Inspection of City of Bradford Metropolitan Borough Council local authority children's services

Inspection dates: 21 November to 2 December 2022

Lead inspector: Matt Reed, His Majesty's Inspector

Judgement	**Grade**
The impact of leaders on social work practice with children and families	Inadequate
The experiences and progress of children who need help and protection	Inadequate
The experiences and progress of children in care and care leavers	Inadequate
Overall effectiveness	Inadequate

Bradford children's social care was last inspected by Ofsted in September 2018 and was judged to be inadequate for the experiences of children who need help and protection and for overall effectiveness. Since that inspection, the experience and progress of many children have declined. There are widespread and serious failures across all service areas. This leaves children at risk of harm, leaves some children in situations of continued harm, and, for many children in care, unnecessary and prolonged delays in achieving permanence.

Ofsted has conducted seven monitoring visits since the previous inadequate judgement. While some progress has been achieved in some discrete areas, overall the pace of these improvements has been very slow. Corporate leaders continue to lack understanding of the scale of improvement required and what actions, time and resources are needed to make improvements happen. This has had a negative impact on progress, particularly in relation to recruitment of staff at all levels. The delays to these improvements have led to a lack of confidence in children's social care by partner agencies, and an inability to provide social workers and managers with an environment where they can practise safely and effectively. While some very recent improvements can be seen to services at the front door and within early help, services have deteriorated overall.

What needs to improve?

- Council and corporate senior leaders should ensure that they fully and effectively discharge their role as corporate parents, and ensure that children's social care is provided with the resources and support required in a timely way to expedite sustainable improvements.
- The sufficiency and stability of the workforce, including senior leaders and managers.
- The quality and timeliness of assessments of risk and need in all their forms, including the response to domestic violence.
- The timely completion of statutory safeguarding checks and compliance with regulation regarding private fostering and connected carers.
- The timeliness and quality of decisions in respect of section 47 enquiries.
- The currency and accuracy of children's records.
- The effectiveness of all multi-agency meetings and their influence in driving children's plans.
- The timely escalation to public law outline (PLO) and timely progression of permanence in all its forms.
- The effectiveness and impact of independent reviewing officers (IROs).
- Foster carer morale, training, recruitment and retention, including the support offered to special guardians.
- The quality and safety of in-house residential provision, including safer recruitment.
- The offer of safe, appropriate and sustainable homes for care leavers and their preparation for leaving care.
- Clarity regarding the process of completing personal education plans (PEPs) so that they are consistently completed by all relevant professionals.
- The quality and effectiveness of supervision to staff at all levels by managers and leaders.

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

1. There are widespread and serious practice and system failures across the help and protection service. While improvements have been achieved in some service areas since 2018, too many children experience drift and delay in

having their needs identified and addressed. Multiple changes of social workers and managers are leading to ineffective and reactive decision-making. This high turnover of staff, and constant reallocation of children's cases, does not enable social workers to fully understand children's histories, the presenting risks, or where some children are experiencing chronic neglect and unmet need.

2. A much-improved and comprehensive early help offer is available. This is enabling more families to have their needs assessed promptly, but not all assessments are of good enough quality. This is leading to unfocused plans and a lack of coordinated support to meet families' needs at the earliest opportunity.

3. Arrangements at the integrated front door have been strengthened and include the very recent implementation of a nationally recognised evidenced-based conversations model for contacts and referrals. The emergency duty team responds effectively to concerns out of hours and takes immediate safeguarding action when needed. Thresholds to access children's social care are well understood by partner agencies and front door staff. Most contacts are screened and progress for assessment or redirection appropriately. Parental consent is considered, but the reasons to dispense with consent are not always well recorded. There is a small number of children where insufficient screening checks with relevant agencies have resulted in a failure to identify risk and need. Some children's cases have been prematurely closed or stepped down to early help, only for children to be rereferred soon after for the same issues. This leaves some children suffering and, at continued risk of, harm.

4. The response to immediate safeguarding concerns is not timely or effective for all children. For some children, delays in the decision to hold a strategy meeting leave children in situations of unassessed risk. Strategy meetings, although well attended by partner agencies, do not always result in joint section 47 investigations with police when they should, and not all outcome decisions are proportionate to the level of presenting or suspected risk of harm. Inspectors saw evidence of one child suffering further serious significant harm, and a small number of children being placed at increased risk because of inappropriate strategy discussion decisions.

