Bury Borough Council

Inspection of services for children in need of help and protection, children looked after and care leavers

And

Review of the effectiveness of the Local Safeguarding Children Board[1]

Inspection dates: 22 February 2016 – 17 March 2016

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Children's services in Bury require improvement to be good		
1. Children who need help and protection		Good
2. Children looked after and achieving permanence		Requires improvement
	2.1 Adoption performance	Good
	2.2 Experiences and progress of care leavers	Requires improvement
3. Leadership, management and governance		Good

[1] Ofsted produces this report under its power to combine reports in accordance with section 152 of the Education and Inspections Act 2006. This report includes the report of the inspection of local authority functions carried out under section 136 of the Education and Inspections Act 2006 and the report of the review of the Local Safeguarding Children Board carried out under the Local Safeguarding Children Boards (Review) Regulations 2013.

Executive summary

Children and young people in Bury are effectively supported and safeguarded by good joint working between children's social care services and partner agencies including the police, adult services and healthcare providers. This is particularly true for children and young people who need early help and safeguarding services. However, services for children and young people who are looked after and for care leavers require further work to ensure good outcomes for all children and young people. Managers understand well the areas of weakness in their service and are taking effective steps to address these, but at the time of the inspection shortfalls were seen in the quality of care and outcomes for children and young people looked after and for care leavers.

Early help services and statutory safeguarding services are good. Early help assessments and interventions are often successful in improving children's and young people's outcomes and avoiding the need for statutory intervention. Partner agencies identify and refer children and young people promptly. The management of risk for children and young people in receipt of statutory safeguarding services is good, with assessments and plans effectively reducing risk, and prompt action taken if improvements are not being achieved. For those children and young people who need to be looked after, the local authority initiates legal proceedings in a timely manner, ensuring that the children and young people are not left in harmful or neglectful situations.

A wide range of effective multi-disciplinary services, including a specialist social work team, support children and young people who have disabilities and their families. Education, health and care (EHC) plans are very good quality, but social work assessments and plans for children and young people who have disabilities require improvement. Too many children and young people do not have an up-to-date plan that supports their care or takes their developing needs into account.

Reporting and accountability arrangements between the children's trust and other strategic boards are clear. Member oversight is predominantly through the corporate parenting board (CPB) and the council's relevant Overview and Scrutiny Committee. These groups carefully consider detailed information and follow up areas of concern.

Although the CPB is properly constituted and active, significant challenges remain. In particular, too many young people aged between 16 and 18, and the majority of 19 to 21-year-olds, are not in education, employment or training (NEET). Current scrutiny is not robust enough to support the work to improve outcomes for children. The achievements of children and young people looked after at key stage 2 and key stage 4 also require improvement. Recent efforts have ensured that all eligible children, young people and care leavers have personal education and pathway plans, but greater focus on the quality of the plans is required as they are not yet measurable and sufficiently ambitious to drive up achievements.

Children and young people looked after have good care from those who look after them, but the quality of social work support requires improvement. Too many children and young people looked after have assessments that require updating, and their changing circumstances do not always inform their plans. Staff who were spoken to understand the needs of their children and young people well, but this is

not always reflected in the written file. The files also lack useful chronologies, so that it is difficult to see quickly what the key events in a child's or young person's life have been and how these inform current and future planning for them.

A good range of permanency options is available for children and young people looked after, and most live with alternative families in or near Bury. Young people can stay with their foster carers after they have reached 18 years of age. A large proportion of young people under the age of 18, including some 16-year-olds, move into semi-independent accommodation. This is a very young age at which to begin living on their own. Far fewer are in this type of accommodation after the age of 18. This profile requires further investigation to ensure that all young people over the age of 16 are in placements that will provide them with sufficient nurturing and resilience for later life.

Caseloads of independent reviewing officers (IROs) are high, with their duty to chair child protection conferences taking priority over the scrutiny of the progress of children and young people looked after in between formal reviews. This means that they are not able to provide enough additional independent oversight and challenge to help to identify and address the shortfalls in the plans of children and young people looked after identified above.

