

9 April 2018

Mr Steve Walker  
Interim Director of Children's Services  
Kirklees Council  
Civic Centre 3  
Huddersfield  
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Dear Mr Walker

### **Monitoring visit of Kirklees Council children's services**

This letter summarises the findings of the monitoring visit to Kirklees Council children's services on 13 and 14 March 2018. The visit was the fourth monitoring visit since the local authority was judged inadequate for services for children in need of help and protection and children looked after in October 2016. This visit was carried out by Her Majesty's Inspectors, Rachel Holden and Matthew Reed and Ofsted Inspector, Cath McEvoy. The local authority has made a small amount of progress in strengthening the foundations for service improvement.

### **Areas covered by the visit**

During the course of this visit, inspectors focused on the experiences of children looked after who are placed with their parents. In addition, inspectors reviewed progress being made in relation to:

- staff support, supervision, induction and training
- the dispute resolution process
- performance data and the quality assurance framework across children's services
- the oversight and challenge of the corporate parenting board.

A range of evidence was considered during the visit, including the tracking and sampling of children's electronic case records, supervision records, audit information and performance information provided by staff and managers. Inspectors spoke to a range of staff, including social workers and managers, as well as the lead member.

## **Overview**

Senior managers are now realistic about service improvement and what more they have to do to ensure that services for children are safely and consistently provided. There is increasing stability at a senior manager level and this is starting to have a positive impact on building the foundations for securing service improvement. The strong support and high level of challenge being modelled by senior managers is starting to have a positive impact on staff morale. A comprehensive professional development framework is better supporting staff to access learning and training opportunities.

Increasingly robust and tailored data reports have been developed and are starting to be used more confidently by frontline managers to support their oversight of practice. However, supervision and management decision-making are not leading to purposeful planning or clear direction and challenge in cases where there is drift or delay. Independent reviewing officers (IROs) are highlighting concerns about children's case progression, but at times the proposed actions are procedural and are not making a difference to children's circumstances. No children were found to be in situations of unassessed risk in the cases seen. However, care planning is not sufficiently effective, and support to families is not sufficiently focused. There is historic drift and delay for some children and some of these issues are entrenched and will take time to address.

## **Findings and evaluation of progress**

Prior to the visit, managers had already completed a series of audits on cases of children placed with their parents. The local authority found that too many cases subject to these orders had not been appropriately managed and that children had been subject to these arrangements for too long. Between October 2016 and March 2018, approximately 40% of these orders had been discharged appropriately and the remaining cases are now subject to regular review by managers. Timescales are now set for the completion of assessments and court dates applied for where appropriate. Inspectors received feedback from a partner agency that there has been an improvement very recently in the quality of applications to court. While further improvements are planned, a tracking system has been implemented, and thus is improving oversight.

All children are assessed as safely placed at home. However, in some of the open cases there is still evidence of recent drift and delay. Children's and families' assessments are not routinely updated and this is impacting on timely planning for children. In addition, managers and IROs are not consistently challenging or being sufficiently impactful about tackling drift and delay for children. The IRO service has recently improved their dispute resolution processes, but there is further work to be done to ensure consistency and to continue to shift the focus from process to practice and the progress of children.

Management oversight and decision-making are not consistently recorded. Decision-making by senior managers at the permanency panel is not always translated into plans for children's care. Senior managers are aware that these decision-making panels are not working effectively and are taking appropriate action to address this, but it is too early to see the impact. In addition, placements with parents' agreements are not adequately completed, and this does not support oversight or focused planning or make expectations clear to parents.

Children are being seen regularly while placed at home, and where appropriate their views are acted upon. Social workers know their children and families well and in some cases have completed effective direct work. However, in some children's files the recording of visits and work that has taken place is at times absent or delayed. Therefore, it is challenging to monitor impact and progress being made. This does not best support the tackling of drift and delay.

The quality assurance framework is being implemented incrementally. Social workers and frontline managers are fully involved in the development of the audit process. This is supporting a shift in culture, with social workers and their managers starting to recognise that the framework is supportive, constructive and a critical aspect both in ensuring that children are safe, and in improving the quality of practice. Audit themes are being used to help inform service prioritisation. However, there is more to do to improve audit quality. The current grading system is not as clear as it needs to be to facilitate scrutiny and robust challenge or to provide assurance that children are safe.

Progress in the use and understanding of data is being embedded. All staff report an increase in the usefulness and usability of data reports. The bespoke reports are now enabling managers to better manage performance. Managers evidenced that they are using the reports to understand and challenge performance issues within teams, although this is not impacting sufficiently on children.

The corporate parenting board is not providing sufficiently robust oversight or challenge about the quality of practice and the pace of change needed in this area has been too slow. The data set presented to the board has until recently been unwieldy, which has prevented effective scrutiny and challenge. There is more to do to ensure appropriate membership of the board, both in relation to partners and influence from children.

All staff who spoke with inspectors say that they are receiving better support from their managers and that they feel more confident to ask for advice and guidance. Where caseloads still remain high in some service areas, they are being monitored, and there is an appropriately focused action plan to address this. A continuous programme of recruitment to secure more permanent and experienced social workers and managers is starting to have an impact.

Staff induction, continual professional development and training pathways have been refreshed. Tracking of mandatory training to measure impact and to ensure that all

staff have the skills required to undertake their work is effective. Recently rolled out restorative practice workshops are helping to embed a culture of strong support and high level of challenge, but it is too soon to see the difference that this is making to children. Some staff say that they need time to trust newer models and ways of working, but morale is improving.

Supervision is now regular and workers report that managers are more accessible. Senior managers are aware that there is still much to do to embed good quality of practice across the service. Poor supervision practice has been a key feature in hindering service improvement and action taken to address this has been slow, albeit with a rationale to ensure that the workforce can contribute to service developments. A group of staff has recently been tasked with devising and trialling a new format for supervision that is currently being piloted.

A copy of this letter will be sent to the Department for Education and published on the Ofsted website.

Yours sincerely

Rachel Holden  
**Her Majesty's Inspector**