

Kirklees Metropolitan Borough Council

Inspection of children's social care services

Inspection dates: 10 June 2019 to 21 June 2019

Lead inspector: Lisa Summers
Her Majesty's Inspector

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

Since the last Ofsted inspection in September 2016, when the local authority was judged inadequate overall, strong and resilient senior leadership has underpinned the improvement in practice from a considerably low base. The pace of change was initially slow, impeded by a lack of stable and effective senior management. In June 2017, a formal arrangement was implemented by the Department for Education (DfE), with Leeds City Council taking responsibility for overseeing improvement. Since March 2018, there has been steady progress in strengthening the foundations for sustainable service improvement. As a result, there are no widespread or serious failures that leave children at risk of harm.

Progress has been achieved through increased corporate commitment and investment in services, clear and focused leadership, strengthening of partnerships, for example the duty and advice team, and improved workforce stability and engagement. Children who need help and protection are now recognised, and risk of significant harm is quickly responded to.

Children have their needs met by social workers who know their children well, and through better-coordinated multi-agency planning. Early permanence for children in care is well considered and progressed. There is strong practice in relation to the quality of direct work with children and young people, particularly for those leaving care, and effective collaboration to address the growing emergence of gang-related activity and child exploitation.

However, the local authority is not delivering good help, protection and care for all children, young people and families. Caseloads for some social workers in the assessment and intervention teams are challenging to manage when they are on duty, and this impacts on quality in some cases. This means that not all children receive help at the earliest opportunity. There are still delays in achieving permanence for some children. This includes children with a plan for long-term fostering and those placed with parents on care orders. Management oversight, challenge and supervision are not sufficiently robust. Mechanisms for monitoring permanence have been strengthened, but these improvements are too recent to have had an impact. The quality of return home interviews for children who go missing from home and care is not consistently robust. Senior managers were not aware of the deterioration in services for children who are privately fostered and those at risk from professionals where allegations have been made. As a result of the findings of this inspection, senior managers took action to consider and amend processes for these children. Disabled children are not receiving a service of sufficient and consistent quality. Before this inspection, senior managers identified these concerns, and moved the management of the service to children's social care. The newly revised quality assurance and performance framework is still developing, and does not fully support senior managers' understanding of children's experiences and the quality of social work practice across the service.

What needs to improve

- The quality of recording, assessments and child protection investigations so that children receive help at the earliest opportunity.
- The quality of written child in need, child protection and care plans, so that they are timebound, with clear and meaningful contingency plans.
- The response to disabled children, children in private fostering arrangements, and children at risk from professionals where allegations have been made.
- The response to children who go missing from home and care, so that all children are offered return home interviews that are of good quality, in order to better understand why children go missing and to inform care planning and strategic priorities.
- The timely permanence for children with plans for long-term fostering and children placed with parents.

- The completion of life-story work for children in care.
- Care leavers' understanding of their health histories.
- The quality of foster carer reviews.
- Management oversight across the service through improved performance and quality assurance.
- Regular supervision of social workers that is reflective, directive and, alongside the work of independent reviewing officers (IROs), challenges poorer practice.

The experiences and progress of children who need help and protection requires improvement to be good

1. There has been steady and continuous progress to improve the initial response to children in need of help and protection since the last Ofsted inspection in 2016. The multi-agency duty and advice team has been strengthened, and children now receive a timely and appropriate initial response when they are referred for a children's social care service. Screening of contacts is effective and is informed by the child's history and appropriate information from partner agencies. Children's voices are routinely considered and sought through discussions with referrers and other professionals known to the child. Consent is consistently secured or appropriately dispensed with where there are risks of significant harm.
2. Kirklees' early help strategy has recently been refreshed, but is not fully embedded. There are examples of good and impactful work with families through community hubs, and appropriate signposting to services. However, the local authority is not evaluating the impact of early help provision, limiting its understanding of what is effective and why. The new multi-systemic therapy service provides edge-of-care provision. The service is still in its infancy and it is too soon to evaluate its effectiveness.
3. When significant harm is identified, the majority of children benefit from swift, well-coordinated strategy meetings. Key partners do not always attend strategy meetings, limiting the richness of discussions, decision-making and planning of investigations. Most strategy meetings identify clear actions to be taken to safeguard children. However, not all set out timescales for their completion.
4. For children who have experienced domestic abuse, there is a solid, well-coordinated multi-agency response. The daily risk assessment multi-agency meeting effectively screens domestic abuse referrals and coordinates the right help and support for victims and children.

