Inspection of Bury local authority children's services

Inspection dates: 25 October 2021 to 5 November 2021

Lead inspector: Lorna Schlechte, Her 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	Requires improvement to be good
Overall effectiveness	Inadequate

There are serious failures which leave too many children at risk of harm in Bury. Children who need help and protection experience drift and delay in having their needs met as a result of frequent changes in social worker, over-optimistic assessments, poor-quality plans, and gaps in supervision and management oversight. In some cases, risk is not always recognised, or responded to, in a timely way, leaving some children with insufficient timely protection.

Since the focused visit in October 2020, the quality of practice has deteriorated, particularly for children in need of help and protection. There has been significant instability in the senior leadership team, and a lack of focus on the areas of improvement needed.

Although an internally commissioned peer review in July 2021 appropriately identified a mixed picture of progress and improvement and led to the establishment of an improvement board, this is very new and has not brought about the level of change required. The appointment of new interim senior leaders in mid-September 2021 has provided opportunities for the changes required to be identified, but this is a fragile situation and there is still much work to do to improve the experience of children in Bury.

What needs to improve?

- The timely recognition and response to risk at the front door.
- The quality of strategy discussions and child protection investigations.
- Manageable caseloads for social workers.
- The quality of assessments, to ensure that they are regularly updated and are not over-optimistic in their analysis.
- The quality of plans and planning for children, to ensure that actions include clear timescales and contingencies, including for those children who require suitable placements when they come into care.
- The response to pre-proceedings to ensure that progress is monitored and tracked more robustly to reduce drift and delay for children.
- The quality of supervision and management challenge to ensure that social workers have time to reflect on complex cases and take account of children's changing circumstances.
- The recruitment and retention of social workers, to stabilise the workforce and reduce multiple changes in social worker for children.
- The stability of the senior leadership team to support implementation of an appropriately focused plan of improvement.

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

1. Children in need of help and protection are not always identified. Consequently, children do not always receive the right help to meet their needs. Although screening of referrals in the multi-agency safeguarding hub (MASH) provides appropriate management oversight informing next steps, there are missed opportunities to identify risks earlier for some children. This is because the impact of cumulative harm on children is not always well understood, especially in relation to domestic abuse, and decisions are based on an overly optimistic assessment of risk. As a result, some children are at risk of further harm before more purposeful action is taken to protect them.

2. The model of co-location with partner agencies in the MASH has been adapted in response to the pandemic, but not all agencies are based together as they were previously. This has reduced the quality of information-sharing, although daily virtual meetings are held with police. Some referrals from partner agencies are not timely and this leads to a delayed protective response.

3. Children and families benefit from sensitive work to meet their needs through detailed early help assessments. However, the thresholds to signpost children

for early help support are inconsistently applied. Some children are signposted to receive early help support when they should have received a statutory social care assessment. As a result, some children do not have their needs understood and met at the right time. This sometimes leads to repeat referrals for the same concern.

4. Strategy meetings do not always identify the necessary actions to progress the child protection enquiry or to keep children safe during the enquiry period. There are missed opportunities to gain a multi-agency response to secure children's immediate safety in some cases. These concerns were raised by inspectors at the last focused visit in October 2020 and have not improved.

5. There is timely and proportionate action when children need a social work response to keep them safe out of office hours, although the detail of screening and decision-making in the emergency duty team (EDT) was not being recorded on electronic systems until the issue was raised by inspectors.

6. Assessments are mostly overly focused on adults and concerned with the presenting problem, to the detriment of understanding the impact of cumulative harm on children's broader needs and risks. Parental capacity for sustained change is not consistently considered in assessments. They are too often based on parental self-reporting, and are not regularly updated when circumstances change. This means that assessments are not focused enough on the impact of harmful experiences on children, which leads to over-optimistic decision-making and unidentified risk.

7. Many children experience multiple changes in social worker. This has an impact on their ability to form secure relationships and to share their views and worries. It is also disruptive to planned work with families and contributes to drift and delay in the delivery of social work interventions, assessments and plans, which repeatedly restart with a new social worker. Caseloads are too high, and this reduces the ability of social workers to complete appropriately focused direct work with children. Although most children are seen regularly, visits often lack purpose and this contributes to a lack of progress in plans.

8. Significant numbers of children experience delay in having their plans progressed. Most plans for children in need and for children subject to child protection planning are confusing, often too generalised and lack clear timescales or contingencies to measure children's progress. Many are adult focused or do not consider the support children need to mitigate the harm they have suffered. As a result, the plans are not easy for parents to understand what needs to be done to achieve the desired outcomes.

