face-to-face contact where it considered that impact on children would be limited. Social workers and other staff have continued to visit families in their homes and where necessary intervened to improve the lives of children.

The impact of the pandemic has resulted in reduced provision from a wide range of other agencies. This has meant a reduction in options for the support of children and families in need. Reduced court sittings have resulted in a backlog of work slowing significantly the discharge of care orders and the making of permanency decisions. Since the return of schooling, there has been a sharp increase in referrals to the authority.

### **What needs to improve in this area of social work practice**

- The quality and monitoring of children in need and child protection plans.
- The speed and progress of children in care towards permanent solutions for their long-term living arrangements.
- A sufficiency of placements where brothers and sisters can live together.
- The recording of management oversight, case directions and supervision.
- Consistency of thresholds in relation to the provision of early help to families.
- The quality of personal education plans for children.

### **Findings**

- Thresholds for early help intervention are not yet fully understood and applied consistently. The early help service continues to hold some cases that are too complex. The quality of early help assessments and subsequent plans and intervention needs to improve. Assessments are not always updated regularly.

Some plans do not reflect the impact of the pandemic on the ability of other services, such as schools, to support children and as a result are unrealistic.

- At the point of contact with children's services, appropriate decisions about intervention are timely in most cases. Management oversight is evident, and decisions are now better recorded. In almost all cases, immediate risk is responded to quickly. In a small number of cases, strategy meetings should have been held and were not. In these cases, not all elements of risk were correctly identified by managers. This led to delay in taking actions to minimise risk for some children.
- The quality of assessments varies significantly. Good assessments demonstrate command of history and detail with recommendations that are commensurate with evidence gathered. Poor assessments do not consider recent changes or escalations in concerns and the reasons for recommendations are poorly analysed. In these cases, subsequent planning, particularly for children in need, does not focus on some key areas and limits the effectiveness of intervention and support.
- Management authorisation of assessments and plans is present in most, although not all cases. Comments by managers do not always provide direction or provide timescales for achievement of tasks. Supervision, while mostly regular, is not systematically reflective and actions are not always tracked from one session to the next. This means that the ability to monitor progress in the child's timescales is compromised and an opportunity to promote good practice is lost.
- Children in need plans vary in quality. Some focus on practical, easy-to-address issues, such as keeping health appointments, but fail to address more deep-rooted issues, which means that any short-term improvements are unlikely to be maintained. Better plans identify core issues and set out interventions to address them.
- Child protection plans do not always include significant actions such as parenting or risk assessments, although these have been agreed with managers or in conferences. This leads to delays in progressing key areas of work and drift in reducing risk for the child.
- Children with behavioural issues do not always receive timely or sufficient child and adolescent mental health services (CAMHS) support. The waiting list for CAMHS services once a referral has been accepted contributes to delay in securing services for children at the right time. The general health needs of children in care are well recognised and progress is monitored appropriately through the review process.
- Numbers of children in care have increased significantly over the last three years, pre-dating the COVID-19 pandemic and are currently significantly above comparator authorities. Numbers have risen partly because too many children wait too long for a permanent home when they cannot return to their family. For some children, it takes too long to be matched and placed for adoption. Where matches have been made, the already significant delay in the making of an adoption order has been compounded by the absence of court hearings due to

the COVID-19 pandemic. There have been no adoption hearings between March and July 2020. Children with other permanency plans, including special guardianship orders (SGOs), are also waiting too long. Over a quarter of children in care have an SGO or a child arrangement order as their final plan but only seven SGOs have been agreed this year.

- Permanence panels are held to make decisions for permanency for children. Despite this, the recording of discussion is not always substantive enough to provide a rationale for decision-making or to detail attempts at family finding. Agencies involved with the child do not make sufficiently detailed contributions to inform decision-making. When an adoptive match cannot be identified, the lack of robust tracking of next steps means that permanence is not achieved in a timely way. Independent reviewing officers do not challenge delays in care planning effectively. Further, their scrutiny of plans in conferences and reviews is poor, meaning that not all potential permanency options for children are explored.
- There is an insufficient number of placements to ensure that children can always be placed with their sisters and brothers when this is appropriate. Similarly, there are not enough fostering-to-adopt placements to enable all children who might benefit from one to be placed. In some instances, placements have been made with carers of a different ethnicity without sufficient assessment of appropriateness.
- Social workers and personal assistants have continued to keep in touch with care leavers during the COVID-19 pandemic. Most young people are in suitable safe accommodation and while the majority had regular remote contact, those most at risk received visits during the lockdown period. The local authority also set up a video support group, 'Tune In', for care leavers during this period. Although currently reported numbers in education, employment or training have improved since 2018/2019, they remain considerably lower than the national average. The local authority acknowledges that some care leavers have not been enabled to have a clear understanding of available schemes such as apprenticeships and that this has contributed to them becoming NEET (not in education, employment or training).
- A high number of children in care has placed significant demands on the virtual school. Leaders, however, have not been able to respond appropriately, with no clear strategy in place for improving provision. A key element to support children to achieve the best educational outcomes, personal education plans (PEPs) are almost uniformly poor. They do not clearly identify targets for achievement and the virtual school has not ensured that the quality of PEPs is improving. Designated teachers have not had the training or feedback they need to produce effective PEPs that support pupils' next steps. Careers development is not given the emphasis needed to ensure that children in care have realistic expectations and relevant information about possible pathways. Too little is being done to secure successful transitions through pathway plans.
- There has been a rise in elective home education since schools have reopened. Children and families are being visited by officers and as a result, some children

have now returned to school. There has also been a small rise in the number of children missing education since the start of lockdown. A 'children causing concern' panel has been created. This is led by education and acts as a forum for next steps discussions and reviews of progress.

- All of the issues described in this letter are known to the local authority. There is now a better understanding and acceptance that services for children and families have been very slow to improve from the last full inspection and that it is only very recently that a trajectory for improvement has been established.
- A relatively new but permanent senior management group has established key building blocks for future practice improvement. Better management information and a more effective quality assurance and audit programme are ensuring that the local authority has a more accurate understanding of the quality and efficiency of the services it delivers. Compliance with procedures and policy is now better embedded, helping to ensure that responses at the front door are timely and that decisions made are better recorded, including the reason for the decision. The journey of a child and family through social care is more easily followed and understood. For some children in Stoke-on-Trent, a positive difference is being made.
- The authority has produced an accurate self-evaluation of its current practice. It is working in conjunction with other local authorities to establish practice baselines and better ways of working. A revised improvement plan is in place with more realistic timescales for change. Budget increases in children's social care services have been secured with political engagement in the services' future development. The local authority is, however, concerned that costs in relation to the local COVID-19 response will place pressure on budgets for children's services in the next financial year.
- The authority has maintained services to children and families throughout the pandemic. It has ensured that those most at risk have continued to receive support and where necessary appropriate intervention. The use of regulatory flexibilities as a consequence of COVID-19 was infrequent and mostly used to vary visits to children in line with an appropriate risk assessment. Partnerships, particularly with schools, are reported to have significantly improved during and post-lockdown, with good levels of attendance at school by vulnerable children and engagement by schools in identifying and supporting children at risk.
- Considerable challenges remain. Although there has been recent success in appointing qualified staff, the numbers of agency staff and turnover of these staff remain high and this makes improvements in culture and practice fragile. The number of children in care continues to rise and this is placing pressure not only on practice quality but also on the ability of the authority to ensure that appropriate placements are available.



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

Yours sincerely

Peter McEntee  
Her Majesty's Inspector