The senior leadership team, supported by elected members, has worked hard to achieve a permanent well-trained workforce. There is good support for newly qualified social workers, accessible and relevant training for all staff, manageable caseloads, additional funding to increase the number of social workers and effective management oversight. Loyalty from the workforce to the local authority is strong, and staff express pride in working for Bury. Senior managers are highly visible, frequently 'walking the floor' and engaging in-depth with social work practice. Bury is a learning organisation, exemplified by leaders making changes as a result of feedback from inspectors, even in minor areas. Despite the stable workforce, too many children and young people, even quite young children, have had several changes of social workers, and this requires attention.

Managers at all levels in children's social care receive regular, accurate performance information, which is shared with elected members and relevant strategic bodies. It is used well to ensure compliance, particularly in safeguarding services. Performance against specific targets, such as timeliness of health assessments for children looked after, is also monitored, but the regular performance report is overly focused on safeguarding performance and lacks the same level of detail for children and young people looked after, care leavers and private fostering. It is these areas that require the greatest improvement and need to be considered as frequently and in as much detail as areas that are performing well, such as adoption which is strong.

Managers know the strengths and weaknesses of children's social care very well. Inspectors did not find key areas that require improvement that were not already known to leaders. Explanations were clear for the delay in improving some services, and leaders strive to achieve improvements by other means if their original strategy is not as effective as they would like. This, coupled with a track record of continuous service improvement, bodes well for achieving good overall effectiveness in the future.

Contents

The local authority

Information about this local authority area[2]

Previous Ofsted inspections

- The local authority does not operate any children's homes.
- The previous inspection of the local authority's safeguarding and services for children and young people looked after was in May 2012. The local authority was judged to be satisfactory for both.
- The previous inspection of the local authority's adoption service was in October 2009. The overall quality rating was satisfactory.

Local leadership

- The Director of Children's Services has been in post since January 2011.
- The chair of the LSCB has been in post since June 2009 and is retiring in March 2016. Her successor has been appointed.
- The LSCB is not shared with other local authorities, but there is a pan-Greater Manchester Safeguarding Partnership, which has harmonised multi-agency safeguarding procedures across all ten LSCBs in Greater Manchester.

Children and young people living in this area

- Approximately 43,000 children and young people under the age of 18 years live in Bury. This is 23% of the total population in the area.
- Approximately 16.4% of the local authority's children and young people are living in poverty.
- The proportion of children and young people entitled to free school meals:
  - in primary schools is 14.9% (the national proportion is 15.6%)
  - in secondary schools is 15.3% (the national proportion is 13.9%).
- Children and young people from minority ethnic groups account for 17.6% of all children and young people living in the area, compared with 21.5% in the country as a whole.
- The largest combined minority ethnic groups of children and young people in the area are Asian/Asian British. The single most populous 0 to 17 years minority ethnic group is Pakistani.

[2] The local authority was given the opportunity to review this section of the report and has updated it with local unvalidated data where this was available.

- The 2011 census indicates that 5.6% of the population of Bury record their religion as Jewish compared with the England proportion of 0.5%.
- The proportion of children and young people with English as an additional language:
  - in primary schools is 17.5% (the national proportion is 19.4%)
  - in secondary schools is 14.6% (the national proportion is 15.0%).

Child protection in this area

- At 22 February 2016, 1,584 children and young people had been identified through assessment as being formally in need of a specialist children's service. This is an increase from 1,475 at 31 March 2015.
- At 22 February 2016, 275 children and young people were the subject of a child protection plan. This is an increase from 200 at 31 March 2015.
- At 22 February 2016, one child lived in a privately arranged fostering placement. This is a reduction from four at 31 March 2015.
- Since the last inspection, six serious incident notifications have been submitted to Ofsted, and three serious case reviews (SCRs) have been completed. None was ongoing at the time of the inspection.

Children and young people looked after in this area

- At 22 February 2016, 300 children and young people were being looked after by the local authority (a rate of 71 per 10,000 children and young people). This is an increase from 293 (69 per 10,000 children and young people) at 31 March 2015. Of this number:
  - 126 (or 42%) live outside the local authority area
  - 21 live in residential children's homes, of whom 90.5% live outside the authority area
  - four live in residential special schools[3], all of whom live outside the authority area
  - 192 live with foster families, of whom 35.9% live outside the authority area
  - 43 live with parents, of whom 16.3% live out of the authority area

[3] These are residential special schools that look after children and young people for 295 days or fewer per year.

