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Dear Sal

Focused visit to Leeds children's services

Her Majesty's Chief Inspector of Education, Children's Services and Skills is leading Ofsted's work into how England's social care system has delivered child-centred practice and care within the context of the restrictions placed on society during the COVID-19 (coronavirus) pandemic.

This letter summarises the findings of a focused visit to Leeds children's services on 20 and 21 July 2021. Her Majesty's Inspectors for this visit were Victoria Horsefield and Matt Reed. Inspectors looked at the local authority's arrangements for the front door, including decision-making for contacts and referrals, child protection enquiries, the decision to step down or step up from early help, and child in need assessments.

This visit was carried out in line with the inspection of local authority children's services (ILACS) framework. However, the delivery model was adapted to reflect the COVID-19 context. The lead inspector and the director of children's services agreed arrangements to deliver this visit effectively while working within national and local guidelines for responding to COVID-19. Both inspectors were on site and held face-to-face discussions with some local authority staff. However, inspectors also used video calls for discussions with local authority staff, managers and leaders.

Headline findings

Leeds has experienced high rates of COVID 19 which has, and continues to have, an impact on all aspects of children's services. During the pandemic, senior leaders have continued to provide a wide range of early help services that have adapted well to meet the demands. Workers, despite the impact of COVID-19, report feeling well supported and proud to work for Leeds. However, the response to some children in need of help and protection is not as consistently strong as it was at the last inspection. When there is a clear identification of risk, children receive a timely and appropriate response. When a child's circumstances are more complex, and more information needs to be gathered to understand what is happening within a family, some children experience delay in their needs being identified and responded to.

When there are concerns that a child may be at risk of significant harm, less than half of the strategy discussions involve key partner agencies.

What needs to improve in this area of social work practice

- The quality and consistency of assessments to ensure that key information and family history is gathered and analysed to inform decision-making, and the quality of children's plans.

- The quality and impact of management oversight and supervision to ensure that decisions are timely and well recorded.

- The quality and independence of audits to ensure that they provide learning to support improvement in social work practice and provide senior managers with an understanding of the quality of that practice.

Main findings

Leeds has experienced high rates of COVID-19 with some areas of the city significantly exceeding national averages. Lockdown restrictions have been in place throughout the pandemic. Senior leaders understand very well the significant impact of COVID-19 for children and families, staff and communities and have a good understanding of the demographics of the areas most affected by the pandemic. The local authority and its partners responded quickly to identify those most affected and are working effectively together to deliver support. Statutory services have been maintained throughout and children have continued to be seen where it is safe to do so. Staff have felt well supported during the pandemic and have received practical and emotional support from senior leaders and managers.

The continued investment in early help services means that there are a wide range of effective early help services available to children and families. For some children, the early help service has successfully diverted them away from formal statutory interventions. Managers in early help have effective oversight and clearly record decisions when children's cases need to be stepped up or when interventions end.

Social work practice and management oversight at the front door is not as consistently strong as it was at the last inspection. A recent external peer review of the front door commissioned by the local authority identified areas of good practice, but also identified similar areas for development found in this focused visit. Senior leaders acknowledged these findings and are working to address shortfalls in practice quality and the timeliness of decision-making.

The front door experienced an increase in contacts during the pandemic, with many of these related to domestic abuse and parental conflict. The front door is well resourced with an experienced and stable workforce who report positively about the 'Leeds way of working'. For most children, timely and proportionate decision-making

leads to them receiving the right service when needed. Where there is a clear identification of risk, children's cases are transferred to the locality teams without delay. Parental consent is well understood and considered and, where necessary, dispensed with to allow further checks to be made. However, where an immediate child protection risk is not clear, decision-making is not always timely. For some children, there is a delay in them receiving the right level of intervention at the earliest opportunity.

Managers at the front door are not demonstrating that they have sufficient oversight of the progress and timeliness of children's cases. Managers do not consistently provide a recorded rationale where timescales for the progression of contacts and referrals are not met. In some instances, this is appropriate and allows further work to be undertaken. However, for some children, this leads to a delay in the analysis of risk and identification of the required intervention.

Many referrals and repeat referrals are due to domestic abuse. In some children's cases, there is not a robust understanding or analysis of the previous history and incidents. For some children, this means that the cumulative impact of domestic abuse is not being considered in the assessment of risk and decision-making. The local authority has recently introduced a daily multi-agency meeting to strengthen their response to domestic abuse. As this is a recent development, it was too soon to identify the impact of these arrangements.

Where there is a clear identification of risk, child protection enquiries are undertaken, and children are seen promptly. In these children's cases, managers consistently record decisions and provide a clear rationale for the next actions to take, including the decision to proceed or not to a child protection conference.

Strategy meetings are taking place. However, less than half of all strategy meetings are attended by the three key safeguarding partners. The lack of attendance, participation and contribution by the two other safeguarding partners, in addition to the attendance by the local authority, means that, for some children, the fullest information about their family circumstances is not being shared to understand risk and inform joint decision-making.

Children are being seen on their own by their social worker on a regular basis. This has continued throughout the pandemic, but there is variability in the quality of assessments being undertaken. Stronger assessments demonstrate a focus on the child with effective information gathering that analyses the child's needs, the strengths and the risks. Where practice is weaker, the assessment is overly descriptive, and the analysis does not clearly focus on the impact of the identified risks on the child.

The quality of children's plans reflects the variability seen in the assessments. The better plans are focused, with clear actions and timescales that measure the child's progress. The weaker plans are too generic and lack focus on the specific needs of

the child and their family. The plans lack clear timescales, making it difficult to monitor progress and assess whether the child's needs will be met by the planned interventions within a timescale that is right for them.

Children's case records evidence regular supervision and social workers reported feeling well supported by their managers. However, in some cases, supervision records were not reflective and were not assisting the worker to analyse their findings or provide an opportunity for learning.

Senior leaders have access to a range of performance data, and audit activity takes place. However, it was not clear to inspectors how this was providing leaders with sufficient understanding and oversight of the quality of practice and management oversight. Team managers audit their own team's work. The audits are not moderated and do not provide independent scrutiny of practice. Although the audit process includes consultation with children and families, this is not embedded in practice and had not taken place in any of the audits reviewed during the visit.

Audits do not routinely identify areas for development and do not provide sufficient evidence to inform workforce development and drive forward practice. While performance data is available and is enabling managers at all levels to have oversight of performance at a service, team and individual level, this management information is incomplete. It does not include all the performance information that managers need to understand the quality of practice and whether practice meets statutory requirements.

Despite an increase in demand over the last 12 months, there has not been a corresponding increase in average caseloads. However, there is variability, with some social workers holding higher than average caseloads. Social workers reported these to be manageable.

Staff are proud to work for Leeds and enthusiastic about the Leeds practice model. There is a stable workforce, with good retention rates. Teams are well established, meaning that many children have a consistent social worker, which supports good relationships. Staff reported positive opportunities for career progression, with many choosing to remain in Leeds throughout their social work careers.

Ofsted will take the findings from this focused visit into account when planning your next inspection or visit.

Yours sincerely

Victoria Horsefield
Her Majesty's Inspector