Piccadilly Gate
Store Street
Manchester M1 2WD

T 0300 123 1231
Textphone 0161 618 8524
enquiries@ofsted.gov.uk
www.gov.uk/ofsted

23 August 2019

Karen Dolton
Executive Director, Children, Young People and Culture
Bury Council
3 Knowsley Place
Duke Street
Bury
BL9 0EJ

Dear Ms Dolton

Focused visit to Bury local authority children's services

This letter summarises the findings of a focused visit to Bury local authority children's services on 31 July and 1 August 2019. The inspectors were Paula Thomson-Jones HMI and Mandy Nightingale HMI.

Inspectors looked at the local authority's arrangements for providing help and protection for vulnerable adolescents. Inspectors considered the response to children at risk of sexual and criminal exploitation and those who go missing from home or from care. They also considered the response of the local authority to concerns about adults who work with children.

Inspectors looked at a range of evidence, including case discussions with social workers and team managers. They also looked at local authority performance management and quality assurance information and children's case records.

Overview

Bury local authority children's services were inspected by Ofsted in 2016, when the overall effectiveness of the service was judged to require improvement to be good, with the experiences of children in need of help and protection judged to be good. At this time, Bury had low numbers of children identified as being at risk of exploitation, and services were judged to be 'robust and improving'.

Undertaken prior to this focused visit, the local authority's self-assessment acknowledged that the experience and progress of children in need of help and

protection has declined since the inspection in 2016. Quality assurance and audit activity over the last 12 months has been focused on trying to ensure that there is compliance with basic requirements. This has supported some improvements in practice with children, such as more regular visits to children and all children now having their needs assessed and a written plan. There has been insufficient success in addressing issues in the quality of practice, and, as a result, the quality of most of the services reviewed during this visit needs further improvement.

Since the last inspection, the partnership has been successful at raising awareness. This had led to the identification of increased numbers of children who are at risk of child sexual exploitation, and they have been provided with help and support. A complex safeguarding team (CST) has been developed in Bury as part of the wider Greater Manchester approach to supporting vulnerable adolescents. The development of this service has reacted to changing demand and has delivered good outcomes for some children, but there is not an up-to-date and coherent strategic approach to support this. As a result, the response to children is not consistently well co-ordinated to ensure that they get the right service at the right time.

There are examples of good-quality practice with some children, which reduces risk and enables them to make good progress. For other children, the weaknesses in the quality of basic social work practice, such as assessments and care plans, mean that the impact of any specialist support or intervention is limited and support and intervention are therefore less effective in reducing risk.

What needs to improve in this area of social work practice

- The quality of assessments and plans for children, to include effective analysis of the impact of historic neglect and abuse.
- The strategic approach to working with vulnerable adolescents to provide a more consistent approach to children at risk of exploitation.
- Timely and effective responses to concerns about adults who work with children by a designated officer.
- The effectiveness of management oversight and quality assurance activity to evaluate the quality of practice, the experiences and progress of children and to identify areas for improvement.

Findings

- Over the last six months, the CST has widened its remit to include criminal exploitation, and has accepted referrals for children who have needs at all levels. These developments have evolved without the benefit of a coherent strategic approach or operating model. As a result, there is lack of clarity about the role and function of the team and about which children it should be working with.

- Over half of the children receiving support from a social worker in the CST are not subject to a multi-agency plan. Some of these children have wider needs and the support they receive would be more effectively coordinated by an early help plan. Other children receiving support from the CST have case-holding social workers in other teams, with the social workers from the CST providing risk assessments and additional specialist support.

- Risk assessments completed by CST are comprehensive and of good quality and they are reviewed regularly to understand if risks to children are decreasing. For some children, the information within the risk assessment is used well by their social worker to inform the case planning, and leads to work with them and their families that helps to reduce the risk of harm. For others, although risk is identified, the information does not result in effective intervention as part of the child's plan, and has limited impact.

- The quality of child and family assessments is not consistently good, and, for a small number of children, significant gaps leave unassessed risk and potential for further harm. For example, in one case that was passed back to the local authority for review, an assessment was undertaken for the oldest child as they were at significant risk of exploitation. This contained limited information or evaluation of the mother's new partner, who was moving in to the home.

- Assessments of children's needs do not routinely contain evidence of their views or lead to a full understanding of their lived experience. For many children, a lack of consideration of historical information about their experiences leads to insufficient analysis of their risks and vulnerabilities; this includes children who have had extensive previous involvement as the result of domestic abuse and neglect. Although there is some awareness of contextual factors, such as the influence of peers or community, these are not fully evaluated as part of the social work analysis.