- Four children are unaccompanied asylum-seeking children.

- In the last 12 months:
  - there have been 19 adoptions
  - 11 children and young people became subjects of special guardianship orders
  - 100 children ceased to be looked after, of whom 3 subsequently returned to be looked after
  - eight children and young people ceased to be looked after and moved on to independent living
  - seven children and young people ceased to be looked after and are now living in houses in multiple occupation.

Recommendations

1. Improve social work practice and management oversight of children and young people looked after to ensure that assessments are up to date, and that plans are specific and achievable and include timescales and contingencies.

2. The CPB should effectively challenge weaker outcomes for children and young people looked after and care leavers, setting ambitious targets to ensure that outcomes for children and young people improve.

3. Ensure that all children and young people looked after and care leavers are supported to sustain education, employment or training (EET). This should be assisted by post-16 personal education plans (PEPs) and pathway plans being clear, relevant and prioritising important issues.

4. Review the suitability and outcomes for 16 to 18-year-olds who are living in semi-independent and supported accommodation and ensure that best use is made of this provision.

5. Ensure that children and young people who have disabilities and their families receive a timely and responsive service that fully meets their needs and is supported by thorough and up-to-date assessments and plans.

6. IROs should improve their scrutiny of the progress made by children and young people looked after and care leavers to check that progress against plans is proceeding as it should, and for concerns to be raised, escalated and recorded if plans are not progressing well.

7. Continue to support all children and young people looked after to achieve their full academic potential, in particular those children at key stage 2 and young people at key stage 4 where results require improvement.

8. Ensure that performance management information includes data and evaluative commentary on the progress of children and young people looked after and care leavers, so that managers are aware of progress in all aspects of social care services.

9. Make every effort to minimise the number of different social workers that children and young people have, so that they can establish trusting relationships over time with their workers.

10. Ensure that children's social care case files include useful and clear chronologies so that current practice takes full account of the child or young person's history.

11. Improve the identification, assessment and support to privately fostered children, young people and their carers.

Summary for children and young people

- Senior managers and councillors in Bury have worked hard to make sure that when children, young people and their families need help they get this quickly and it usually helps to stop problems getting worse, improves family life, and results in children and young people doing better.

- When children and young people are not being looked after properly by their parents, this is spotted quickly. Staff, including social workers, see children and young people on their own to find out what they think and what they want to happen. Some children and young people are helped by having a child-in-need plan or a child protection plan. When this happens, the main people who can help, such as teachers, school nurses, health visitors, social workers and sometimes other people, like police officers, meet with family members to make the changes that are needed. Everyone is good at working together, being respectful to families but not forgetting to keep the child or young person at the front of their minds while dealing with the problems of the parents.

- If the child-in-need or child protection plans don't work or don't make changes quickly enough, social workers step things up and let parents know that they are thinking of asking the court to place a legal order on the child or young person. This is so that the social workers can have more say in how the child or young person is being cared for. It is important that this happens, as otherwise children and young people could be left in homes where they are not safe or are neglected for too long.

- Children and young people who cannot live with their parents are helped to find other people to look after them who they will be happy and feel secure with. These might be other family members such as aunts and uncles. Sometimes they are foster carers or adopters. Social workers and their bosses take a lot of care to make sure that every child and young person is in the place that will suit them best. This means that very few children and young people ever have to move because it has not worked out for them. Children and young people can stay in touch with family members when they want to, and there is good support for this.

- Children and young people in care can join the Children in Care Council and have a lot of say in what the council does for children and young people looked after. This affects things like making sure that care leavers have enough money to set up home and helping to interview new social workers for jobs in Bury.

- Managers and the council need to improve some services for children and young people. This includes being better at supporting children and young people who have disabilities, making sure that children and young people in care have up-to-date plans and assessments, and helping more children and young people in care and care leavers to have a school or college place or some kind of training, apprenticeship or work that they like and want to do. The council needs to have high ambitions for all children and young people looked after and care leavers, and to give them good support to achieve their goals.

