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Mr Steve Walker
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Dear Mr Walker

Monitoring visit of Kirklees children's services

This letter summarises the findings of the monitoring visit to Kirklees children's services on 27 and 28 June. The visit was the second monitoring visit since the local authority was judged inadequate in the inspection of children in need of help and protection and children looked after in October 2016. The local authority is making limited progress in improving services for children and families. The visit was carried out by Her Majesty's Inspector, Rachel Holden, and Ofsted Inspector, Cath McEvoy.

Areas covered by the visit

During the course of this visit, inspectors reviewed the progress made in the following areas:

- The effectiveness of multi-agency arrangements and decision-making to support children in need of help and protection, including children on the edge of care and children who have recently become looked after
- The quality of social work practice, including assessments and plans, with a focus on pre-proceedings and contingency planning
- Management, child protection chairs and/or independent reviewing officers oversight, support and challenge.

The visit considered a range of evidence, including electronic case records, supervision files, observation of social workers and related documents provided by staff and managers. In addition, inspectors spoke to parents, a range of staff, including managers, child protection chairs, independent reviewing officers and community school hub leaders, and other practitioners. Inspectors had access to a range of performance information and tracking spreadsheets.

Overview

There is an increased understanding among senior leaders about what needs to improve for children and families in Kirklees. However, progress towards achieving the necessary improvements remains limited. Plans to address the deficits are not firmly established or well understood and are too recent to have had an impact for children and families.

Although there are pockets of discrete improvement in the quality of practice, this is not consistent. The pace of change is being hindered by workforce instability and high social work caseloads. Not all actions taken by senior managers to tackle drift and delay for children have been effective, and some children have been left in risky situations for too long.

Findings and evaluation of progress

Social workers are not able to complete all the tasks needed to support children and families effectively, because their caseloads are too high. A high turnover of staff is impacting adversely on continuity for children. The local authority is doing all that it can to recruit experienced and high-quality staff, but has not secured a stable and experienced workforce. Ten social workers have been recruited very recently, but are not yet in post.

In spite of the challenges facing the authority, the staff observed carrying out their work and those with whom inspectors spoke were child focused and motivated to improve children's experiences. For some, though, morale is low.

There is evidence of improved management oversight, but the management challenge is not sufficiently robust. In the majority of cases seen, there is evidence of very recent drift and delay for children. Supervision of staff is taking place regularly in most cases, but at times this is not supporting staff well enough to improve their practice or helping to drive forward plans for children.

Senior managers are appropriately focused on embedding a performance culture with frontline managers, through improving datasets and daily performance meetings. Progress has been made in relation to promoting a shared understanding of the data by providing a narrative of the story behind the data. This is starting to be used to identify areas of practice that are not meeting the local authority's set targets, although, due to required data cleansing, the data cannot be relied on fully to inform performance decline or improvements in some practice areas, such as the timeliness of core group meetings.

Local authority engagement with partner agencies is showing some early signs of improvement. School-led community hubs are working in a more joined-up way with the local authority to support children and families at an early stage. The hubs are supporting agencies to understand and apply thresholds better and to deliver more timely early intervention provision. However, it is too early for the local authority to assess the impact of this.

Edge of care services for children in the cases reviewed by inspectors were either absent or ineffective, leading to increased pressure on social work provision. Senior managers are aware that the current model for service delivery is not effective in supporting families. Plans to implement an alternative delivery model are not fully formed.

Senior managers have introduced a number of new processes, including performance trackers, to improve support for and oversight of legal planning. Although these processes and trackers provide a wide range of data to help managers to monitor and improve practice and to better understand demand, the systems put in place are not sufficiently responsive to emerging risks and needs. Inspectors saw examples of continuing delay for children and of children remaining in risky situations for too long, because of adherence to rigid processes. For example, a social worker had been asked to resubmit information about a child because insufficient detail had been recorded. This led to a significant delay in any action being taken to reduce the level of risk and for care proceedings to commence.

There are some improvements in the quality of practice. Assessments seen appropriately consider the family's history and individual children, and there is improving identification and analysis of risk. Children are seen and spoken to alone. However, social workers' consideration of children's identity and diversity issues and an analysis of their lived experience within the household continue to be areas for improvement.

Children's care planning and the quality of child protection plans are not sufficiently robust. Plans do not outline clearly what parents are expected to do to achieve the changes needed to safeguard children, the support to be offered to achieve change or the timescales for the change to be achieved. In some cases, plans are absent or out of date, or there are a number of different plans on children's files. Poor-quality outline plans from child protection conferences are not supporting a clear focus for agencies from the outset. This means that core group meetings are not effective in ensuring that plans are progressed, either to reduce risks or to ensure that agencies take decisive action when the risks are not reduced. 'Risk sensible' plans are not an effective tool to help practitioners to identify readily and reduce risks to children. Information is duplicated, and this is not leading to a sufficiently sharp focus on what needs to change. The local authority has recognised this, but these plans remain current practice.

The pre-proceedings process is not embedded in practice. There is delay in initiating the Public Law Outline and court proceedings, despite, in some cases, significant involvement by the local authority, and there is little or no sustained parental change evident. The quality of the local authority's record of decision–making, that of the letters issued to parents before proceedings and that of the subsequent contract of expectations are poor. This means that parents are often not clear about what they need to do to secure changes and in what timescales. Contingency planning is inconsistent and, while inspectors saw clear plans that involved timely assessments of wider family members, for some children there was no contingency planning evident. This builds in delay for children at an early stage.

There is good multi-agency attendance at child protection conferences and review meetings for children looked after. In the cases reviewed by inspectors, children regularly attend and are helped to share their views about future plans. In some cases, the decisions to reduce intervention for children were not sufficiently well informed, due to social workers' reports lacking depth or being absent.

Independent reviewing officers and child protection chairs are improving their oversight and review of children's plans. They are making appropriate challenge, particularly of absent reports, poor plans and drift and delay for children, but this is not improving children's experiences sufficiently.

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

Yours sincerely

Rachel Holden
Her Majesty's Inspector