# Stockton-on-Tees

## Inspection of children's social care services

**Inspection dates: 20 May 2019 to 24 May 2019**

**Lead inspector: Matt Reed**
**Her 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 and care leavers | Requires improvement to be good |
| Overall effectiveness | Requires improvement to be good |

Since the last inspection in 2016, there has been a decline in the overall effectiveness of children's social care services in Stockton. While some services are strong, there has been insufficient management oversight and grip across the full range of services, and this is leading to unnecessary delay for some children in their assessed needs being met.

Managers have concentrated heavily on improvements, including an updated electronic recording system, the early help offer and services to children on the edges of care. However, there has been a decline in practice in some areas. For example, managers have not identified and addressed the extent of drift and delay in pre-proceedings work, or delays for children becoming looked after when they are living with their family and friends by arrangement with the local authority. Unqualified workers are holding children's cases and making social work decisions.

The local authority self-evaluation identifies many of the key findings of this inspection. However, the scale of delay for some children was not fully recognised by the local authority until it was identified by inspectors. This reflects a decline in

the quality assurance and performance management systems. Immediate action was taken during the inspection by senior managers to begin to rectify these issues.

Notwithstanding deficits, the early help offer has been strengthened. Effective multi-agency arrangements in the Children's Hub (CHUB) ensure that thresholds are appropriately applied. Direct work with children continues to be a strength. Edge of care and family group conferencing services have been developed and are working well. When children remain in care, most benefit from placement stability and a very high number make effective progress in their education. Timescales for children achieving permanence through adoption are improving. Care leavers continue to receive a strong service. They are well supported, and a comparatively high number are in higher education.

Key to the success of many areas of the service is the fact that workforce stability has significantly improved. Social work vacancy rates and staff turnover have reduced, and workloads are manageable. This is enabling social workers to undertake meaningful work with children and their families.

## What needs to improve

- Timeliness in delivering children's plans without delay across all services by generally improving management oversight and grip.
- More effective tracking of children who are the subject of pre-proceedings work under the Public Law Outline (PLO) procedures.
- Better recognition and approval of family and friends as carers under Regulation 24 arrangements.
- All case work decisions to be made by qualified workers.
- The quality and sustainable impact of assessment and intervention with families who are repeatedly the subject of referrals and plans.
- Clarity in supervision records about both positive and negative changes to children's circumstances, and challenge from managers to any delay in agreed actions being achieved.

## The experiences and progress of children who need help and protection: Requires improvement to be good.

1. While many of the services that keep children safe are effective, the absence of management oversight and grip on several key child protection processes means that sustainable change is not sufficiently assured. The chances of re-referral for families for the same risk factors are too high. When services are stepped up to pre-proceedings work, ineffective monitoring means that there can be delay in presenting children's cases to court.

2. Notwithstanding deficits at higher levels of need, a range of commissioned interventions offer a timely, responsive and creative approach to early help. At this threshold for involvement, highly effective multi-agency partnerships support families at the lowest form of intervention and the earliest opportunity. Family group conferencing (FGC) was developed 18 months ago. As a result, more families are benefiting from support to find their own solutions for issues at the lowest level of intervention when it is safe to do so.

3. A well-established children's hub (CHUB), including a wide range of partner agencies, has now been established. This facilitates positive and effective partnership working. The local authority designated officer, based in the CHUB, ensures that allegations against professionals are responded to thoroughly. Learning from incidents is shared effectively with all agencies to promote future learning and improved practice.

4. Swift and effective triage within the CHUB ensures that concerns about children are responded to in a timely way. There is clear management oversight and application of thresholds at the initial stages of contact and referral. This ensures that children and families access appropriate services without delay.

5. Effective links between the CHUB and the assessment teams result in children who need a statutory intervention being allocated quickly to a social worker. Immediate safeguarding concerns are addressed without delay. Most strategy meetings are well attended by partner agencies. Effective information-sharing leads to well-coordinated child protection investigations and the effective assessment of immediate safeguarding risk to children.

6. Most assessments of need are suitably detailed. Workers see children regularly during assessments. They utilise a range of direct work methods to gather children's wishes and feelings. However, some re-assessments add extra information to the original assessment without summarising it and, as a result, they are too long. Children's unique identity needs are not articulated clearly enough and do not always influence assessment and future planning. Chronologies do not always include a good enough consideration of the impact of significant events on the child. This means that the impact of

repeated concerns about their long-term well-being is not always readily understood.