5. Most assessments and some child protection enquiries are not good enough. While presenting risks are responded to, wider needs are not always identified. Too many assessments lack depth and do not demonstrate an understanding of children's experiences. Children's history and information from partners are not effectively considered to inform social workers' analysis. As a result, some children's needs had not been identified and met at the earliest opportunity, and some children have been subject to repeat assessments. A high proportion of both assessments and child protection enquiries do not result in any action from children's social care.
6. Resultant written plans for children in need and those subject to child protection plans focus appropriately on the presenting issues identified from assessments. However, many lack timescales to help focus families and professionals on goals that need to be achieved and clear contingency arrangements to help parents to understand what would happen if the outcomes were not met.
7. Children benefit from recently improved practices in planning, with social workers able to drive the work, supported through effective multi-agency arrangements. This is helping children to be safer and have their needs well met. Positively, planning becomes more focused on meeting children's broader needs as social workers get to know children and their families. Social workers use a restorative approach to positively engage with families. This enables meaningful relationships to be secured, so that families can shape and influence their plan. Social workers speak knowledgeably about children and families. This is helping children and their families to progress their plans.
8. Some groups of vulnerable children receive effective support. The work of the multi-agency risk and vulnerability team is starting to embed, and the response to exploitation is better coordinated. There has been demonstrable success in diverting young people away from crime, including working with those involved in gangs and knife crime. The response to child sexual exploitation is well-coordinated to mitigate risk. As a result, the circumstances of many of these children are improving.
9. Young people aged 16 and 17 who present as homeless are well supported. Pathways and joint working with housing are well established, which means that their immediate accommodation needs are assessed and met. Young people are informed of their right to come into care.
10. The recently formed education safeguarding team is working increasingly well with a range of partners to track and monitor children missing from education. Stronger actions are currently being taken to respond to the significant growth in the number of pupils receiving elective home education.
11. Senior managers have recognised that the disabled children's service did not provide sufficiently child-centred social work, and moved the management of

this team to children's services. Social workers working in the children's service have not had the appropriate training or access to tools to enable them to communicate effectively with their children. Some basic social work tasks, such as plans and assessments, are not being consistently completed.

12. Senior managers were unaware that the arrangements to support children who are privately fostered had deteriorated since the last inspection and are poor. Children's needs and the suitability of the arrangements have not been assessed and appropriate checks are not being undertaken.
13. The response to allegations against professionals is not consistently robust, and allegations are not always fully explored to inform the action that needs to be taken. Oversight and management arrangements are not effective in the designated officers' absence. This potentially leaves children exposed to risky situations.
14. Not all children who go missing are offered a return home interview. When these are completed, the quality is inconsistent and does not give a good enough understanding as to why children go missing in order to inform care planning or disruption activity to reduce further missing episodes.

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

15. Senior managers have improved services for children in care and care leavers in Kirklees since the last inspection. However, services are not consistently good for all children and young people. Shortfalls in the quality of care planning and a lack of manager and IRO challenge and oversight mean permanence for some children is delayed.
16. Inspectors saw appropriate use of the public law outline (PLO). Improved monitoring of timescales through the PLO tracker is leading to decisive action being taken to safeguard children when changes are not made. Managers are aware of the need to further improve letters to families before proceedings, to ensure that parents are clear on the changes that are required to safeguard children from further harm.
17. Staff from a range of services, including the multi-systemic team, family group conferencing and the risk and vulnerabilities team, work effectively to support children to remain in the care of their families, and as part of plans for reunification where appropriate. When it is not possible for children to remain in the care of their families, appropriate action is taken for the majority of children to enter care in a timely manner.
18. For children coming into care more recently, the development of a permanence panel and associated trackers is resulting in more effective early permanence planning. Robust sibling assessments provide a clear rationale

for whether children should be placed with or apart from their brothers or sisters. For children with a plan for adoption, even those traditionally regarded as hard to place, the identification of adoptive families is swift, and the placement achieves permanence in a timely manner. Children enjoy stability through well-embedded post-adoption support and good use of the adoption support fund. The overall timeliness of adoptions is improving.

