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Dear Mark Douglas

Monitoring visit of Bradford children's services

This letter summarises the findings of the monitoring visit to Bradford children's services on 25 February 2020. The visit was the fourth monitoring visit since the local authority was judged inadequate in October 2018. The inspectors were Jan Edwards, Her Majesty's Inspector, and Neil Penswick, Her Majesty's Inspector.

The local authority is at the very early stages of making some progress in improving services for its children and young people in care. This was judged to require improvement at the last inspection. However, the progress and experience of children is characterised by widescale delay in having their permanence plans confirmed.

Areas covered by the visit

During this visit, inspectors reviewed the progress made in achieving permanence for children in care. Inspectors also considered whether performance management information and quality assurance activity provide managers and leaders with an accurate view of social work practice and children's experiences.

A range of evidence was considered, including electronic case records, performance management information, and case file audits. Inspectors spoke to a range of staff, including elected members, leaders and managers, and social workers. Inspectors also met with a small group of children who shared their experience of what it was like to be a child in care in Bradford.

Overview

There is extensive drift and delay for children achieving permanence. Senior leaders have been significantly challenged by the scale and enduring nature of the delay and

the quality of care planning. The improvement plan had initially stalled due to a delay in recruiting permanent senior leaders, and in securing an understanding of the scale of the inadequacy by politicians and across the partnership. The new leadership team have now embarked on a wholescale restructuring of the service, which has required stripping the service back to basics. The service is now starting to address this legacy of poor practice and ineffective management and work through children's cases to ensure the right planning is in place. While inspectors also found issues with current practice, particularly in relation to the effectiveness of managers in ensuring that children achieve timely permanence, there was also some pockets of better practice, which is benefiting some children in care.

Leaders are now appropriately focused on the development of an infrastructure across the whole service to support improved care planning practice and compliance. A new senior management team has been recruited with the right level of qualification and knowledge. However, these recent improvements are yet to demonstrate an impact on the experience of most children in care who require stable and secure permanent homes.

Leaders are appropriately focused on safely reducing the numbers of children in care and improving care planning. There is a developing understanding of the child care profile and performance management. However, practice evaluations are not always making a positive difference to practice. Manager oversight and their grip of planning lacks effectiveness in ensuring that there is timely and effective permanence planning for children.

There is a firm commitment from council members and at executive level to children's services to support investment in the innovation and improvement programme. Significant recurring funding has been provided. There is now a recognition of the widescale and deep-rooted inadequacy across the whole service and that improvements will take time, but that there is now a need to step-up the urgency and traction of improvement following this monitoring visit.

Findings and evaluation of progress

The self-assessment accurately reflects that senior leaders have identified that permanence planning is not embedded in the service and has been compounded by weaknesses in help and protection practice, weak assessments, weak care planning and ineffective management oversight. The strategic director of children's services (DCS) is taking authoritative action to ensure that these deficits in practice are addressed as a priority. Since the DCS came into post in July 2019, there has been a widescale improvement plan which is addressing improvement from the child's first contact with the service. The service has very recently moved to a locality model of service delivery, where teams hold case responsibility across the child's journey. New locality head of service appointments have been made with the intention of providing a clearer oversight of practice and performance and tighter accountability for specific areas of practice. In addition, permanence panels and a new

permanence tracker are being developed, but these are so new that it is too soon to report on their effectiveness in progressing children's plans.

Practice evaluations are now regular, but they are overly compliance- or process-led at the expense of focusing on the experience and progress of the child. The lack of follow up of actions in all cases seen means that these evaluations are not making a difference to social work practice. In addition, themed audits are not robust and fail to provide senior managers with the information they need to accurately understand a specific area of practice.

Leaders now have a clear understanding of the child in care profile, which is helping them to forward plan for future service development. They are clear that there are too many children who remain in care and who are subject to statutory processes which are no longer necessary. These children are being reviewed and care orders are being discharged where it is safe and appropriate to do so.

Notwithstanding the work being undertaken to safely reduce numbers, there remains a large number of children in care. There are significant challenges with providing placement choice for children, particularly for those who need to live with their brothers and sisters. As a result, external placements are being used, with 21% of children being placed out of area. Sufficiency of placements is being addressed through a specific workstream of the improvement programme, including a review of provider services and the inhouse fostering service.

Decisions to separate children from their brothers and sisters are often not sufficiently assessed when children come into care in an emergency and are based on the availability of carers. However, when these decisions are part of longer-term planning, together and apart assessments are generally detailed, with good consideration of the risks and strengths of placement options.