7. Parental risk factors associated with mental health, domestic abuse and substance misuse are clearly identified in assessments. Appropriate and immediate responses are made to safeguard children from the impact of such issues. Joint prioritisation of concerns by both professionals and families in meetings demonstrates a collaborative approach to identifying risk. This leads to joint ownership of issues, making it clear to families that there is a shared concern about and response to risk. However, planned intervention lacks clearly defined timescales of deadlines by which progress is expected.

8. While assessments are mostly thorough, a high number of children are re-referred to the service or become subject to repeat child protection plans for the same presenting reasons. Management oversight and decision-making when children's cases close or step down to lower level interventions are not always robust. Insufficient consideration is given to whether risks have ameliorated or to whether changes in family circumstances are sustainable.

9. Social workers in the complex care team know their children well. The support needs of disabled children in need are fully understood. This results in children having their additional needs met effectively. However, child protection practice in this team is not as strong. For a small number of children with a disability, this has resulted in delays in identifying, assessing and addressing safeguarding issues.

10. Senior family workers are allocated statutory child in need work. While assessments have been completed by social workers, senior family workers are making subsequent case decisions. For example, senior family workers chair meetings on plans for children in need and inform managers of the rationale for closure. Managers are therefore relying on the opinion of unqualified workers to inform the next steps for children.

11. When children are subject to pre-proceedings under the public law outline (PLO), there is a lack of management oversight of and grip on children's progress. The PLO tracker is ineffective and legal advice is inconsistent. In a small number of cases, this has resulted in a delay in managers taking decisive action to enter care proceedings when children's circumstances do not improve.

12. Contextual safeguarding is well understood. Strong multi-agency partnership responses identify and intervene effectively to safeguard children and young people. Children at risk of exploitation are well supported and closely monitored through the vulnerable exploitation missing and trafficked (VEMT) process. Assessments of risk are detailed, providing a clear analysis that identifies actions needed to reduce risks. When children go missing from home and care, return home interviews are offered in a timely way. This

contributes to the identification of risks, which are tracked and passed on to the relevant agencies for action.

13. Children who are electively home educated or excluded from school are well monitored. They are supported to access education. The local authority has strengthened its role in the pupil inclusion panel and this is ensuring greater scrutiny of all exclusion decisions.

14. Private fostering arrangements are well recognised. Thorough assessments of these arrangements take place to ensure that they are meeting the child's needs. Children are seen regularly and there is effective monitoring of the situation to ensure that it remains appropriate.

15. 16- and 17-year-olds who present as homeless receive an appropriate response to their circumstances. Assessments of their needs are detailed and, for some, this has resulted in the successful return to parental care where it is safe to do so. Suitable accommodation is provided if attempts to find a solution with friends and the wider family prove unsuccessful.

## The experiences and progress of children in care and care leavers: Requires improvement to be good.

16. The local authority has successfully developed an edge of care service, 'Our Place'. For several years, Stockton has had a high number of children in care. Their self-evaluation accurately reflects the reasons why, and resultant actions are beginning to provide an appropriate alternative. After 12 months, initial reviews of the service are showing success. Reunification is now well considered and, if judged safe and appropriate, takes place at the child's pace with ongoing support. This, alongside the work of FGC, is assisting in the appropriate reduction in the rate at which children are entering and remain in care.

17. Children in care are seen regularly by their social workers, who have long-term, positive relationships with them. Direct work is meaningful and life-story work is of a good standard for all children in care. This is helping children to understand their circumstances and is aiding placement stability. However, not all children enter care within a timescale that meets their needs, and this leads to a subsequent delay in securing timely legal permanence for them. Feedback from the Children and Family Court Advisory and Support Service (CAFCASS) and the local judiciary reflects that social workers are not always receiving appropriate management support when preparing for care proceedings and attending court. This has led to a lack of confidence among partners in the robustness of the local authority court care plans.

18. The previous inspection report published in May 2016 identified that procedures and guidance for placing children with connected carers were not

understood or followed. This practice has not improved, and procedures have remained unclear. Some children continue to live in family arrangements as children in need when the local authority have arranged their placement and they should have become children in care. These children do not therefore have the benefit of their plans being independently reviewed, although their social workers know them well and their outcomes are not as negatively affected as they might potentially be.