19. Senior managers have been too slow to address poor practice identified at the last inspection in relation to children placed with their parents on care orders for significant periods. Senior managers have reviewed all children in these arrangements and are now monitoring them through the permanence panel. Although a number of these children have achieved permanence as a result, there are still too many children waiting for permanence to be secured.
20. Some children experience delays in family finding. There are also delays in ensuring permanence matches for children in long-term foster care and for a small number of children waiting to be adopted. Delays are due to several issues, including changes in social workers and/or IROs, and lead to a loss of continuity in delivering care plans, and a lack of long-term foster carers and adopters, meaning that some children wait too long for a match. Recommendations from some reviews were unclear as to what actions needed to be taken to secure permanence. The tracking of these children is very recent, and at the time of the inspection, senior managers were unclear about how many children were still waiting to be matched with their long-term foster families.
21. The majority of children benefit from living in a range of placements that meet their individual needs. Most children live with carers who provide activities and opportunities that enable them to enjoy life, improve their progress and promote a rounded childhood. A dedicated connected carers' team offers a high level of support to children who live with friends and family, which is effective in reinforcing and sustaining permanence. This means that these arrangements seldom break down.
22. Senior managers are working to increase the number of local placements, through an ambitious fostering recruitment strategy and working closely with external providers. Foster carers spoke positively about improvements to induction, regular training and carer support groups. However, reviews of foster carers are not sufficiently robust. Although timely, they lack reflection of children's views, and there is not enough exploration of significant incidents or information about mandatory training completed. Senior managers have recently recruited an IRO to undertake this work. Mechanisms to routinely evaluate the overall performance of the team are not in place, so managers are unable to assure themselves that standards in compliance and mandatory training are met.

23. When children are placed at some distance from their home, effective notification takes place to ensure that host local authorities are informed. However, social workers do not routinely consult with host local authorities before children are placed to ensure that they receive timely services to meet their needs.
24. Children's placement stability is monitored by senior managers. Performance figures are currently going through a manual data cleanse following integration from a previous electronic recording system. For most of the children, supportive action is taken promptly when concerns are identified. Bespoke support is delivered by the placement support service to enable children to remain in their placements when appropriate. When placements end in an unplanned way, disruption meetings are not routinely held to help workers understand why this happened or to inform future placement decisions. This hinders future matching.
25. Children in Kirklees increasingly benefit from good support from advocates and independent visitors. This allows children to share their views and opinions at a range of regular reviews and meetings.
26. Social workers and personal advisers have a good understanding of the children and young people they work with, although this is not always consistently evidenced in case recording. There are examples of sensitive direct work, including life-story work to help children to understand their individual circumstances. This is not consistent for children living in long-term foster placements. Managers are aware of the need to develop this further.
27. The children in care council has been developed since the last inspection. It offers a wide variety of activities to children to participate in and give their views, and celebrates the achievements of children in care and care leavers through an annual celebration event. The number of members of the children in care council is very low, and managers are aware of the need to increase this so that children have a meaningful influence on service developments and training.
28. Children in care are given good support to become physically and emotionally healthier. They are routinely taken for dental and optician appointments and their health needs are met. Workers consider and assess individual needs effectively, and specialist provision is sought where necessary. A multidisciplinary emotional well-being clinic provides timely and accessible emotional support for children and carers, and clinical expertise and advice are embedded throughout the service. Although records indicate that young people receive their health histories, these are not recorded on their case records and care leavers say that they have not received information about them.