5. When practice moves away from the integrated front door, management oversight is weaker, and social work practice is adversely impacted on by high staff turnover and high caseloads. Despite the best efforts of social workers, children are unable to develop meaningful relationships with their social workers due to the constant churn of staff. Gaps in children's records mean that newly allocated social workers do not have an accurate understanding of children's circumstances or children's plans. Some children and their families have to retell their story multiple times. Caseload pressures have resulted in many children not having an allocated worker for periods of time. Many

children's assessments have stopped as social workers leave, and then restarted when new social workers and managers are appointed. This inconsistency in assessment, planning and management direction results in delays for children having their needs identified, and delays in help, support and protection being provided when it is needed.

6. Assessment quality is negatively impacted by the high social work turnover and workload pressures. Although average caseloads have reduced, there are some social workers who continue to have high numbers of children, requiring them to prioritise which children's cases need the most attention. The impact is that not all assessments identify need and risk. Pressures on social workers to move children's cases on mean that, for some children, statutory interventions are ended without assessments being updated, and often with overly optimistic assessments about parental capacity to change. Although social workers try to obtain children's views in most assessments where possible, children's views are not always reflected thereafter in their plans. Gaps in supervision and ineffective management oversight and direction are not challenging poor assessment quality, or driving children's plans to ensure that children are safeguarded. Too many children are exposed to repeat episodes of harm and multiple interventions.

7. In too many cases, domestic abuse is seen as a single episode. Although domestic abuse referrals are effectively triaged at the front door, subsequent assessments and planning focus mostly on the presenting issue, are adult focused and make recommendations based on short-term changes. Management decision-making does not always recognise the long-term and negative impact on children of witnessing domestic abuse before agreeing to case closures. Consequently, children continue to be exposed to harm and some are rereferred multiple times for the same issue.

8. The vulnerabilities of children subject to private fostering arrangements are not routinely recognised by social workers or managers. Relevant checks are not undertaken, and most assessments seen during this inspection are incomplete. Managers do not apply due diligence to assure themselves that the placements are suitable and safe, potentially leaving children at risk of harm.

9. Child in need and child protection planning is ineffective for too many children. Some children do not make timely progress and their needs remain unmet. Many children's plans are adult focused and lack consideration of the child's needs and the impact of risks on them. Multi-agency meetings are not consistently challenging or progressing plans to effect positive change for children. Not all key safeguarding meetings take place at the required frequency and, consequently, some children's plans are not monitored in the required timescale. Child protection chairs do not consistently identify when there is drift and delay or concerns about practice. When child protection chairs do escalate concerns, they have limited impact. Some child protection

plans are ended without clear evidence of sustainable change and reduced risk. There is an overreliance on written safety plans as recommendations of conferences to manage risk, which rely heavily and inappropriately on parents understanding the risk and being compliant with plans.

10. Many children's records are not updated when important decisions are made, or when actions are taken to safeguard them. When children are visited, they are seen alone where appropriate. Their views are usually recorded with some evidence of direct work to help them understand their experiences, when social workers are able. However, visits to children are not always purposeful or link to a plan. Recordings are descriptive and do not evidence what has changed, what progress is made, or why improvements have not been made. Should children choose to access their records at a later date, they will be unable to gain an understanding of professional interventions into their lives and why decisions were made about them.

11. When risks to children escalate and are known, not all children progress to the pre-proceedings stage of the PLO in a timely way. There are delays in more detailed and specialised assessments being undertaken. These delays are further impacted on by changes of social worker and manager. There have been some very recent improvements in the oversight of PLO processes by the current senior leadership team, which has expedited plans for some children. However, there remains an overriding legacy of significant drift and delay for many children who have remained in situations of harm for too long, and whose plans should have progressed much sooner to care applications.

12. Practice in the children's health and disability service is stronger than in other parts of the service. The team is more stable. However, caseloads in the team are so high that some children are not allocated to a social worker when their assessed need clearly indicates this is necessary. While there is some management oversight of these children's cases, the inability of the manager to allocate a child's case to a social worker means that some children's plans have not progressed when they should.