19. Ongoing capacity issues within the fostering service have impacted on the timely completion of assessments of connected carers. While assessments of family carers are undertaken to ensure these arrangements are safe, family carers do not have the benefit of the support and training of the fostering service to assist them in meeting the child's overall needs. Capacity issues have also resulted in some important safeguarding mechanisms being missed. Some foster carers' annual reviews are out of date, and not all carers have completed mandatory training. Some carers have not had an unannounced visit in the last year to ensure that the children's living environment remains appropriate.

20. Care plans are regularly reviewed and updated. Children's wishes, and feelings are sought, listened to, and, where appropriate, acted on. Children have access to an advocate where necessary, and this service is used well to support children and ensure that their voice is heard. Social workers can verbalise a child's plan well, but this is not always reflected in the written plan on the child's file. Consequently, it is not always clear from the child's records whether the child is making progress or whether more support or intervention may be needed, although no child was seen to be placed at risk by this issue.

21. Suitable plans for permanence are routinely ratified at a child's second review. They are appropriately signed off by independent reviewing officers (IROs). Together and apart assessments are used well to ensure that family relationships are maintained wherever possible, in the best interests of the children. However, there is a lack of routine challenge by IROs and a lack of evidence of escalation to senior managers if progress is not being made. This has contributed to drift in planning for a small number of children.

22. Adoption timeliness is slowly improving from a low base. High-quality support and training for adopters is now minimising the risk of future placement breakdowns. However, opportunities are missed to find children a permanent home at an early stage. Fostering to adopt is underdeveloped as an option for securing early permanence. Its low use means that some very young children avoidably change placements between foster carers and adopters.

23. The high number of children in care has created pressures on the availability of suitable placements for children who have recently come into care. Despite maintaining a high level of residential provision, and steadily increasing the number of foster carers, there continue to be insufficient placements to meet

demand in the short term. For some children with complex needs, this has led to a delay in finding the right placement at the right time. For a small number of adolescents, this has resulted in short-term placement moves and the use of provision that is risk assessed but unregulated. Senior managers recognise the need to increase residential provision and have plans to review the fostering service.

24. Despite these pressures, placement stability is sustained in the longer term. Children are supported to live in stable placements that are meeting their needs. Most children in care do not move placement unnecessarily. This is enabling them to form positive relationships with their carers. Contact with birth families is based on the individual needs of the child. For some children, this involves well-managed but complex contact arrangements. This ensures that significant relationships are safely promoted and maintained, while also supporting improved placement stability.

25. Children's physical and emotional health needs are well recognised and met. There are good links with the child and adolescent mental health services (CAMHS). This results in a timely response when children need additional support and interventions.

26. Children in care and care leavers are represented by an active child in care council, Let's Take Action (LTA), and 'The Big Committee'. These groups are consulted and influence service design and delivery. Children's views are also obtained via an app which enables children to share their views electronically. Young people spoken to were able to describe changes made because of their views. They described ways in which their successes are celebrated. However, young people do not always receive regular feedback about ongoing service development and plans.

27. The virtual school is highly valued by local schools. The support it provides is enabling a strong sense of corporate responsibility towards children in care. School attendance is good at 96%. Children are supported to remain in school against a backdrop more generally of increasing exclusions. Children of all ages are making progress, and outcomes for children in care, particularly in the early years, have improved over time. Effective work by youth participation officers ensures that almost all children progress onto further education after key stage 4.

28. The care leaving team continues to offer a strong service. The number of care leavers in education, employment and training is improving and this is further enhancing their life chances. Education outcomes for a significant number of young people are good and a comparatively high number of care leavers are being supported to attend university. A good range of placement options are available, including staying put with foster carers. Strong and effective links with housing providers offer young people a choice of accommodation that meets their changing needs. To encourage outside interests and promote

their well-being, care leavers have been given leisure passes. While ongoing physical and health needs are met effectively, young people are not routinely offered access to their health records when they leave care.

29. Personal assistants are committed to their young people. They maintain regular and meaningful contact. They actively encourage young people to be aspirational in achieving their goals. A dedicated IRO sits within the review and development service. However, not all written plans are of good enough quality. This reduces their effectiveness as live documents to which young people can easily relate. Notwithstanding this, young people are achieving positive outcomes and their needs are being well met.

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

30. The self-evaluation of practice strengths and weaknesses is mostly accurate. However, senior leaders were not fully aware of the scale of some of the weaknesses in management oversight and grip found during this inspection. This reflects a decline in the quality assurance and performance management systems. Immediate action was taken during the inspection by senior managers to begin to rectify the issues.