29. The majority of children's care plans are updated and monitored regularly by IROs at timely reviews. Plans do not always clearly identify how permanence will be achieved, and many lack timescales to minimise drift. Child-friendly care plans are of better quality and are routinely used to help children understand their plans. There is clear evidence of IROs' oversight. However, IROs do not routinely challenge and escalate concerns about drift and delay.
30. The effective virtual school has high aspirations for the progress and well-being of children in its care. The virtual school has developed increasingly purposeful links with schools and colleagues in social care to check pupils' progress and provide additional support. Personal education plans are thorough and clearly capture the views of children, young people and carers on the support they receive. The virtual headteacher has supported the creative use of additional funding to improve attendance, provide extra tuition and promote children's involvement in wider experiences. As a result, children in care have achieved outcomes that are largely in line with children in care nationally. Additional support for young people over the age of 16 is encouraging increasing numbers to remain in education, employment or training.
31. Care leavers increasingly receive an improving service, key to which is the allocation of skilled personal advisers who have manageable workloads, enabling them to get to know their young people very well. Quality pathway plans, in which young people's voices clearly shine through, appropriately identify the tasks and timescales needed for them to achieve independence. However, senior leaders are aware that more work is required to ensure that this is consistent for disabled children and young people.
32. The local authority is in touch with the vast majority of its care leavers. The No. 11 service provides a high-quality resource for care leavers to use as a drop-in when they need advice and support. There is an appropriate focus on helping young people to prepare for independence through the provision of support and training, and to build resilience, for example through budgeting.
33. A dedicated careers officer adds significant value to the service by offering young people the opportunity to enter the world of work at their own pace and according to their own preferences. This means that many care leavers are in education, employment or training.
34. The vast majority of care leavers live in suitable accommodation and benefit from good support to maintain their living arrangements. 'Staying-put' arrangements, for care leavers to remain living with their former foster carers beyond the age of 18, are readily available, across both local authority and independent fostering agency placements. At the time of the inspection, 27 young people were living in such arrangements. Care leavers living within the borough are exempt from paying council tax, an initiative that was developed to support them to live independently. Solid partnerships with local housing

providers mean most young people are found suitable places to stay near where they lived in residential and foster care or near family. This enables their support networks to be suitably maintained.

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

35. Senior leaders have taken a systematic approach to improve the quality of services since the last Ofsted inspection in 2016, which judged the service to be inadequate. Initially, the pace of improvement was slow, impeded by instability in staffing and a lack of consistent and effective leadership. This included four changes of director of children's services in a short period of time. Latterly, the pace of improvement has accelerated as a result of the DfE's formal arrangement for Leeds City Council to take responsibility for overseeing improvement. This arrangement secured strong foundations for the recently appointed permanent DCS to build on when taking up her post in December 2018. There is a renewed energy and determination to continue improvements for children and families in Kirklees. However, there is more to do to ensure that all children who need help and protection and those in care receive a good service that improves their experiences.
36. Children's social care has been well supported across the council, both financially and culturally, in order to achieve the improvements needed. Elected members, leaders and senior managers have made significant improvements in corporate parenting. They are now clear about their responsibilities and are proactive, highly ambitious and aspirational for children in care and care leavers, and they are taking pride in their achievements.
37. Leaders are creating the right conditions for social work practice to flourish. Managers have targeted areas of great impact for children through a whole-service reform to support and sustain the improvements needed. Senior managers have re-established relationships with partners and have built stronger services, such as the improved multi-agency duty and advice team, while stabilising the workforce and repairing fractured relationships between social workers and senior managers.
38. Leaders have reviewed and restructured services for children in need of help and protection and children in care. As a result, most children now receive an appropriate response to protect them, and experiences of children in care are improving. Now that this has been achieved, and services have been secured, senior managers are in a positive position to look more broadly across the wider service.
39. Senior managers understand the needs of children and their families well. They have worked hard to rebuild trusting relationships and there are shared

priorities with partner agencies. This is enabling them to respond appropriately and effectively to new demands. For example, the creation of the multi-agency risk and vulnerability team is effectively addressing the growing emergence of gang-related activity and growing numbers of children vulnerable to exploitation. The response to children who go missing from home and care needs a stronger focus to ensure that all children receive a consistent service; maximise opportunities to understand push and pull trends; better manage risk; and identify themes to inform strategic planning.