13. The multi-agency child exploitation hub provides an effective, joined-up forum to share information. Professionals within the hub develop multi-agency support plans, which aim to reduce vulnerability and risk to children at risk of exploitation. However, the effectiveness of this forum is undermined by weaknesses in the quality of the child exploitation risk assessments which are shared with, and directed from, the meeting. When the forum lays down recommendations, these do not routinely translate into children's plans to ensure joined-up working to safeguard children. When exploitation concerns escalate, appropriate child safeguarding enquiries are undertaken. However, these address mostly immediate safeguarding concerns and do not inform longer-term planning to safeguard children.

14. When children go missing from home and care, return home interviews are offered to all children, and missing co-ordinators offer a consistent response to children and their families. Their effectiveness is reduced as recordings of the interviews are not all of a good quality for some children, and the findings do not consistently read across to influence the child's safety plan.

15. Staff in the education safeguarding team make swift and appropriate checks on children who may be vulnerable to missing some of their education. Children who are missing education are tracked down quickly and returned to school wherever possible. Some of this work is affected and often delayed by the regular changes of social worker and a lack of coherence in how different services work together.

16. When there are allegations against professionals who work with children, there is a thorough and detailed response from the designated officer for the local authority. Leaders have had increased capacity in this area to ensure that allegations are tracked, and appropriate conclusions and actions are reached and undertaken.

17. When children aged 16 or 17 present as homeless, there is a timely and effective response. Children are advised of their rights to enable them to make informed choices. Mediation with families is undertaken to prevent the child entering care if appropriate, or moving into temporary homeless accommodation.

The experiences and progress of children in care and care leavers: inadequate

18. High staff and manager turnover has negatively impacted on the experiences of children in care and care leavers. Too many children have experienced multiple changes of social worker. This has created delays in care planning decisions and has impacted on how social workers are able to achieve and support permanence for children.

19. Not all children enter care at a time that is right for them. Some children enter care in a crisis, despite being known to children's social care and in receipt of services for a long time. A lack of risk-based assessments, and a lack of effective interventions when children need help and protection, have left many children living in situations of harm for too long. Social workers are responding to the immediate crisis, resulting in placements being determined by the availability of places rather than the child's assessed needs. Once a temporary placement is made, some placements drift into a long-term approach without an appropriate review or thorough assessment of need.

20. There are weaknesses in care planning. Not all social workers are supported by their managers to explore and test potential permanence options and what they will mean for the child and their family. Not all permanence options are

pursued. Wider family members are considered as potential carers, but delays in assessments starting, and a lack of statutory checks, delay timely and safe placement and permanence planning. Kinship assessments do not thoroughly consider the strengths and weaknesses of prospective placements with family and friends when identifying what assistance families might need to provide a safe and effective long-term home for a child. A previous lack of support for carers who wished to become special guardians means that, until recently, carers have been reluctant to pursue this option. This has limited some children's chances of permanence with family members or with long-term foster carers. Recently, the local authority has increased its fostering allowances via a newly implemented fostering policy. As well as increasing support to mainstream and kinship carers, special guardianship allowances have also increased. However, the impact of these changes is yet to be fully realised.

21. Appropriate consideration is given to decisions to place brothers and sisters together or apart, as well as to any unique cultural characteristics. However, insufficiency of appropriate placements means this is not always possible. Assessments are influenced by several factors, including the needs of individual children, the individual relationships of the children with each other, and the family size. Children are supported to maintain relationships with people who are important to them. Family time is promoted, and arrangements adapted to meet the needs of the child.

22. When care proceedings are issued, social work evidence is detailed and provides a rationale for the application. However, due to the frequent changes of social workers and managers, not all applications are made in a timely way. Some court applications show that more could have been done to avoid proceedings by providing better support services to prevent children entering care, and by making more effective use of the pre-proceedings process. This has led to a lack of confidence in local authority plans by the courts and is contributing to further assessments being ordered, delaying children achieving permanence. The Children and Family Court Advisory and Support Service (CAFCASS) reports recent and much-improved relationships with the local authority. It reports that, more recently, practice is improving, leading to better outcomes for some children.

23. A high number of children live with their parents. Many are subject to legal orders, either because the plan submitted to court did not meet the threshold for removal, or because plans for children subject to final care orders have drifted. When considering returning children home from care, or placing them within their wider family, not all arrangements have been sufficiently assessed to ensure they are safe for children. There are gaps in safeguarding and suitability checks, and not all placements have the necessary approval of senior leaders. There is not enough consideration about what support can be provided by the local authority, and why any risks are, or are not, manageable with this support in place.

