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City of Bradford Metropolitan District Council

Inspection of children's social care services

Inspection dates: 17 September to 28 September 2018

Lead inspector: Neil Penswick HMI

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	Inadequate
The experiences and progress of children in care and care leavers	Requires improvement to be good
Overall effectiveness	Inadequate

Services for children in Bradford have rapidly deteriorated since the last inspection, the Joint Targeted Area Inspection (JTAI), in April 2017. The major contributory factor has been an increased demand for services at the same time as the loss of a significant number of experienced social workers and managers, who left to work for other local authorities. Politicians were made aware of the issues and they committed additional resources to rectify the problems. Improvement plans prioritised the strengthening of the structure of the service, including the recruitment of staff.

Across child protection and children in need services, too many children are not getting the right help they need at the right time. Inspectors found clear evidence of the detrimental impact of changes of social workers and managers, as well as resultant poor practice, leaving children at risk of significant harm.

Senior managers have been addressing the issues and have developed key decision-making panels, have improved quality assurance and have recruited to new teams to better support children in care in particular. Further new key management appointments and social workers have been recruited and are due to start after the completion of this inspection.

This has ensured that most children in care and care leavers are now receiving better support to promote their well-being and improve their outcomes. This has yet to be sufficiently consistent for all children in care. An insufficiency of carers also meant that some children were in placements that did not meet their needs, and this has impacted negatively on them and other children in those placements.

What needs to improve:

- the identification and response to risk, particularly the longer-term impact of domestic abuse and neglect
- clarity about what change is needed by families and by when during pre-proceedings
- the prioritisation and timely, proportionate response to contacts, including gaining parental consent
- social work practice, including the quality of assessments and plans and their implementation
- multi-agency child protection work, including strategy meetings, child protection conferences, core groups and child in need reviews
- the response to children with specific vulnerabilities, including children aged 16 to 17 who present as homeless and children privately fostered, as well as the oversight and monitoring of allegations against professionals working with children
- sufficiency of local placements to meet the needs of children in care
- the provision of life-story work for all children in care
- completion of mandatory training for all foster carers
- supervision of social work staff, which provides direction, to be regular and reflective.

The experiences and progress of children who need help and protection is inadequate

1. Services for children in need of help and protection in Bradford are inadequate because serious failures leave children at risk of significant harm.

2. Children in need of protection are not consistently identified and are not given the right help at the right time to meet their needs. Screening of contacts in the multi-agency safeguarding hub (MASH) is ineffective despite sizeable

commitment from children’s services resourcing and partnership investment. Inspectors identified too many children in potentially harmful situations whose cases had been closed by the MASH, or whose cases had been inappropriately stepped down to early help provision, without protective action being taken.

3. Inappropriately, all contacts involve a full duty social work review. Extensive information is obtained and collated from multiple agencies as a matter of routine. Sometimes this is not compliant with national guidance because consent has not been agreed and there are no overriding child protection concerns. This leads to too many children being subject to unnecessary and disproportionate social work processes, while others who need help and protection are not prioritised. Children are inappropriately interviewed by partner agencies, sometimes without parental consent, to gain their views or their versions of events to inform social care decision-making.

4. When risk is identified, strategy meetings, although timely, do not always include representation from all appropriate partners. Multi-agency safety planning is inferred rather than defined while safeguarding enquiries are taking place. Other children do not always have the benefit of timely multi-agency arrangements due to delays progressing to initial child protection conferences.

5. Children do not always receive timely or effective help. The local authority has assumed responsibility for assessing all cases that potentially need early help, and this additional burden delays decision-making when identifying services to help children and their families. All neglect cases are identified as early help, and this does not ensure that children’s needs and their safety are at the centre of decision-making. Requests stepped down following MASH screening can take up to three weeks before support services are identified.

6. Social work practice across locality teams varies in both quality and impact. The local authority has heavily invested in an established social work model. However, this is not always enriching social work practice. For example, assessments are not consistently good. Weaker assessments are not always up to date to reflect children’s current needs or to appropriately scale risk. Some are too detailed or repetitive without showing understanding of what the world looks like for the child. Resultant plans are not good enough. Most plans have lengthy descriptions of concerns without identifying what needs to happen and by when. Actions are not always linked to the specific risks and needs, and contingency plans are too general.