40. Leaders and senior managers have an improving understanding of the quality of frontline practice through recent peer reviews, Ofsted monitoring visits and the use of sector specialists to improve their services. Senior managers and leaders have regular contact and discussions with children and young people to better understand their priorities and improve services. For example, the lead member has been instrumental in securing free transport passes and free driving lessons for young people leaving care. The improvement board routinely scrutinises areas of practice through its 'spotlight on practice', inviting children and young people, social workers and managers to share their experiences of services and identify areas for improvement. Feedback is well used to inform service developments, for example the creation of No. 11, the care leavers service.
41. The newly revised quality assurance and performance framework is still developing. Currently, it does not enable senior managers to fully understand children's experiences and the quality of social work practice across the service. Some areas of performance are not routinely monitored or evaluated to inform a sufficiently comprehensive understanding of practice. For example, the local authority does not routinely monitor its adoption performance, relying on the regional adoption agency to provide this. The low conversion rates from child protection enquiries to initial child protection conferences and children assessed as not requiring a social care service have not been interrogated to understand what this means for children. Frontline managers now receive weekly reports, enabling them to better manage workflows and compliance.
42. Changes in the electronic recording system and inconsistencies in recording practices are impacting on data integrity. As a result, great time and effort are focused on data cleansing and some managers are creating and maintaining additional methods of overseeing performance. Although this is necessary, the process is inefficient.
43. Monitoring of some key areas of practice that significantly impact on children has been too slow to develop. For example, tracking of permanence for children with plans for long-term fostering, adoption and those placed with parents is very new and has been implemented following a peer review commissioned by the new DCS. This was an area of improvement identified at the last inspection. Although managers have reviewed permanence for those

children placed with parents, managers have not systematically prioritised those children most at risk of drift and delay with plans for long-term fostering. As a result, too many children have experienced delay in achieving longer-term permanence, and for some, this is still not secured.

44. Senior managers were not aware of the deterioration in the response to children who are privately fostered and those at risk from professionals where allegations have been made. These had been areas of practice identified as stronger in the last inspection. In response to the concerns raised by inspectors, senior managers took action to amend processes for children who are privately fostered.
45. Auditing has been strengthened since the last inspection. However, there is insufficient focus on children's experiences, and this leads to inflated judgements about the quality of social work practice across the service. Some audit findings lack the level of clarity needed to sufficiently target and inform improvement. The DCS recognises that not all managers share a common understanding of what good practice looks like and senior managers are addressing this through recent auditor training. When audits have been more focused, this has supported an effective response to identified shortfalls, such as a drift in child protection and child in need planning. Themes identified from monitoring visits have been used well to shape core training in recording, assessment and planning. At the time of this inspection, only training in recording had been completed.
46. Staff stability and confidence in core social work practice have significantly improved since the last inspection. A key strength is the quality of direct work and relationships between social workers, personal advisers and their children, underpinned by the local authority's restorative practice model. This is not the case for disabled children, where social workers have not received training or do not have access to basic tools to enable them to communicate with children in line with their diverse needs.
47. Senior managers have successfully recruited and retained social workers, resulting in a significant reduction in the dependency of agency staff, despite the recruitment challenges regionally and nationally. This had been a significant issue at the last inspection. This improving stability, alongside the decision not to use agency staff, has reduced the number of changes in social worker that children experience. This is helping social workers build durable relationships with children and their families. Kirklees Council nurtures and develops its new social work staff. Newly appointed social workers spoke highly of their protected four-week induction, which provides clarity of expectation and practice standards through core training and shadowing. The newly introduced advanced practitioner posts provide specialist knowledge, advice and support through co-working, as well as creating career development opportunities.

48. Although caseloads have reduced, some social workers in the assessment and intervention teams reported that there is a sharp increase in work allocated to them when they undertake duty. They reported that this impacts on the quality of their work and their ability to complete specific recording tasks. Some of these challenges are mitigated through co-working some cases with highly skilled advanced practitioners, who bring specialist guidance and oversight. Senior managers regularly review caseloads and recognise increases in demand for social care services. For example, as a result of the growing emergence of gang-related activity and a recent complex joint police investigation, they have appropriately recruited an additional team. Social workers in this team are due to take up their posts in September.
49. Morale across the service has significantly improved. Social workers feel safe and supported by trusted senior and frontline managers. However, supervision is not consistently regular and the rationale behind key decisions affecting children's lives is not always recorded. Supervision lacks case reflection and clear management direction, and poorer practice is not routinely challenged by frontline managers or IROs. Senior managers recognise that this requires further improvement, and plans are in place to deliver bespoke management training across the service.



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