The experiences and progress of children who need help and protection	Good

Summary

Access to a wide range of effective help and support services for children, young people and their families results in risks being minimised and children's and young people's welfare improving. The outcomes for children and young people in need of help and protection are also improving for the vast majority of children and young people. The interface between early help and child protection services is clearly understood by partner agencies. The multi-agency early help panel ensures that children, young people and families receive support at the right level for their needs.

Risk for all children and young people is well understood by partner agencies, including adult services. Responsive and swift action from staff ensures that children and young people at immediate risk of harm are safe. A wide range of partners is consulted when safeguarding concerns are suspected or known. Working together well, these partners ensure the immediate protection of children and young people who need this. When risks escalate or new risks emerge, social workers and partners respond promptly and appropriately, adjusting the level of intervention accordingly.

Timely assessments make effective use of historical information. Children's and young people's wishes and feelings are well recorded, and children and young people can have an independent advocate. Assessments result in multi-agency plans that improve outcomes and reduce risks.

Assessments of young people who present as homeless are completed swiftly, resulting in multi-agency plans that address their needs.

A good range of effective services is available for children and young people who are at risk of harm from domestic abuse, providing increasingly early identification and intervention in domestic abuse situations. Social workers and partner agencies understand the impact of multiple parental difficulties, such as domestic abuse combined with substance misuse and poor mental health.

Well-established systems are effective in determining the risk for children and young people who go missing or who may be at risk of sexual exploitation. Children and young people are provided with appropriate interventions that reduce harm.

The needs of children and young people who have disabilities are met with a range of good and helpful services. However, some assessments and plans for children and young people who have disabilities are not always updated frequently enough to ensure that the support is relevant to the changing needs of each child or young person as they mature.

Children and young people who are privately fostered are not identified or supported appropriately.

Management oversight and direction is good. Clear and unambiguous decision-making by team managers, supported by effective supervision for social workers, ensures safe social work practice, a strong management grip and a culture of learning.

Inspection findings

12. Robust, coordinated and effective multi-agency early help services prevent the need for escalation to statutory services for many children, young people and their families. The early help team and the common assessment framework consultants are pivotal in enabling easy access to early help services by providing a single point of contact, advice and guidance to all those who work with children, young people and families. These staff have a firm grip of early help assessment activity across the borough and work hard to improve constantly the quality of assessments and plans. Current standards are high and are maintained by robust monitoring and quality assurance. Assessments are thorough and detailed, enhanced by the voice and views of the child or young person and other family members. Staff use a good range of direct work methods to engage families well. Meetings are well attended, and plans are effective with specific targets, timescales and contingency planning. This enables many children, young people and families to improve their situations without the need for intervention from children's social care services. Responsibility for delivering early help services is shared across the partnership, with lead responsibility being taken by, for example, school staff, health visitors and other child welfare professionals. The troubled families programme is fully integrated into the early help service, providing effective support for families with multiple needs.

13. Integrated early help support is facilitated by a bespoke electronic case-recording system, which enables all agencies to record their work with children, young people and families, so that everyone involved can see the impact of their joint help. To meet the needs of children, young people and families more effectively, packages of support are adjusted when necessary. The case-recording system supports good-quality performance management information, which, in turn, is used to inform service development. Management oversight and supervision of early help workers is in place, but supervision is insufficiently reflective.

14. The multi-agency safeguarding hub (MASH) is an effective central point for all referrals for children, young people and families. Referrers receive good-quality verbal advice and guidance, supported by clear written guidance in the multi-agency referral form and the threshold document. The threshold for statutory social work services is well understood by all agencies and, consequently, the vast majority of referrals to the MASH are appropriate. Thorough information gathering from a wide range of agencies informs decisions about next steps and ensures that the right services are in place for each child or young person. The outcome of professional referrals is shared with the referring agency in a timely way. During the inspection, the local authority issued updated guidance to ensure that consent is always sought from families to enable agencies to share and record their personal information safely.

15. Most contacts into the MASH regarding domestic abuse are from the police, and these account for about 40% of all contacts. The vast majority of these are appropriate and timely. Attending police officers routinely complete a specialist domestic abuse risk-assessment tool, and thorough completion at the time of an incident minimises delays in notifying children's social care of serious situations. However, instances assessed as less serious can take several days to come to the attention of the MASH, where a fuller multi-agency assessment of risk can occur, and agency information not known to the attending police officer can be taken into account.