7. Core groups and child in need meetings share updates on children’s current circumstances. However, meetings are not always sufficiently regular. Progress against plans is not always reviewed or changed in order to identify further actions. Children are not always seen by social workers in line with their plans, and this limits their ability to form stable and trusting relationships. This impacts on the timeliness of direct work and actions being

completed. Consequently, some children remain on child protection plans for long periods without their situations improving, or child protection plans are removed too early without their needs being adequately addressed or the impact being tested. The effect of regular changes in social workers, due to staff leaving the authority, further contributes to delays in progressing planning. Mostly, when children are seen regularly by the same social worker, positive changes are made, and children's lives improve.

8. When children's circumstances do not improve, timely alternative decisive action is not always taken. The local authority recognises that the use of the public law outline (PLO) is not robust. Letters identify and list areas of concern. However, actions are not specific enough for families to understand what needs to change and by when to prevent escalation. Some children are in PLO too long without regular review to decide whether alternative action needs to be taken to keep them safe. Some children suffering ongoing neglect do not enter care soon enough. Consequently, some children are left in harmful situations for too long.

9. Vulnerability of some specific groups of children is not always recognised or appropriately responded to. The impact of ongoing neglect or domestic abuse is not always recognised. Homeless 16- and 17-year-olds are evaluated by homeless services, but are not assessed by social workers to ensure that their full needs are identified or that they are appropriately supported, or to ensure that protective action is taken. There is little evidence that these highly vulnerable young people understand their right to become looked after or the longer-term benefits that this would bring. The response to children privately fostered is poor. Their needs are not assessed, and a lack of planning does not ensure that they are appropriately protected and supported. Increased investment in the local authority's designated officer coverage has not yet resulted in consistently effective monitoring of allegations against professionals.

10. Other vulnerable children receive good support. For example, the response to children at risk of child sexual exploitation is a strength. A dedicated multi-agency child sexual exploitation hub ensures a thorough analysis of risk through daily meetings. Work is underpinned by solid information-sharing, detailed research and thorough exploration of all the potential risks. Actions are clear and mitigate risks. Return home interviews are routinely offered and taken up. However, these are not as detailed as those for children who go missing from care. Well-embedded systems ensure that children missing education and those who are electively home educated are safeguarded. Children who are identified as being at risk of radicalisation receive good, tailored support.

The experiences and progress of children in care and care leavers requires improvement to be good

11. Children in care and care leavers are not yet receiving consistently good help to promote their well-being and to improve their outcomes. There had been a decline in the overall quality of services since the last Ofsted inspection. However, actions by managers are addressing the issues and there are evident recent improvements in the support being offered.

12. Senior managers have recognised that there is an increasing complexity in children's needs when they come into care. They have invested in edge of care services to ensure that, wherever possible, children are able to remain with their birth families or are rehabilitated with their families at the earliest opportunity. These initiatives are still in the early stages, but are showing some initial signs of success. Despite overall children in care numbers rising, the Be Positive Pathway aimed at 10- to 17-year-olds, together with the intensive intervention from a specialist children's home, is reducing the numbers of children of this age range needing to be in care.

13. The Children and Family Court Advisory and Support Service and the local Designated Family Judge told inspectors that applications to court are appropriate and accepted. However, the quality of evidence in the reports can vary, resulting in the need for further assessment work to be conducted and delays in a small number of cases. Senior managers have invested in a dedicated court team to support social workers and this is delivering improvements to the quality and timeliness of this work.

14. Most children in care benefit well from the support of social workers. In the locality teams, where children in care receive a service prior to a permanency decision being made, social work contact is not always from the same social worker, and a small number of children experience delays. In the throughcare teams, in the main, inspectors saw high-quality support and regular contact consistent with the needs of the child, resulting in good progress being made in the delivery of plans. In these throughcare teams, social workers know their children well and are focused on achieving positive outcomes for children.

15. Specialist multi-agency teams robustly address concerns about child sexual exploitation and respond well to incidents when children go missing. Due to the high-quality focused work, the numbers of children in care who have gone missing, and the frequency of episodes of going missing, have greatly reduced over the last year.