24. The rising numbers of children entering care in Bradford, many unplanned due to crisis, mean that senior leaders are struggling to meet their sufficiency duty. An increase in children who require specialist provision that can support complex needs is adding further pressure on a placement system already under immense pressure. The local authority has very recently implemented a sufficiency strategy to address shortfalls. However, it is too soon for this to have had an impact. Unaccompanied asylum-seeking children receive a timely and sensitive response from a commissioned provider.

25. Issues with capacity in the social care workforce and the challenges with the recruitment and retention of foster carers are barriers to achieving safe and permanent homes for children. Foster carers report feeling supported by their supervising social workers, but they report that the high turnover of children's social workers has negatively affected the support that foster carers and the children require and is impacting on their morale and retention.

26. The local authority is part of a regional adoption agency (One Adoption West Yorkshire) and there is a clear adoption support offer in place for adopters. The numbers of children leaving care through adoption have fluctuated, but are currently increasing. However, the high turnover of social workers is negatively impacting on the timeliness of achieving permanence through adoption for some children.

27. There has been insufficient senior leadership grip on residential services until recently, resulting in some children experiencing instability and multiple moves due to poor matching and poor care planning. Children who live in local authority children's homes experience multiple changes of staff and changes of social worker, which mean that they do not have consistent, reliable relationships with adults. The inspection identified a small number of children aged under 16 living in unlawful placements. There is a lack of oversight by senior managers of these arrangements. Drift in planning results in vulnerable children remaining in these arrangements for extended periods without any additional safeguards in place.

28. Frequent changes of worker mean that not all children are being supported to understand their life history and the reasons for the decisions that are made about them. Evidence of direct work is limited, and life story work is not routinely completed. Children's plans are brief and are not reflective of all the work verbally described by workers. While children are mostly seen regularly by a social worker, the multiple changes of social worker have negatively affected some children's willingness to engage with visits. Not all children who live out of the area have received regular face-to-face visits.

29. IROs are not fulfilling their roles effectively. While most children's reviews are held within timescale, social work turnover and lack of IRO capacity adversely impact on IROs' ability to make appropriate recommendations in the review,

and to ensure that any ascertained wishes and feelings of children in care are given due consideration by the local authority. Weaknesses and gaps in children's care plans do not sufficiently address children's needs or support their routes to permanence. There is access to an advocacy service for children in care, but there is limited evidence in children's records that this is used effectively to support children's voices. When IROs identify drift and delay, or have concerns about individual children or social work practice, they do not always challenge decisions when they should; when they do, their challenge is often ineffective. There is insufficient management support and endorsement of IRO activities, which inhibits the IROs' ability to contribute to care planning and to contribute to system-wide learning.

30. Young Voice, Youth Voice and Your Voice are the names chosen for the three groups that make up the children in care council. Children reported to inspectors their poor experiences of numerous changes of social worker and multiple changes of carer in residential children's homes. Children reported how some social workers are good, but not all social workers do what they say they will do. Inspectors could see how children and care leavers are now playing an active role in some corporate parenting board meetings. The children's voice is beginning to shape some services, but this is a relatively new development and is yet to have a significant impact on the quality of services to children in care.

31. Children are supported to meet their physical health needs. For some children in care and care leavers, there are delays in accessing support from child and adolescent mental health services for their emotional health needs, with no evidence of how senior managers are addressing this.

32. The virtual school makes regular checks on the attendance and progress of children in care, and most children achieve well in school. PEPs do not reflect ambition for what children in care can achieve. Quality assurance processes are not effective, and often important aspects of each PEP are not completed, resulting in some children in care not achieving as well as they could.

33. Most care leavers are visited regularly according to their needs. Pathway plans identify some needs and are completed with care leavers. However, not all pathway plans are completed in a timescale to ensure that children are adequately supported leading up to leaving care. There is a significant gap in helping care leavers to develop some of the most basic independence skills, for example budgeting or cooking, needed to prepare for adulthood. This is not assisted by delays in the allocation of a personal adviser. Care leavers have access to their health histories and important documents to support their transition into adulthood.

34. Personal advisers are persistent in their approach to supporting care leavers to consider education, employment and training opportunities. Increasing numbers of children are accessing these opportunities, and apprenticeships

are actively encouraged. However, not all care leavers receive the support they need early enough to assist their progression to further education to enable them to reach their potential.

