Clive House
70 Petty France
Westminster
London SW1H 9EX

T 0300 123 1231
enquiries@ofsted.gov.uk
www.ofsted.gov.uk

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Mr Steve Walker
Interim Director of Children's Services
Kirklees Council
Civic Centre 3
Huddersfield
HD1 2YZ

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 11 and 12 July 2018. The visit was the fifth 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 Inspector, Rachel Holden and Ofsted Inspector, Cath McEvoy. The local authority has increased the pace of improvement since the last monitoring visit, which has resulted in some steady progress being made. There is more work to do to improve and embed the quality and timeliness of the social work response to children and families, and to tackle drift and delay.

Areas covered by the visit

During this visit, inspectors focused on the experiences of children in need of help and protection. Inspectors reviewed progress being made in relation to:

- the quality and timeliness of assessments and plans, including pre-birth assessments
- the multi-agency response to children in need of help and protection
- the consideration of children's individual needs in assessments and planning.
- complaints from children and families and how learning from those complaints is disseminated
- the effectiveness of management oversight and challenge.

A range of evidence was considered during the visit, including children's electronic case records, supervision records, case file audits and performance information. Inspectors spoke to parents and a range of staff, including social workers and managers.

Overview

The senior leadership team has a comprehensive understanding of progress and areas for continued development. Since the last monitoring visit, the local authority has made steady progress, and firm foundations are now in place for securing improvements in service delivery. There is an improving picture in relation to: management oversight through systematic case auditing and regular supervision; staff engagement and morale; the response to pre-birth concerns; workforce stability; and partnership working. No children were seen where risk of immediate harm was unassessed and not responded to.

Some of these changes are very recent and not embedded in practice. The cumulative impact of risk is not always recognised in assessments and planning. The quality of social work practice is still too variable, and this is not ensuring that children and families consistently receive a timely response to their needs. Caseloads in some teams remain too high and in some instances there are still too many changes in social worker. The challenge of management and child protection chairs is not sufficiently robust and is not making a difference to children. This is contributing to drift and delay in too many of the cases seen.

Findings and evaluation of progress

The senior leadership team has a thorough and realistic understanding of the areas for improvement. The self-assessment is robust and there are appropriately focused plans to improve services for children and families. Firm foundations are now in place to move the service forward, and there is increasingly sound monitoring of progress, for example through the systematic auditing of cases and improved regularity of supervision. However, managers are not always recognising when they need to challenge drift and delay for children.

Progress is accelerated in securing a more stable workforce at a senior and frontline manager level. Almost all posts are now filled. In addition, very recently advanced practitioners have been appointed to every social work team. These are non-case holding practitioners recruited to support the development of social work practice. Staff have articulated that this is starting to support and promote service improvement. Increasing permanence of frontline staff is improving continuity of case ownership, and social workers with whom inspectors spoke articulate well the needs of the children and families, and the direct work being undertaken with them to meet their needs. The impact of this direct work with children is not always reflected in children's case records, reducing accountability, oversight and the ability to challenge where there is drift.

Morale is much improved and social workers are better engaged. Social workers report that support is more readily available and that senior leaders are approachable. Leaders are systematically focused on reducing caseloads, and this is

having a positive impact for some teams, but for others, caseloads are still too high. Case supervision is now regular, task-orientated and appropriately focused on securing compliance. Recent opportunities for more reflective supervision with advanced practitioners are starting to provide social workers with scope to consider their practice in a more qualitative way. It is too soon to see the impact of this on children.

There is an improving multi-agency response to children at risk of significant harm. The recent relocation of some social work teams into localities is starting to facilitate better working together and an improved recognition of and response to the presenting risk. Children are being seen alone in these cases, and the views of children and parents are well considered and recorded. However, for children who are already known to children's social care and where there is arising risk, partners are not routinely engaged in strategy discussions and cumulative risks are not always recognised or addressed. In some cases, there is insufficient assessment of and response to children who are living in family arrangements.

The quality of assessments remains variable. In the cases seen, assessments are superficial and lack information about the ethnicity and identity of families. They do not sufficiently depict or explore the lived experiences of children and young people. The format of the assessments is restrictive and does not give social workers the space to enable them to sufficiently analyse impact. Assessments are not always updated in order to inform child protection reviews, and in a small number of cases seen children came off a child protection plan prior to full information being received. Some cases had several changes of social worker within a short timeframe, and this was contributing to drift and delay and a lack of continuity for children.

Families speaking with inspectors during the visit said that their contact with children's social care had been initially poor but had been improving recently. The individual needs and experiences or brothers and sisters are now being addressed within the assessments seen, and the response to pre-birth concerns is improving. Staff are now undertaking timely assessments prior to birth, and planning to ensure the safeguarding of new born babies. A recent change in the pre-birth assessment pathway is having a positive impact on practice.

Although the timeliness of child protection reviews and practice is improving from a low base, initial child protection conferences, social work visits to children and core group meetings do not always happen within the child's timeframe or within timescales set out in statutory guidance. Although the responsiveness and challenge of child protection chairs is improving, there is not a consistently robust challenge to drift and delay.

Where children and families have been subject to a child protection plan and risk reduces, appropriate and timely decisions have been made for children to come off plans in the majority of cases seen. Appropriate levels of support are being provided in order to promote resilience in families. However, the response to children in need is not sufficiently robust. The local authority recognises this and plans to fully audit

children's cases in this area. Inspectors saw some examples in these cases where children needed a more protective response.

The local authority is appropriately focused on improving the quality of plans and planning for children. Social workers have recently received training in this regard, but this is not yet embedded and it is too soon to see the impact of these on children. The poor quality of some assessments and inconsistent recognition of cumulative risk is not contributing to sharp planning for children.

The audited cases tracked demonstrate recent improvements in social work practice. The findings from the audits had been actioned and this is improving the social work response to children and families in these cases. Some variability remains in the quality of audits. For example, some audits failed to address deficits in practice. Leaders are aware that the audit process needs further embedding, but that it is already starting to challenge and highlight areas of weaker and stronger practice.

The local authority response to children's complaints is improving and all complaints are now responded to in a timely manner. A children's rights service is readily available to support children to make complaints and to advocate on their behalf. Senior managers now have oversight of complaints, which is facilitating complaint resolution at an earlier stage and lower level. There is improved learning.

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