9. Some children do not receive sufficient protection when they are subject to child protection planning. There is an overreliance on unrealistic written agreements with parents to protect children. When risks increase, there are delays in taking appropriate protective action. Decisions to cease child protection plans are influenced by parental self-reporting and engagement with

services, rather than considering what has changed for children. The rationale for decision-making by social care and partners in child protection conferences is often unclear. Some children step down from child protection planning too early when actions are incomplete, or before an updated assessment is completed to consider whether risks have reduced. Consequently, too many children experience repeated episodes of child protection planning and lengthy social care involvement, without change being sustained. This means children are not always afforded the appropriate level of protection they need.

10. Core groups are not consistently effective forums to drive and measure progress when children are subject to a child protection plan. There is insufficient focus by social care and partners on the impact of interventions to reduce risk, and what additional actions are needed to meet children's needs in response to a lack of progress. Virtual review meetings held during the pandemic are mostly well attended.

11. When parenting does not improve, timely authoritative action to escalate into the pre-proceedings stage of the public law outline (PLO) is not always taken, leaving some children in ongoing situations of neglect. The monitoring of these children is not robust, and some children repeatedly step in and out of the PLO, despite risks not always reducing, or change being sustained.

12. Once cases are escalated into pre-proceedings, there is inconsistent management oversight to support timely applications into court should change not be achieved. Review and tracking mechanisms are not regular enough, lack rigour and do not challenge delays in completing actions. Cases in the pre-proceedings stage are sometimes extended inappropriately in response to continued risk of harm. The system of review does not consider current risks to children or reflect on changes in their circumstances to support critical decisions to extend, or step down from pre-proceedings. When risks escalate and decisions are made for children to come into care, they sometimes remain in unsuitable placements with extended family members, while alternative foster placements are sought.

13. Some disabled children have experienced significant drift and delay in having their need for help and protection met. Assessments and work undertaken with disabled children and their families is too adult focused and does not consistently identify the risk and harmful circumstances in which some disabled children have been living. A new team manager has appropriately identified what needs to change, but has limited capacity to implement the improvements needed. Children face further delay while the newly expanded team forms relationships with them, understands their communication needs, and completes updated assessments. It is acknowledged by senior leaders that the team, mostly made up of agency social workers, lacks the necessary skills to undertake direct work with some disabled children to understand their experiences. A training and development plan identifies the shortfalls but has not been implemented.

14. Children at risk of exploitation are seen regularly by social workers in the complex safeguarding team, who build meaningful relationships with them. This supports purposeful work in helping children understand and recognise when they are being exploited. However, detailed risk assessments do not sufficiently inform multi-agency plans to support these children. The service is still evolving and mapping meetings have only recently been introduced to engage wider partners to share information and intelligence. As such, this is not resulting in a comprehensive multi-agency approach to reduce risks.

15. When children go missing, the local authority response is not consistently robust. Although return home interviews are mostly timely, they lack clear analysis of push and pull factors. When children refuse to engage, information is not consistently sought from carers to understand prior events to inform intelligence gathering. Strategy meetings are appropriately triggered when children go missing for long periods or on multiple occasions, but this does not result in clear multi-agency safety planning. There is a lack of planning to minimise risk for children who regularly go missing. Plans are too broad to identify longer-term work to mitigate future risks.

16. Children aged 16 to 17 years old who present as homeless receive appropriate support to live in suitable accommodation. Although their needs are well assessed, they are not routinely informed of their rights and the benefits of entering care, which limits their understanding of what support is on offer.

17. Monitoring systems for children who are electively home educated and those missing from education are slow and inefficient. Although there have been recent improvements in the way children are tracked and monitored, capacity issues in the team have meant that visits have not routinely taken place. This also means that the lead for children missing education does not have time to sufficiently develop the network of contacts which are needed to locate children and young people efficiently. As such, the arrangements to ensure that children's whereabouts are known and closely monitored are not as effective as they need to be.

18. Allegations against professionals are mostly well managed by the designated officer. The response is timely, thorough and robust. However, when the designated officer is absent, the role is covered by two child protection chairs. This leads to delays in allegations being progressed, and actions not being completed in a timely way. Allegations management meetings are used effectively to share information and identify actions, which are regularly reviewed. Effective information-sharing between the designated officer and MASH ensures that children at risk are identified and action is taken. Tracking mechanisms are robust; however, workload demands have reduced the designated officer's ability to keep records up to date and this reduces oversight.

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

19. The majority of children come into care in a planned way and senior managers have appropriate oversight of key decisions. However, some children have waited too long in neglectful or harmful circumstances before coming into care and this has increased the complexity of their needs. In some cases, placement decision-making is influenced by the lack of foster placements to meet the needs of vulnerable children.

20. Although there is a clear focus on keeping children with family members where it is safe to do so, a minority of children have had to remain at home once the threshold is met to come into care, while a more suitable placement is found, because there are insufficient placements to meet the needs of some children.