16. Children's views are always obtained, although they are not always well reflected in their records or plans. Written plans are not always sufficiently specific in identifying the child's needs and the support necessary. However, social workers are, in the main, better able to articulate the focus of the support. Most reviews happen in a timely manner. Inspectors saw excellent formal challenge by Independent Reviewing Officers (IROs) auditing cases

between reviews, as well as during the review, ensuring that where practice is not of a good standard, it is urgently addressed.

17. Bradford local authority is committed to ensuring that, wherever possible, children remain close to their families. This has resulted in some children who had been previously placed a distance from Bradford being returned to live closer to their families. While some children have benefited from this, others have experienced placement breakdown due to poor assessments and decision-making. There have been strenuous efforts made to increase the number of foster carers, and inspectors saw an introduction to foster care event very well attended by interested people from across the communities of Bradford. Commissioning looks at a range of potential placements, including from the private sector. However, there is an insufficient range of local carers, and too many children are being placed in placements that don't meet their needs. This results in them experiencing further instability in their lives. Feedback from foster carers was variable, with some reporting a good level of support, while others who requested to speak to inspectors, described support as being poor. Not all foster carers are provided with mandatory training, including on safeguarding issues.

18. Inspectors saw much good work to ensure that children remain in contact with family and friends. For some children, though, the arrangements are not sufficient to enable continued contact with important people in their lives. Many children do not have the opportunity to undertake life-story work that would enhance their understanding of their histories and about why key decisions had been made about their lives.

19. Children in care are encouraged to keep themselves healthy, and their health needs are appropriately and regularly assessed. However, local child and mental health support is not available in a timely way. Aware of the complexities of children's needs, and to better support placements, senior managers have recently recruited to a new set of posts for children in care – therapeutic social workers – to provide assistance and guidance to social workers and carers to better meet the emotional needs of the most vulnerable children.

20. The virtual school has focused on improving the attendance and outcomes of children in care in partnership with schools and social work colleagues. As a result, attendance has steadily risen over the past five years, and in 2017–2018, attendance was at 96.2% for children in care. No children in care have been permanently excluded and fixed-term exclusions are reducing. This has yet to ensure that children's outcomes by the end of key stages 2 and 4 are good enough, in particular in progress measures. Personal education plans are too variable, with some lacking clear targets for improvement. A strength of the virtual school team is the guidance and advice programme they offer to young people and the different opportunities that are in place through the team to ensure that the most vulnerable young people get personalised

support and advice. This is particularly evident for those in education, employment and training (EET); 84% of 16- and 17-year-old children in care are EET, which is a strong performance and higher than the national average. Children's achievement events celebrate and acknowledge successes and raise aspirations. Inspectors also saw good examples of children being supported to pursue their own hobbies, interests and sports.

21. Permanence is considered, and permanence planning has been improving to ensure that children are living with adoptive carers promptly and under special guardianship orders when these meet their needs. Bradford council is a partner of One Adoption West Yorkshire, a regional adoption agency (RAA). Adoption recruitment, training and support is effective. This ensures that adopters have the right information, knowledge and support to secure permanence for children. Careful matching is supported through life appreciation days which provide adopters with first-hand knowledge of the people who have been significant in the child's life. Adopters receive suitable support and training while they are waiting for an appropriate match. Post-adoption support is carefully considered at the matching stage through individualised support packages coordinated by the adoption team.

22. There is an active child in care council which is proud of its involvement in improving some aspects of service delivery, staff training and recruitment. The members of the council are active in both regional and national children in care council events. The local authority does consult on their views. However, some of the children spoken to by inspectors felt that the consultation was 'tokenistic' rather than meaningful engagement.

23. Children leaving care receive inconsistent support as they move towards independence. All care leavers have allocated social workers until they are 18, with community resource workers (CRW) providing regular support between 18 to 25 years old. However, there was mixed feedback from care leavers who met inspectors. Some reported good relationships with their workers, while others were critical of a lack of support. There are a range of housing options available, including staying put, and the vast majority of young people are in suitable accommodation. Not all care leavers have access to key documents such as their health passports, national insurance numbers and passports, which they will need as they start their life as young adults. Pathway plans are not user friendly and the recording of the young person's voice and engagement in the computer-based planning record is minimal.

