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Dear Mark

Monitoring visit of Bradford children's services

This letter summarises the findings of the monitoring visit to Bradford children's services on 16 October 2019. The visit was the third monitoring visit since the local authority was judged inadequate in September 2018. The inspectors were Jan Edwards, Her Majesty's Inspector, and Lisa Summers, Her Majesty's Inspector.

The local authority is making progress in improving services for children in need of help and protection in some discrete areas of practice, but the pace of change has been too slow.

Areas covered by the visit

During this visit, inspectors reviewed the progress made in services for children in need of help and protection, with a particular focus on children subject to a child protection plan, children subject to pre-proceedings and children on the edge of care.

A range of evidence was considered during the visit, including electronic case records, performance management information, case file audits and other information provided by senior managers. In addition, we spoke to a range of staff, including managers, social workers and other practitioners.

Overview

Since the last monitoring visit, a new permanent director of children's services (DCS) has taken up post. In addition, a newly recruited deputy director with experience of improvement work is due to take up post in November. Since coming into post in July 2019, the DCS has appropriately taken the time to understand the scale of the improvement required, and is embarking on a restructure of the service. It is planned that this restructure will reduce the number of transition points for children

and families, increase managerial oversight and place children's social work teams in local communities alongside early help provision.

The local authority has particular challenges in significant areas of practice. There are significant deficits in the quality of practice in assessments, children's plans, manager oversight and supervision quality at all operational levels. Further issues remain in the resilience and capacity of the workforce and in partners' contribution to keeping children safe and improving their experience and progress.

Politicians and leaders now have a better understanding of the scale of the improvements required to improve children's circumstances. They have committed considerable finances to increasing workforce capacity and to supporting a restructure of social care and early help. As a result, the DCS is now confident that the right foundations are in place for the local authority to sustain the rate of progress and support continued improvement.

There has been improvement in the timeliness of child protection conferences, in reducing the numbers of children who have experienced delay while in pre-proceedings, and in reducing most social work caseloads. Further changes have been made to the visiting frequency for children and supervision practice standards, and in developing the quality assurance framework. A new threshold document has been developed to support professionals to make appropriate referrals. Positively, children on the edge of care are being effectively supported to remain safely at home. This practice was in its early stages at the time of the last inspection.

Findings and evaluation of progress

There are some discrete areas of strength, some areas where improvement is occurring, and some areas where we considered that progress has not met the expectations and ambitions of the local authority.

Senior managers and leaders recognise that there is considerably more work to do to improve the quality of practice for children in need of help and protection. The significant instability of the workforce at all levels has hindered the pace of change, and, to date, this has been too slow. A continuing risk to improvement is the lack of resilience in the workforce. This is evidenced by a recent deterioration in performance over the summer, when social workers were on leave. Senior leaders recognise that workforce instability brings with it several risks, including inconsistency in the quality of practice. Consequently, the recruitment and retention of staff are appropriately priorities for improvement. This includes securing a financial commitment to retain agency social work staff for the next 18 months in order to provide much-needed stability. The local authority is actively engaged in relevant initiatives to support social work recruitment, retention and staff development.

Following the inspection in September 2018, the local authority was too slow to secure permanent leadership arrangements. This had a detrimental impact on the ability to achieve any meaningful improvement or to positively impact on children's

experiences. The overly bureaucratic processes reported in the last monitoring visit are now being addressed through embedding human resources in children's social care in order to support a more seamless recruitment process reducing unnecessary delay.

Social workers in Bradford are motivated to help children and families improve their circumstances. This is as a result of their engagement in the improvement plan and their shared understanding of the vision for children's social care. There is some effective social work practice, which is improving the experience and progress for some children. However, many children are experiencing delay in receiving an initial protective response and in having their needs identified and met. Too many changes in social worker means discontinuity for children, and this is impacting on the timely progression of their plans. There are delays for children in being able to access timely support and interventions, particularly for Child and Adolescent Mental Health Services (CAMHS), domestic abuse services, and intensive family support. When senior managers have become involved to resolve issues of delay in accessing services, these actions have been effective.

Assessment reports and casework, in some cases, are overly optimistic and lack professional curiosity in testing out parental self-reporting. This has resulted, in these cases, in premature case closure before work has been completed or change has been tested. It also means that, for a small number of children, risk was not fully understood or managed. In these cases, there has been insufficient management oversight and critical challenge.

Social work caseloads are reducing due to additional capacity being provided in localities where demand is greatest. This is enabling social workers to visit children more frequently. However, most records of visits lack evidence of a clear purpose and the quality of the recording is inconsistent, particularly in relation to the voice of the child.

Conference minutes do not provide a clear and accountable record of the information shared. As a result, it is difficult to understand what the priority actions are to address immediate risks. Children's care planning and the quality of child protection plans are not sufficiently robust. Plans are overly descriptive and many lack clarity about the support to be offered to achieve change, the focus, and the timescales for the change to be achieved. Most are adult focused without clearly identifying what is needed to improve in children's lives.

Key professionals do not always attend critical meetings, including conferences and some core groups. This is particularly the case for health services. This means that there are missed opportunities to maximise a wider professional network to support safety planning and reduce risk. The local authority and the safeguarding partners have plans in place to address this. Inspectors saw some effective multi-agency working that provided targeted intervention to keep children safe.

Since the last inspection, senior managers' oversight of work in pre-proceedings has significantly improved through more effective tracking and monitoring. This is

successfully reducing the drift and delay that children had previously experienced, with the average time in pre-proceedings being three months. Where there are delays, these are understood, and some delays are deliberate, particularly when new assessments are needed to determine whether families can be removed from the public law outline. The letters before proceedings have improved. These are now personalised and more succinctly outline the local authority's concerns, as well as the actions needed to be made by families to ensure that their children's circumstances improve. Senior managers recognise that there is more work to do to ensure that the quality of work is consistently good.

When children are at risk of coming into care, the 'B Positive' pathway team effectively supports children to remain safely at home. It also supports children who are in care to return home to their families. The multidisciplinary staff team is trained in a recognised risk methodology and attachment models. The team is working successfully with children with the most complex and challenging needs in order to understand their risks and vulnerabilities and to support parents to manage differently. The team members' specialisms contribute to a holistic understanding of the child. These specialisms include psychology, speech and language, occupational therapy, education, residential outreach workers and police, and provide insights into issues that have previously not been understood. The team has worked with complex issues of child sexual and criminal exploitation, and has successfully diverted children from gang activity. The team is highly regarded by social workers, who have benefited from their knowledge and expertise in intensively supporting children and their families and in helping them to think differently.

There is improved management oversight, but management challenge is not sufficiently robust. In some cases, drift and delay remain for children. Supervision of staff is now taking place, but it is not always regular, and it is not supporting staff well enough to improve their practice or helping to drive forward plans for children. A programme of back-to-basics training has been introduced for all social work staff, who report how useful it has been in establishing standards of practice. This is too early in its development to show impact for children.

Senior managers have recently implemented an improved performance dataset, which is enabling frontline managers to address compliance with key performance indicators. Since the last monitoring visit, the quality assurance framework has been developed to better support an understanding of practice. The recently developed approach of collaborative auditing between managers and social workers is supporting a more accurate system of assurance, but it is in its early stages and is not fully embedded. Audits have shown that there is more to do to improve the quality of social work practice in relation to assessment, plans, management footprint and the voice of the child. These are identified by the local authority in its self-evaluation, which provides an accurate understanding of its areas for improvement.

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

Yours sincerely

Jan Edwards
Her Majesty's Inspector