35. Although most care leavers are in suitable accommodation, the housing offer does not meet the needs of all care leavers. Although increasing numbers of children remain with foster carers in staying put arrangements, overall there is insufficient accommodation support to prepare children for independence. The system for allocating housing is not tailored to individual needs and results in some care leavers living in poor-quality homeless accommodation.

The impact of leaders on social work practice with children and families: inadequate

36. In September 2018, Bradford children's social care was judged to be inadequate by Ofsted. Since that inspection, corporate and senior leaders have failed to improve services, and have overseen further decline. Despite some improvements in specific service areas, there remain widespread failures across service areas. This included the management of the council's residential children's homes until some very recent improvements in some children's homes.

37. Ofsted has completed seven monitoring visits since the inadequate judgement and has consistently expressed serious concern about the slow pace of change. As a result of these concerns, in September 2021, the Secretary of State for Education appointed a Commissioner of Children's Services. In January 2022, the Commissioner recommended that children's social care could no longer be run by the council. The process of establishing a not-for-profit trust, owned by Bradford Council but operated at arms-length under the control of an independent chair and board of directors, is underway and is set to go live in April 2023.

38. There are multiple factors which have contributed to the overall deterioration in services to children and their families. Long-term instability in the senior leadership team, including at the Director of Children's Social Care level, has resulted in the absence of a clear vision and an incoherent approach to improvement work. Corporate leaders have consistently failed to understand the scale of improvements needed and have failed to comprehend the time it will take for services to improve. Improvement has been severely restricted by obstacles to funding, which have delayed recruitment in particular. Until recently, the failure to appoint knowledgeable and skilled managers at all levels has resulted in ineffective lines of oversight and accountability, and a failure to ensure that children benefit from safe and effective social work.

39. Previously weak and inconsistent strategic planning has contributed to staff insecurity and instability, resulting in significant workforce challenges which

remain. While there has been investment to increase staffing through the use of agency workers, which is beginning to have an impact on reducing caseloads for some social workers, corporate obstacles to securing the required resources when needed have been a barrier. A social work academy has been developed and the workforce development offer has been revised. However, it is too early for these strategies to have a significant impact to enable an environment where good social work can flourish.

40. Performance management systems, while improving, do not provide senior leaders with a good enough understanding of what the data is telling them, to facilitate further improvements. The data does not accurately reflect children's experiences as many children's records have gaps, are out of date and do not accurately reflect the child's circumstances, histories or what interventions have taken place and why.

41. Quality assurance processes focus too greatly on compliance and do not provide senior leaders with an accurate understanding of children's experiences or practice quality. The lack of collaboration with social workers when conducting audits limits their effectiveness in improving social work practice and filling these gaps. This is recognised by the current senior leadership team, which has commissioned an external agency to work alongside internal auditors to improve the focus on the quality of practice. The ability of managers to improve the quality of practice and achieve a level of consistency is impacted on greatly by the constant churn in the workforce.

42. The self-evaluation provided by the current senor leadership team provides a more realistic overview of practice than previously. The current interim DCS has led some improvements from a very low base. The DCS has begun to constructively engage external agencies and partner agencies to support the improvement work. This has resulted in some very recent improvements in the front door, exploitation hub and early help. However, the legacy of improvement delays, high staff turnover and poor decision-making mean there is a lot more work needed to increase partner agency confidence, particularly in relation to schools and the courts, in children's social care.

43. The local authority is not acting as a strong and effective corporate parent. Although the corporate parenting board arrangements have recently been strengthened through the inclusion of children and identification of areas for priority action, the corporate parenting strategy remains incomplete and is not demonstrating how it impacts on the quality of services to children in care. There has been insufficient attention given to improving the fostering service, improving children's homes, and improving the experiences of care leavers.

44. Social workers spoken to during the inspection reported recent improvements in the visibility of managers and reflected on a greater sense of calm and clarity of direction. They report having access to training, but not all can easily access this due to workload pressures. It is evident that social workers are

committed to doing their best for children, but it is also evident that staff morale has been adversely impacted on by working in a very challenging landscape.

45. Social workers are not helped by weaknesses in frontline managers' oversight. Gaps in supervision for many social workers mean they are not given the opportunity to reflect on their practice, or receive constructive discussions about how children are to be helped and supported. When decisions are made, this is not evident on all children's records and there is limited evidence of managers driving progress in plans for children.

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