21. Senior managers have recognised the drift and delay in care planning linked to high caseloads and commissioned an additional specialist court team. This team has improved the quality of social work practice since it was established in July 2021. Work is now being progressed more effectively for children in the court arena in this team.

22. The majority of children who have a plan to return home to their parents are able to return safely because of purposeful work both before and after they are reunited. A few children have remained at home with parents on care orders for too long. For some children, discharge of care orders is not progressed quickly enough, where it is appropriate to do so. For these children, an up-to-date assessment of their needs has not been undertaken to inform a decision about whether statutory intervention is still required.

23. Children's wishes and feelings about who they want to live with are carefully obtained and inform court statements. The quality of assessment of parents and connected carers is inconsistent. This leads to delayed court proceedings and some children having to wait too long to have their long-term plan of permanence confirmed. This is in addition to the delays in the family court, which are due to the impact of COVID-19 over the past year.

24. Children receive independent reviewing officer (IRO) visits before their reviews to gain their wishes and feelings. Reviews are written sensitively and in a way that helps the child to understand their care plan. IROs routinely escalate concerns where there is evidence of drift and delay in care planning, or when court timescales are at risk of delay. However, this is not always effective in achieving the required change swiftly.

25. Visits to children in care are mostly regular and social workers have a good understanding of children's individual needs. However, this level of understanding is not always evident in the child's record and the purpose of visits is sometimes unclear. Too many children have experienced multiple

changes of social worker due to the high turnover of agency staff. This has an impact on children forming relationships with social workers.

26. Children in care benefit from timely accessible support through a dedicated child and adolescent mental health services team. Most children's health needs are well considered and children receive appropriate medical and therapeutic support. There are delays for some children in accessing Healthy Young Minds.

27. The new virtual headteacher (VHT) has a clear focus on promoting the achievement and well-being of all children and young people in care. The experienced virtual school team is quick to respond to the needs of children, carers and the schools or provisions they attend. The VHT has quickly identified priorities to improve the quality of personal education plans (PEPs) and the use of pupil premium to enhance children's achievements. Almost all children have a PEP, although the quality is inconsistent, which means that the impact they have on children's education and achievement is variable.

28. Most children live in placements that meet their needs for care and stability and they make positive progress. However, a small number of children are still waiting to live in a permanent home. Work has progressed to increase the number of children who are subject to special guardianship orders, and to match children to their long-term placements.

29. Foster carers are well supported by their supervising social workers and receive regular supervision and virtual support. This has been particularly important due to the impact of COVID-19 on fostering families. Recruitment of new foster carers is a clear priority, albeit a challenge in the current climate, and work is undertaken collaboratively across Greater Manchester to increase the pool of carers available. Experienced foster carers act as 'ambassadors' for the service. Panel processes offer sufficient scrutiny and challenge to the recruitment and approval of foster carers.

30. There is mostly effective planning of early permanence, especially for babies and younger children. Adopters feel very well supported through the matching process, the suitability of prospective adopters is scrutinised effectively by panel and there has been an increase in the number of children matched with adopters. Training and post-adoption support are appropriately considered. Children have been supported to keep in touch with their brothers and sisters and other family members after adoption, where this is in their best interests.

31. Children in care are helped to maintain contact with people who are important to them. The impact of family time is routinely reviewed to ensure that it is in the child's best interests. There is appropriate consideration given to whether brothers and sisters can live together.

32. Care leavers benefit from positive relationships with personal advisers who are caring, conscientious and committed members of staff. During the pandemic, personal advisers have seen care leavers regularly and sent letters, sweets,

toiletries, and parcels to care leavers to keep in touch and show they care. The reopening of the hub for care leavers recently has provided a valued drop-in space for support and advice to be offered.

33. There is an appropriate focus in pathway planning on the things that matter to care leavers, such as becoming independent, keeping well, learning and finding work. Children's views are captured in their own words and plans are carefully written to encourage positive choices. Some plans need to be strengthened because they lack detail and do not sufficiently address all identified needs.

34. Care leavers are helped to understand their physical and mental health needs. When it is necessary, the looked after children nurse supports timely access to a range of specialist services. Care leavers do not always understand their health histories or why this information is important for them to have.

35. Care leavers, including unaccompanied asylum-seeking children, benefit from dedicated support with education, training and employment. There is proactive work completed to encourage work experience and apprenticeships. Often, this leads to employment and further training. Some children have been supported to achieve success through further education and university.

36. Most care leavers are living in suitable, safe accommodation with the right levels of support. Personal advisers work with the tenancy sustainment worker and support care leavers to secure permanent accommodation. The housing, employment and new opportunities project is an effective collaboration to achieve this. However, some care leavers are unclear about their entitlements.

