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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 25 and 26 July 2018. The inspectors were Sheena Doyle and Shabana Abasi, Her Majesty's Inspectors.

Inspectors reviewed the local authority's arrangements for contacts and referrals in the multi-agency safeguarding hub (MASH) for children who need help, including safeguarding. Inspectors considered thresholds for early help and statutory services for children in need, including those in need of safeguarding.

Inspectors considered a range of evidence, including case discussions with administrators, social workers, managers, representatives from partner agencies, and senior staff responsible for quality assurance and performance management. Performance data and management reports were reviewed, and children's case records were sampled.

Overview

Bury local authority children's services were last inspected by Ofsted in 2016, when the overall effectiveness of the service was judged to require improvement to be good, with the services for children who need help and protection judged to be good. At that time, the MASH was functioning effectively, and this continues to be the case. Contacts are screened promptly and take account of background information held by children's social care and education services, as well as information provided by partner agencies. Where their input is available, the contribution of the co-located education and health specialists strengthen decision-

making, but they have insufficient time allocated to this work to meet the demand and cannot participate in all the strategy meetings held in the MASH.

At the last inspection, early help services were effective in meeting children and families' needs and safely reducing their need for statutory services. However, performance has deteriorated since then, and there is insufficient scrutiny of the effectiveness of early help support, particularly for those families who have multiple needs. The service has also not been subject to audit and therefore the weaknesses that have been found at this focused visit were not well understood by the authority.

What needs to improve in this area of social work practice

- The input from all relevant professionals to decision-making at the MASH, including strategy meetings.
- Repeated contacts expressing concerns about children who are allocated to targeted early help services should trigger a prompt review of whether statutory services are required instead.
- The effective oversight, management and review of early help cases in order to ensure that sufficient account is taken of history, that cases are held at the appropriate level in proportion to risk, including escalation to statutory services, and that appropriate support and intervention is resulting in positive change for children.

Findings

- The MASH is an effective multi-disciplinary service which provides clear pathways for members of the public and professionals to raise concerns about children. Contacts are prioritised and processed in a timely way by skilled and experienced staff. Management oversight is robust and all recommendations for next steps are reviewed prior to authorisation.
- Contacts and referrals are authorised promptly by managers and there is no backlog. Partner agencies routinely use the agreed referral form. Consent is sought from families, and referrers are informed of the outcome of their referral. This ensures that families' rights are fully considered, and that referrers know what is happening in response to their referral and what to do if they disagree.
- Information-sharing by those partner agencies in the MASH is a strength. If a child needs specialist services, this triggers swift information-gathering from a range of agencies. Responses are generally prompt, and all gaps are followed up.
- Decision-making and information-sharing is supported by co-location and effective joint working between children's social care, police, health and education staff. Information from different providers is gathered and analysed by the health specialist, ensuring that the significance of health information is understood. However, the education and health specialists spend only part of their time in the MASH. Alternative arrangements are in place to access information in their absence, but the rigour of information-gathering and decision-making is weakened. The absence of adult social care representation means that the 'think family' approach is under-developed.
- Strategy meetings in the MASH are convened swiftly and have improved significantly since the internal audit at the end of 2017. Composition, chairing and minuting have all improved. However, the MASH health and education specialists are unable to participate in all meetings, although background information from their service area is gathered and shared. Strategy meetings held in other teams are well attended and minuted, and the rationale for decisions made is set out. Social workers have to undertake the administrative tasks associated with strategy meetings, reducing the time that they can spend working with children and families.
- Children who may have complex safeguarding needs, such as children who go missing from home or care and those who may be vulnerable to sexual exploitation, benefit from prompt consideration by staff in the specialist complex safeguarding team. Contacts are swiftly routed from the MASH to the appropriate service. Children who go missing receive prompt return home interviews, but this is a pressurised service and lacks dedicated administrative support.
- Children who require social work assessments are allocated promptly to staff in the initial response teams. The social workers know their children well and can articulate the strengths and difficulties in families, which means that the right support can be put in place.

- The local authority has used themed audits well to highlight areas that need attention, and they have provided guidance to staff and managers to help them to improve their practice. Audits have focused on, for example, chronologies and case summaries. On the sampled and audited cases, inspectors saw cases that were well written and up to date, with clear summaries of the history and current concerns, as well as suitable plans. Assessments vary on how well historical factors are analysed, as does the interplay with current concerns. Some do this very well, but others are too superficial.
- The voice of the child is not consistently found on case files. Some children's files set out their views strongly and provide a sense of how children they experience their lives. Other files lack this insight, or do not give the children's views enough prominence.
- The quality of management oversight is better in the MASH, but is inconsistent in other service areas. Some managers routinely note the rationale for their advice and decisions, others do not. Some files contain unhelpful managerial comments and are therefore of limited use to improving practice.
- Referrals for early help support are screened by team Oasis, the multi-disciplinary team that includes social workers, and work with children in families with complex needs is timely. Families are contacted promptly and all decisions on next steps are authorised by managers. Most screening decisions are appropriate, but some are not. For example, a family was referred to a children's centre because one child was an infant, but insufficient attention was paid to other concerns, including the mother's mental health, self-harm and alcohol misuse.
- Most children sampled from team Oasis have had previous involvement with children's social care, including safeguarding services, and some over many years. Early help assessments take insufficient account of long histories, and do not analyse current concerns well enough against this backdrop. Poor decision-making is compounded by an over-reliance on positive parental reporting. For one young child, a brief assessment led to the withdrawal of statutory services despite multiple risk factors, including drug misuse, serious mental ill-health, and familial sexual abuse, because of parental self-reporting. In this case, multiple subsequent contacts led to safeguarding services and legal action. The pattern of multiple subsequent contacts was replicated in other cases, and, as in this instance, it was not seen as an indication that the children needed statutory services as children in need or children in need of protection quickly enough.
- Children and families are in receipt of the services of team Oasis without a robust review of their progress. Some children have been allocated for years or many months without their outcomes improving or with the outcomes improving too slowly. Some case files showed that there had been no multi-agency meetings for over six months. Children's assessments are not updated periodically.
- Audited cases show that there are plans for some vulnerable children to be stepped down from statutory services to early help support despite a number of risk factors and high levels of need in families. Some children living in families with complex needs have optimistic plans predicated on the best outcomes, with

no contingency plan in place should the expected positive outcomes not be achieved.

- Supervision of early help social workers is variable. There are sometimes clear actions and timescales, but other records are too brief, are predominantly descriptive without analysis, and do not address outstanding actions.
- Children's early help records vary in quality. Some lack case summaries, and existing records are not always clear and up to date. Chronologies are poor. In contrast, records of home visits and sessions with children are comprehensive. Descriptions of children are good, but there is insufficient analysis of their progress, and it is not clear how their views inform plans.
- Performance management in children's social care is well embedded, rigorous and detailed. Auditing of children's social care files is continuously strengthening, and it helps to improve practice. The findings from themed audits are used well to inform future improvement plans. There is coherence between areas looked at in audits, and the practice standards of the local authority. Practice in team Oasis has not been audited and this is a missed opportunity to improve practice in early help.

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

Yours sincerely

Sheena Doyle
Her Majesty's Inspector