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Mr Steve Walker
Interim Director of Children's Services
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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 8 and 9 November 2017. The visit was the third 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 Rachel Holden, Her Majesty's Inspector, and Cath McEvoy, Ofsted Inspector.

Areas covered by the visit

During the course of this visit, inspectors reviewed the progress made in help and protection. In particular, inspectors focused on:

- initial responses to children in need of help and protection
- assessment of risk within the initial response
- management decision-making, oversight and supervision
- information sharing and the multi-agency response to risk
- application of thresholds
- children being seen by a social worker and seen alone. Their experiences are considered when making assessments of risk.

A range of evidence was considered during the visit, including the tracking and sampling of electronic case records, supervision files, observation of social workers, and performance information provided by staff and managers. In addition, inspectors spoke to parents and a range of staff, including managers and other practitioners.

Overview

Since the previous monitoring visit in June, the director of children's services of a neighbouring authority has been appointed by Kirklees council as director of children's services in addition to his existing role. This is part of an agreement between the two local authorities to establish a formal partnership arrangement for a period of two years, with leadership, management, capacity and expertise being provided to support improvement in Kirklees.

The focus of this visit was agreed with the director of children's services, six weeks prior to fieldwork, as an area in which it was hoped that progress could be demonstrated, as plans were already being actioned in the Multi-Agency Safeguarding Hub, which was identified as ineffective in the inspection in 2016. However, the action taken during this time has not led to the improvements anticipated, and children are being left in situations of unacceptable and unassessed risk.

The pace of change in Kirklees is too slow, and widespread and serious failures remain in the first response to children in need of help and protection. Inspectors identified a deterioration in the management of risk to vulnerable children and in the quality of decision-making and assessment.

Findings and evaluation of progress

Over the last four months, experienced senior managers from a neighbouring local authority have been supporting managers and staff in Kirklees to improve services for children, working in the last two months alongside managers to coach, mentor and implement safer working practices at the 'front door'. Inspectors found that opportunities to strengthen decision-making at the 'front door' at an earlier stage have been missed. Actions taken have not led to evidence of improved management of risk or effective challenge to the drift and delay for children in the vast majority of cases seen.

Recent activity in the duty and advice team has included an external review of process commissioned by Kirklees Safeguarding Children's Board, followed by training of partners to help them to better understand thresholds and their role in supporting children and families. Changes to process are assisting the flow and volume of work. Data is now being more effectively used, for example to demonstrate whether compliance is achieved in meeting statutory requirements. Increased focus has been given to engaging staff and providing better support in order to create the right conditions for social work to flourish. However, these changes are too recent to have made a difference to the services that children and families are receiving.

Thresholds are not well understood by partner agencies. The level of contacts made by other agencies to children's social care remains high, and many of these contacts do not meet the threshold for statutory intervention.

In the majority of cases seen, managers' application of the thresholds is inconsistent and inappropriate. There has been a recent focus on reducing the numbers of contacts to children's social care and, while this has been achieved in data terms, it has led in a number of cases of children not receiving a social work response that meets their needs. The 'step in' team, established by a previous interim manager prior to the monitoring visit, and which is an early help team offering support to families, is being inappropriately deployed in some cases when the presenting issues require social work assessment and intervention. Senior managers are aware of this, but have not taken action to address it.

Immediate risk to children is not always recognised and responded to in a timely way. Drift and delay in responding to children were evident in the majority of cases sampled. A high number of cases seen by inspectors were referred back to the local authority for immediate action to ensure that children were safeguarded. The remedial action taken in one case, following inspectors raising serious concerns about safety planning, did not reduce the risk of significant harm to children. Decision-making, risk assessment and the resulting actions are not ensuring children's safety.

Focused engagement with partners about their role in strategy meetings has recently increased multi-agency attendance, and this is leading to increased information sharing and more effective analysis and identification of risk. However, when decisions are made to undertake section 47 investigations, there are delays in action being taken to safeguard children, and children are not being seen quickly enough.

There is an appropriately focused overarching improvement plan and work is underway to reduce the level of caseloads, which are still high in the assessment teams. Improvements to the 'front door' are expected to help with this, but to date there is no discernible impact.

The quality of the majority of assessments seen is poor. A focus to ensure that assessments comply with the timescales of presenting risk has resulted in a reduction in their quality. Staff also report that, in an effort to meet deadlines, quality is being compromised. Historical information is not always recorded or considered, and key information is often absent. The impact of identity and diversity is not addressed in the majority of cases.

When children are seen, they are seen alone by social workers, and the child's voice is clearly recorded in most cases. However, the impact of the child's voice is not always widely assessed or evident in safety planning. There is insufficient attention given to individual children's needs. For example, in the case of brothers and sisters, information is sometimes duplicated for each child and the majority of assessments lack analysis of children's lived experience.

Better staff engagement by the new senior leadership team is beginning to improve both support to the frontline and staff morale, but it is too soon to evaluate its

impact on social work practice. The recruitment and retention of experienced staff are an appropriate priority for the local authority, but workforce stability remains fragile.

Social workers do not always benefit from high-quality, reflective supervision. Individual supervision has not been taking place in some of the teams in the duty and advice service and, in other service areas supervision is not regular and has not been effective in improving the quality of social work practice.

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