37. Young people have access to a children's rights advocate who supports them if they wish to make a complaint.

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

38. During the last year, the changes in senior leadership in children's services have led to turmoil, instability and drift at a strategic and operational level. As a consequence, there has been an insufficient focus on children's experiences, and the quality of frontline practice has deteriorated since the last Ofsted focused visit in 2020.

39. These leadership changes culminated in the departure of both the director of children's services (DCS) and an assistant director (AD). While these interim arrangements were put in place promptly, they are still very recent. In September 2021 the Director of Education and AD Early Help stepped into these roles until permanent appointments could be secured.

40. There were mounting concerns from November 2020 onwards about high caseloads, the level of workforce churn, and the negative impact this was having on children and families, where there was significant drift and delay.

Although operational managers raised these concerns persistently at the time with senior leaders, and requested additional capacity to address high caseloads, these concerns have not been appropriately prioritised by senior leaders until recently.

41. As concerns escalated throughout the early part of 2021, the chief executive of the council commissioned an LGA peer review which was completed in July this year. This was a wide-ranging review which explored the broader corporate responsibilities of the council in relation to recruitment and retention of social workers, as well as concerns about the quality of social work practice. The findings were hard-hitting and described a mixed picture of progress and improvement aligned with inspection findings.

42. Although the response to the peer review led to the establishment of an independently chaired improvement board in late August 2021, and a review of cases in early help and children in need to address concerns about the quality of practice, corporate leaders have been too slow to act from the point of the initial concerns being raised in January 2021. This has meant that long-term sustainable improvement has not been achieved and there is still much work to do to address the known concerns.

43. A newly managed service (court team) was brought in to address high caseloads in the safeguarding teams in July 2021. Inspectors have seen the positive impact of this service on practice very recently as it features reduced caseloads, reflective supervision and more purposeful and effective practice. This has begun to address significant drift and delay in that team, but it is not making a difference to all children.

44. Since their appointment eight weeks ago, the interim DCS and AD have taken some swift action to strengthen services. This included securing another managed service team to address high caseloads in the initial response teams, although this was not established at the time of inspection and it is too soon to say if this will lead to the improvement needed.

45. The new senior leaders are more visible and accessible to frontline staff and they have appropriately prioritised the known areas for improvement in recognition of there being too much drift and delay, over-optimism and workforce churn. They have also responded quickly to concerns raised by inspectors about risk to individual children. This has led to some immediate protective action being taken to protect children, and a strengthening of practice, including a refresh of operational protocols in MASH and EDT. However, it is too early for this to have brought about the significant changes in the quality of practice required.

46. Senior leaders have struggled to implement the new model of practice during the pandemic, and it is still not embedded. Training has been rolled out virtually, but it has been difficult for staff to prioritise it, due to high caseloads. The workforce churn and a frustration with online learning have further

hindered the implementation of this model. The situation has been exacerbated by the different approaches to implementation employed by external consultants. This has led to mixed messages and a lack of clear service direction. Staff have struggled with the practice templates, and do not fully embrace the model of practice, or understand it.

47. There is a robust support programme for ASYE and established links with the local teaching partnership. Senior leaders are committed to supporting and developing newly qualified social workers and have refreshed the workforce development strategy.

48. Audits of practice have continued to be moderated and sometimes involve social workers and families. Audits identify appropriate practice issues, and mostly tell senior leaders what they need to know. However, there is more work to do to ensure that audits focus on children's experiences, and that learning leads to positive and sustainable changes in practice.

49. The approach to performance management has changed in recent weeks since the arrival of the new senior leadership team. Over the last year, there was too much attention on process and compliance, especially for children in need of help and protection, where there was insufficient focus on children's experiences to inform critical decisions. The new approach aims to encourage a more inclusive, less compliance-focused, reporting system which can close the learning loop. It is too early to see the impact of this in terms of shaping service priorities, in order to improve social work practice.

50. The new interim senior leadership team is appropriately sighted on the need to prioritise recruitment and retention, improve the Bury offer to encourage more permanent staff, and reduce the reliance on agency social workers in order to stabilise the workforce. However, there is still a long way to go for this to lead to the long-term sustainable changes required. The impact of working at home during a pandemic has also been difficult and staff have only very recently started to return to the office.

51. The Children in Care Council (CiCC) has worked hard to construct the Bury Promise. Children attend the corporate parenting board and present feedback from the CiCC on what matters to them. The council is a committed corporate parent, although it has acknowledged that the strategic approach could be strengthened in line with peer review recommendations.

52. The quality of supervision for social workers is too variable, and there are gaps in frequency across the service. This means that the level of reflection and ability to consider children's experiences is inconsistently recorded. Supervision does not always challenge unidentified risk, or drift and delay, effectively. Despite this, staff have continued to work diligently in a difficult COVID-19 context and report being supported by their managers.

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