16. Effective arrangements are in place between daytime and the out-of-hours service. Activity undertaken out of hours is recorded on children's and young people's files promptly. Good liaison is promoted by the manager of the out-of-hours service attending daytime meetings in the MASH, and this facilitates stronger handover arrangements.

17. Management oversight of contacts and referrals is good. Contacts are progressed swiftly to referral and assessment within children's social care when appropriate. If needs change, children and young people are 'stepped up or down' to receive an appropriate service while continuing to receive support. All children and young people at risk of significant harm are responded to promptly, with effective action taken to keep them safe. Careful attention is paid to historical information and the prevalence of multiple difficulties, such as combinations of adult mental health difficulties, substance misuse and domestic abuse. Qualified social workers undertake comprehensive investigations, children and young people are seen and spoken to, and decision-making is timely and appropriate. The majority of strategy discussions are timely and well attended by partner agencies that fully contribute to decisions about next steps. Children's and young people's cases tracked and sampled by inspectors confirmed this standard of work, and no children or young people were seen to be unsafe.

18. Management oversight and direction for social workers is good. Team managers provide good support for their staff, and this gives them the confidence to develop. This high-quality management oversight ensures safe social work practice, and there is an embedded culture of learning. Children and young people who have recently been allocated to workers have their cases reviewed by team managers to ensure that the case is progressing well. There is no delay in children and young people being allocated and, when a different type of service is required, transfer across social work teams is seamless, with no delay in seeing children and young people and starting assessments for the majority of children and young people.

19. Children and young people in need of help or protection have their needs assessed promptly and thoroughly. The majority of assessments, including pre-birth assessments, are of good quality, are analytical, come to appropriate conclusions and lead to the provision of appropriate support and help. Research findings and the child's or young person's voice inform assessments. Good examples of parenting capacity assessments were seen, with some being commended as good practice during care proceedings.

20. Chronologies on children's and young people's case files are not routinely created and updated by social workers. The exceptions are those for children and young people in care proceedings, who benefit from good-quality chronologies that set out key events in their lives. The absence of chronologies for most children and young people makes it difficult for social workers to understand what has happened to them previously and to consider this in current assessments and interventions. This is particularly significant for workers who take over a child's or young person's case and need to get a clear sense of the child's or young person's life up to that point in time (Recommendation).

21. Children and young people are seen regularly on their own by social workers, when appropriate, so that their views can be recorded and used to inform assessments and planning. Visits to children and young people on child protection plans are timely, with 96% in time in the last three months. Work seen demonstrates that social workers build trusting relationships with parents, which assists with promoting children's and young people's welfare.

22. Child protection conferences support effective multi-agency information sharing and planning to reduce the risks to children and young people. Conferences are well attended by partner agencies, but resource shortages have resulted in the police failing to attend some initial conferences, although written reports are provided. This is a known area of weakness, which partners are working hard to resolve. In 2014–15, only 52% of initial conferences were held within 15 days, which was well below the national level of 75%. At the point of the inspection, this had improved to nearly 86% of initial conferences being timely. Children and young people do not stay on plans for too long, with no child or young person being on a plan for over two years, and low numbers being subject to second or subsequent plans.

23. The proportion of children and young people on plans for neglect is high at 51%, but this reflects the good efforts made across the partnership to improve understanding of neglect. The local authority has invested in the graded care profile to support neglect assessments. However, this is not used consistently by workers when it should be, and there is more to do to embed this in practice. Senior managers are aware of and monitor this.

24. Conference chairs are proactive in checking that children's and young people's plans are progressing and that reports for conferences are of a good quality. Child protection plans are progressed by well-attended, multi-agency core group meetings. Family group meetings are used appropriately to support alternative family arrangements. Meetings involve family members as appropriate, and effective information sharing and joint working successfully reduce risk for many children and young people. Children and young people who need additional services but do not need to be on a child protection plan are also provided with a range of services appropriate to their needs.