Senior leaders have an improved understanding of the data, as demonstrated in their permanence self-assessment. They know that only 33% of children who are on section 20, or who are living with family and friends or in foster care, have their permanence plans ratified at their second children in care review. Inspectors saw very complex cases, often of large sibling groups, where there was active twin or triple planning, to assess parenting capacity, sibling relationships, and other family members, and this impacted on timely decision-making. Where children were subject to section 20, inspectors found some children being left without anyone exercising parenting responsibility. For some older children with specific vulnerabilities, risk was not being addressed when they went missing, and there was a lack of appropriate safety planning. Inspectors saw significant drift in planning and children experiencing delay when the plan is adoption and in securing permanence for children on section 20. Both of these areas were known to senior managers, and plans are in place to address this aspect of planning. Work is also underway to review the links with the regional adoption agency to determine where improvement can be found in the timeliness for family finding.

When children and young people return home following a period of being in care under voluntary arrangements, this is done following a current assessment of need and with appropriate levels of support. Where decisions are made to return children home, there is evidence of independent reviewing officer (IRO) oversight and challenge when necessary to ensure the best outcomes for young people. For those children who are living at home and remain on care orders, there is assessment under placement with parent regulations. These assessments vary in quality, but in the main include other professionals' information and views of all parties and a safety plan. Many of these children are well prepared, with a programme of gradual reintroduction and a clear support plan. Visiting is regular to ensure that these arrangements continue to be suitable in meeting the child's needs.

Around 20% of children in care are living with connected carers. Many of these carers are not assessed quickly enough or sufficiently risk assessed. When these placements are providing good support and care for children, there is not a sharp enough focus on ensuring that the arrangements are secured through special guardianship orders.

In spite of the significant delay, children live in foster care or residential homes which are meeting their needs, and they are making good progress from their individual starting points. When children are out of area, they are being visited and seen according to their plan. There is an issue for some children having their education needs resolved in a timely way when living out of Bradford, but the virtual school is involved in negotiating arrangements.

Some Bradford foster carers feel dissatisfied with the service and with children experiencing a significant number of changes of social worker. Senior managers know that they have a lot of work to do to improve this service and the offer to their carers in a competitive market place.

Assessments are updated for every child in care review, but these are of poor quality and simply provide an update from the last review. There is a lack of identification of children's changing needs or of family circumstances, particularly of an analysis of risk around current parenting capacity. This leads to plans which lack focus on emerging need and priorities. Reviews are regular and in the main are well attended and of good quality, but they need to be more sharply focused on the progress of the plan, particularly if permanence has not been achieved.

There is evidence that permanence is starting to become embedded in some social work practice in the locality and children in care teams from this low base. There is some effective social work practice and direct work with children and their families to support children in their new homes. Senior managers are reviewing specific cohorts of children and there is a clear audit trail of this oversight. Social workers and their managers understand the importance of children being able to achieve permanence to enable them to have improved experiences and make progress. However, this isn't being translated into timely practice and effective manager oversight in all cases. Supervision is not sufficiently effective in driving the work and in ensuring that plans are achieved in a timely way. There is some evidence of

improving supervision, which has a focus on permanence, but it is not always providing timescales for this. There is good evidence of oversight by IROs through their own auditing and monitoring and in keeping in touch with social workers.

Social workers see children regularly, although the written record of these visits does not always demonstrate the purpose or show whether children are seen alone if appropriate to do so. Children and young people told inspectors that they had experienced changes of social worker and this has been a source of frustration and dissatisfaction for them. They also said that their social workers do not take them out regularly, and, as a result, they do not have enough opportunities to build trusting relationships with their worker. They were unaware of the children in care council, which means that they have had limited opportunities to have their voice heard by senior managers. They have also had limited opportunities to be involved with children in care activities, such as celebration events.

Children are not being consistently helped to understand their long-term plan and why they came into care. This is leaving some children anxious, and their emotional well-being is not being adequately addressed. There is insufficient access to, and availability of, therapeutic provision to respond to children's emotional and mental health needs. There are pockets of life-story work being completed, but this is usually for children who have a plan for adoption.

The corporate parenting board meets regularly and has a well-established link to the children in care council, which regularly challenges them to do better for children. Corporate parenting is being refreshed with new priorities for supporting children in care more effectively and a focus on improving wider children's participation.

Many social workers are positive about working for Bradford and understood the need to make improvements for the benefit of the children they work with. There were some social workers who told inspectors that they were unhappy with the changes and the disruption that this had caused to children, particularly from having changes of social worker.

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