- Children's needs in respect of their identity are not consistently recognised and responded to. For some children, who have needs in respect of their gender identity, this is considered well and responded to sensitively. For others, including those from ethnic minority backgrounds, their identity is only superficially considered within assessments and this does not result in effective consideration of these needs as part of planning.

- Social workers know children who are in care well, and in many cases have been the child's social worker for a long time. This has supported good relationships to develop and leads to a clear understanding of children's needs. For other children, social workers do try to build effective relationships, but the level of staff turnover in some teams means that some children have had too many social workers and the relationships are not meaningful.

- When children are not being seen as often as they should be, there is evidence of social workers making repeat visits to the family home rather than using more creative or flexible approaches. There is little evidence of social workers seeing children at different places or different times of day, and this limits their success. In some cases, workers use a relationship-based approach to support their discussions with children and this is more effective when one key person or professional has been identified to build a relationship with a child. In other cases, there were multiple professionals trying to 'engage' with children, leading to frustration for some children and families.

- CST social workers undertake direct work with children, and, for many, this is supportive and helps them to understand the risks they are experiencing, or the impact of their family's neglect or abuse. It is often not clear from children's plans what the expectations of this direct work are or how it is informing the child's plan.

- For those children at risk of exploitation who have a child in need, child protection or child in care plan, these plans are reviewed regularly. In a small number of cases, plans reflect the risks identified in the assessments, use simple language and are clear in what needs to happen and when, to reduce risks for children. In many other cases, plans are not focused on outcomes, and it would not be clear to children or families what needs to improve or change. They do not consistently set targets or timescales and do not outline how any intervention will improve the child's quality of life and reduce risk.

- Children who go missing are quickly offered a return home interview. These are undertaken in person, and for many children they take place within a few days of the incident of going missing. When there are delays, it is not clearly recorded what the reason for this is and it is therefore not clear why the young person has not been seen more quickly. Most records of return home interviews are thorough and contain good information about the young person's period of being missing while also offering some insight into their views. This information is not consistently well used to reduce the risk of future missing episodes or to inform future care planning or more strategic thinking and planning.

- When children go missing repeatedly, strategy meetings are well attended by relevant partners, who share information and accurately identify current risks. In some cases, information gained from these meetings is not robustly followed through to explore or address the concerns identified. For example, when a child

was known to be at risk of criminal exploitation, there was little evidence of a thorough investigation of known associates, ownership of cars, or review of phone records. As a result, the impact of the multi-agency meetings was limited and did not lead to long-term reduction of risk.

- Children at risk of child exploitation or going missing who have additional needs relating to their education are considered well. A clear joined-up approach means that professionals across the council share risks regarding individual children to inform assessments.

- When concerns are raised about adults who work with children, the local authority response is not consistently timely or effective. There is insufficient capacity to respond effectively to the concerns, with demand increasing significantly over the last four years. In addition, until very recently, there were ineffective arrangements in place to ensure that there was an immediate response to concerns at all times. Although no children were put at further risk by weaknesses in arrangements, there remain some delays in responding to referrals and progressing formal meetings. Performance management arrangements for the designated officer functions are weak, and there is a lack of clear systems and scrutiny by senior leaders. The local authority acknowledged the concerns raised by inspectors and agreed to review the designated officer arrangements.

- Local authority quality assurance over the past 12 months has focused on the compliance with basic social work standards. Audits identify areas for improvement and actions to address these. However, they do not sufficiently evaluate the quality of social work practice and do not provide learning and feedback to workers or the organisation to ensure that this quality assurance activity leads to improvement.

- The partnership has considered a number of serious incidents involving teenagers over the last six months and has made appropriate decisions to commission three serious case reviews and one further learning review. Emerging key themes regarding the response to neglect of adolescents, and the response of health services, have not yet led to a review of practice or resulted in any positive changes for children. The local safeguarding partnership has a plan in place to share findings and inform learning at an event planned for the autumn 2019.

- Management oversight is evident on children's files, but this is mostly brief, and task focused and does not lead to good-quality social work practice with children. There is insufficient challenge about the quality of practice, or evidence of managers ensuring that children make progress and experience improved outcomes as a result of social work input. When concerns about the quality of practice were identified during this inspection, reviews undertaken by the local authority also primarily focused on compliance with basic processes. Response to inspectors did not demonstrate that an accurate evaluation of the quality of

practice had taken place, or that senior managers had sufficiently considered the experiences of children.

- Current caseloads across many teams are high, with half of social workers working with over 20 children, and a small number with up to 28 children. Social workers are completing basic requirements, but many do not have sufficient time to undertake meaningful direct work and build positive relationships with children.

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

Yours sincerely

Paula Thomson-Jones
Her Majesty's Inspector