25. Arrangements for identifying and supporting children and young people at risk of child sexual exploitation are robust and improving. Numbers of children and young people at risk are low, compared with many neighbouring authorities, but partners are not complacent, and all those at potential risk receive good-quality detailed assessments. Partner agencies understand the risks of child sexual exploitation and work together well to identify and assess the level of risk faced by vulnerable children and young people. The specialist multi-agency child sexual exploitation team carefully gathers and analyses information about child sexual exploitation in the borough, provides advice to other professionals and supports children and young people. Detailed screening and assessment by social workers in the team clarify the extent of risk to each child or young person. Prompt interventions lead to reduced risks for the vast majority. Those children and young people at potential risk are well understood, and all have multi-agency support plans. Regular, independently chaired, multi-agency meetings consider each child and young person, providing additional oversight and scrutiny. The electronic child-recording system has been adapted to enable risks of child sexual exploitation to be recorded, so that these are clear to authorised viewers, reducing the likelihood of potential risks being overlooked. Effective analysis of intelligence has led to successful disruption activity and some successful prosecutions of perpetrators.

26. Arrangements to conduct independent return interviews for children and young people who go missing from home are effective and are embedded into practice. Overall numbers are low, but this is kept under scrutiny to ensure that children and young people are reported as missing when they should be. In many cases, return interviews are followed by direct work, and this reduces future risk, resulting in low numbers who repeatedly go missing from home. Good information sharing and joint working between the police and children's services result in a detailed understanding of the cohort and any emerging themes or issues. Any possible links between missing children and young people and the potential for child sexual exploitation are routinely considered, with effective use of a screening tool. Children and young people who go missing from education are followed up promptly and robustly. The local authority maintains accurate records of children and young people missing from education and diligently pursues them until their locations and educational arrangements are known.

27. At the time of inspection, 86 children and young people were being educated at home. The local authority routinely checks on their educational progress. Considerable effort has resulted in good relationships with parents who value the support and guidance that they receive on a regular basis. Staff visit at least 95% of all home-educated children and young people annually, and specialist caseworkers have a good understanding of their needs. Twelve children and young people have access to home tuition and 13 have access to 'not in school and ill' services so that they can study at home until they are well enough to return to school.

28. A particular strength is the work of the emotional health and well-being coordinator who supports all schools to improve teaching about bullying, transgender and any other relevant issues identified by schools. Many good and effective activities take place to promote tolerance and anti-discriminatory attitudes among school-age children and young people, including an event to celebrate transgender young people.

29. Professionals are good at identifying children and young people living with domestic abuse. In all domestic abuse cases seen during the inspection, appropriate services are in place to help reduce risk and support child, young person and adult victims. Perpetrators of domestic abuse are able to access a voluntary perpetrator programme, which further increases safety planning. Regular and consistent attendance at the multi-agency risk-assessment conference by partners results in good-quality information sharing and actions to reduce risk to the most vulnerable children, young people and adults. Robust follow-up by the chair ensures that actions are completed.

30. Most children and young people who have disabilities and their families are well supported through a range of services to help meet their needs. However, too many children and young people who have disabilities do not have up-to-date social work assessments and plans that underpin the services they receive. For those who have a plan, their views, demeanour and responses are not always described sufficiently well. Children's and young people's records do not tell a clear story about the child or young person and their family, their journey and the impact of disability on the child or young person, their brothers and sisters or parents or carers in their everyday lives. Managers are aware of these issues and are currently undertaking a review of the support offered to children and young people who have disabilities (Recommendation).

31. In sharp contrast, education, health and care plans involve the child or young person throughout the process and are effective in identifying support needs. Staff complete EHC plans well, and the child or young person is in clear focus throughout. EHC plans include pictures and scanned documents produced by the child or young person. Objectives are child-centred and professionals include the child or young person in deciding actions.

32. Young people who present as homeless are appropriately assessed and provided with relevant support. There have been no young people placed in bed and breakfast accommodation for the past 12 months.

33. Children's and young people's participation in meetings that consider their needs, including their safeguarding needs, is high. Independent advocates are available to assist children and young people in having their views heard in child-in-need and child protection meetings. The service is promoted by child protection conference chairs recommending advocacy as part of the outline plan. However, this is not followed up by children's social workers in all cases. Increased use of independent advocates would further encourage children's and young people's participation.