The impact of leaders on social work practice with children and families is requires improvement to be good

24. Leaders have been aware of the extent of serious failures in social work practice in Bradford. They have been responding to those issues, some of which, but not all, have been effectively prioritised and challenged, and improvements have been made.

25. In April 2017, the JTAI on the multi-agency response to abuse and neglect in Bradford reported a range of good services that had positively impacted on the lives of vulnerable children. This inspection found that there had been a recent and rapid decline in those services, with some children now being left at risk of significant harm. Other services have continued to offer a better-quality response that meets the varying needs of the children.

26. In the last 12 months, Bradford local authority children's services rapidly lost a high proportion of its most experienced social workers and managers, some of whom left to work in neighbouring boroughs offering better financial returns. This was at the same time as Bradford experienced significant increases in demand across all areas, reflecting the rapid growth of children subject to child protection planning and those needing to be looked after. The numbers of agency and short-term staff increased significantly. External consultants were recruited to evaluate the quality of the services to enable senior managers to fully understand the impact from loss of staff. As a result, a broader audit programme commenced to explore the scale of the problems. At that time, approximately a quarter of all cases were found to be receiving 'inadequate' support and protection. The most recent audits are showing some improvements in the quality of work.

27. Inspectors could clearly see that Bradford local authority children's services responded to the recommendations from the last Ofsted full-service inspection in May 2014, and to the JTAI in April 2017. Documentation, performance data and quality assurance demonstrated the necessary improvements. However, at the time of this inspection, most of those earlier improvements were no longer being sustained. For instance, although the local authority ensured that all initial child protection conferences happened within the national minimum timescales for over two years, the most recent performance has dipped to only 71% of these happening in a timely manner.

28. The SDCS has kept the leader of the council, lead member for children and chief executive fully involved, and they all have a good awareness of the issues in children's services. Well-disseminated management information ensures a good understanding of the performance issues. Additional finance has also been allocated from the council to address the immediate weaknesses and to enable longer-term improvements. For instance, additional managers have been recruited, while whole scale-reviews of the 'front door' to services and the PLO are underway.

29. A service-wide improvement plan has prioritised areas including staff recruitment and continued auditing of casework. This has resulted in an improvement in permanent staffing and a reduction from 38 social worker vacancies to only five. The plan has been further developed, during this inspection, to respond to the issues that inspectors were raising. However, inspectors found there was insufficient prioritisation being given to ensuring

that children's lived experiences were at the centre of the service improvements.

30. Staffing vacancies, and use of agency staff, is an issue in some of the social work teams. The assessment teams and locality teams, which work with children in need and child protection, have seen a rapid changeover of staff, and this has impacted on some children having too many changes of social worker and work not being completed in a timely manner. The throughcare teams, which work with children in care and care leavers, have seen fewer changes of staff and managers, and this has enabled children to build better relationships with their social workers and ensure that work has been completed in a timely manner. Inspectors did see examples of good work throughout children's services, but more consistently in the throughcare teams.

31. Leaders have continued to focus on improving services for children. There is strong partnership sign-up to multi-agency work. For instance, the multi-agency commitment to an established model of social work practice has ensured that over 2,000 staff from different agencies are trained in its use, with many using this in their daily work to promote the welfare of children. There is also a well-located set of early help hubs, financed from core funding with an additional contribution from the National Troubled Families programme, with agencies working together to provide ongoing support to families with lower levels of need. There are good multi-agency services to respond to child sexual exploitation and children who go missing. There are also a number of creative initiatives that the local authority has been developing for children in care, including the Be Positive Pathways, to provide services to prevent children coming into care. Therapeutic social workers have also been recently employed to further address the emotional and mental health needs of children in care. The court team has also improved the quality and timeliness of work done prior to proceedings.

32. The vast majority of social workers and staff met by inspectors report that Bradford local authority is a good place to work, with good support, including access to training and workable caseloads. Formal supervision is not always happening regularly, though, and is not sufficiently reflective. This was recognised by senior managers, who have developed a practice supervisor role to bolster the quality and frequency of management oversight. This has resulted, in particular, in recently qualified social workers now receiving better quality support that addresses their needs.

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Piccadilly Gate
Store Street
Manchester
M1 2WD

T: 0300 123 1231
Textphone: 0161 618 8524
E: enquiries@ofsted.gov.uk
W: www.gov.uk/ofsted

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