31. The current electronic system does not support senior leaders and managers' understanding of their effectiveness or where they need to improve. Senior leaders are fully aware of this weakness and have implemented several workarounds to address the issue. They have developed much closer links with their performance team over the last year to mitigate against the shortfalls. However, this is not yet facilitating robust scrutiny of performance or the quality of practice.

32. Management oversight of frontline practice has declined since the last inspection and is impacting on some children's outcomes. Weaknesses in management oversight of achieving sustainable change within families mean that rates of re-referral and repeat child protection plans have increased. Also, there is drift and delay in pre-proceedings work, as well as delay for those children entering care when living in family and friends' care placements that are wrongly designated as family arrangements.

33. The numbers of children who are subject to statutory intervention remain high in line with comparators. However, effective early help interventions mean that both the rate at which children become children in need and the rate at which children become subject to child protection procedures are appropriately reducing. This brings Stockton more closely in line with comparators. The response to children on the edge of care has improved since the last inspection and the rate at which children enter care is reducing. The development of services such as 'Our Place' and FGCs are having some success in preventing concerns from escalating. Many families are being

better supported, and this is reducing the need for some children to enter care and is promoting a safe return to family where appropriate.

34. Since the last inspection in May 2016, senior leaders have concentrated heavily on improvements, including the early help offer and services to children on the edges of care. Greater stability has been achieved in the workforce with the development of a comprehensive recruitment and retention strategy, together with an aligned workforce development plan. The success of this is assisting in the move to a more relationship-based and restorative practice.

35. The ongoing recruitment of experienced workers, alongside a process of developing new workers through 'grow your own' and 'step up to social work', has resulted in the significant reduction in vacancy and turnover rates. There is less reliance on agency staff. Social workers have manageable caseloads. This is enabling them to develop longer-term, more meaningful relationships with children and families. It also mitigates to some extent management deficiencies because it means that children have their needs effectively met while they wait to have their plans fulfilled.

36. Social workers spoken to were positive about working for Stockton. Social workers and managers receive regular supervision. The focus on professional development and progression is strong. There is evidence of managers discussing children and their families regularly on children's files. However, the content of the supervision records often reflects information repeated from the previous supervision. Actions to progress children's plans are also often repeated with no challenge to repetition and delay. This makes the tracking of progress from one supervision to the next unnecessarily difficult.

37. Case audits are undertaken regularly by managers at all levels and they suitably identify where practice could improve. Themes are collated into 'one-minute guides' to support staff and enhance their learning. However, not all audits are completed collaboratively with workers and managers. This does not support a greater understanding of the child's progress or where social work practice needs to improve.

38. Senior leaders are very open to external scrutiny. They actively seek and contribute to peer reviews to enhance their own learning. Multi-agency and cross-authority arrangements are strong. They facilitate effective partnerships to safeguard children. This is particularly evident in the newly enhanced CHUB. Swift and accurate information-exchange is resulting in appropriate decision-making at the initial stages of involvement. Vulnerable children are safeguarded through close and effective strategic and operational multi-agency risk management and coordination through the VEMT process.

39. Recently, senior managers approached the local judiciary to consider how to improve social work practice in court. They recognise that managers at all

levels do not have good enough oversight of PLO practice. There are plans to integrate PLO tracking into the current electronic recording system in the coming months. However, these plans are not due to be implemented until November 2019. This will not help children now impacted on by drift and delay from poor management oversight of pre-proceedings work. The local authority took decisive action during the inspection to review the arrangements for the small number of children concerned. Policies and procedures have been amended to provide some reassurance that the issues will be more swiftly addressed.

40. The director of children's services (DCS) recognises that while there are positive service developments, there is more work to do to improve and embed the quality of social work and strengthen management oversight. Strong political support for children's services has been sustained. The required changes have been acknowledged and agreed. The incoming managing director (formerly known as the chief executive officer) and the lead member are well informed of the key priority areas identified for improvement. They fulfil their corporate parenting responsibilities satisfactorily. The experiences of children, young people and families are valued and actively sought.

41. Leaders are committed to ensuring that young people are influencing service development, and they have sponsored the 'Big Committee', a committee of young people who work with the council on issues facing young people in the town. The Big Committee developed their own 'Big Plan'. This is a plan written and developed entirely by young people on how they will continue to work with the council to improve services for the young people of Stockton.

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Piccadilly Gate
Store Street
Manchester
M1 2WD

T: 0300 123 1231
Textphone: 0161 618 8524
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