34. Good arrangements are in place to manage allegations against professionals who work with children and young people, and referrals to the designated officer have increased from a range of agencies. Effective awareness raising and targeted training have been undertaken. Good links have been established with the major faith groups in the area, resulting in referrals being made. Detailed records show robust oversight of case progress and outcomes.

35. Arrangements for children and young people who are privately fostered are under-developed. Small numbers of children and young people have been identified over time. When children and young people are identified, they are not visited quickly enough. Only one of six children and young people known to be privately fostered during the previous year was seen within seven days. Actions outlined in the most recent annual report to improve practice have not progressed, although plans are in place to remedy this shortfall (Recommendation).

The experiences and progress of children looked after and achieving permanence	Requires improvement

Summary

When children and young people need to become looked after, decisions are appropriate. Children and young people who are on the edge of care benefit from good use of legal proceedings and the Public Law Outline (PLO) that is helping families to access a range of support services. This helps some children and young people to remain safely at home with their families.

When children and young people looked after return home to the care of their parents, there is not always a comprehensive assessment and plan in place to help families to prepare for this. Assessments of the needs of children and young people looked after are not updated regularly and do not contain enough information and analysis about important issues. Care plans are not specific enough and lack timescales and contingencies.

Some children and young people have too many changes of social worker, which makes it difficult to progress plans in a timely way and to build trusting relationships over time. IROs are not providing sufficiently robust challenge or quality assurance of children's and young people's plans. They do not routinely monitor the progress of plans between reviews.

The timeliness and quality of initial health assessments for children and young people looked after are improving. However, some children and young people still wait too long to have their health needs identified and addressed.

Children's and young people's educational outcomes at key stages 2 and 4 require improvement.

When children and young people looked after go missing, they receive timely, independent return interviews to identify and reduce any risk of harm, including sexual exploitation.

Adoption is considered for all children and young people at the earliest stage, and delay is minimised through the adoption process. Social work with birth families and adopters is sensitive and robust.

The vast majority of children and young people live in suitable placements with carers who meet their needs well. A high proportion of young people looked after aged 16 to 18 live in semi-independent accommodation. Accommodation options for 16 to 18-year-olds require analysis to establish the best way to promote good outcomes for these young people.

Care leavers have good access to a range of suitable health services and good support from their personal advisors (PAs). Despite this, too many are NEET.

Inspection findings

36. Decisions to look after children and young people are proportionate and appropriate. Children and young people do not enter the care system unnecessarily. Understanding and application of thresholds are largely appropriate.

37. Effective family support services and a range of evidence-based programmes help children, young people, parents and carers when there is a risk of family breakdown. The range of help on offer to children and young people on the edge of care, and their families, includes family group conferences and family therapy. This work is good quality and has helped some children and young people to stay at home with their parents or to live with other family members. The work also supports foster carers who are struggling to care for a child or young person. Although there has been no formal evaluation and analysis of this work, the improved outcomes in children's and young people's cases seen on this inspection demonstrate its positive impact.

38. Management of cases within the PLO is good. Effective legal planning meetings and close monitoring and tracking of cases in PLO mean that children and young people move swiftly through the system. The average time taken for proceedings is now 27 weeks, with performance for the quarter prior to this inspection showing timescales of 23 weeks. This compares very well with a national average of 30 weeks.

39. The quality of work being placed before the court is good and improving. The Children and Family Court Advisory and Support Service (Cafcass) and the local judiciary report that preparation and planning for cases in proceedings is mostly very thorough, and the authority has produced some good pieces of work. The judiciary regards the local authority's use of section 20 Children Act 1989 orders (voluntary care) as an appropriate way to look after some children and young people. Children and young people subject to these orders are regularly monitored to ensure that these remain the right orders for the child or young person. Thorough, well-researched parenting assessments are undertaken by the local authority's children and family centre. These assessments are held in high regard and make a strong contribution to the overall social work assessment on a child or young person and their family in care proceedings.

40. Some children's and young people's case files lack chronologies, and the overall standard of existing ones requires improvement. Some chronologies seen have not been kept up to date. Too many are replicated from case notes. This makes it difficult to understand the history of a child or young person or for any new workers to grasp quickly a sense of the important things that have happened (Recommendation).

41. Assessments of children, young people and families are generally good and thorough when the children and young people begin to be looked after, but thereafter are rarely updated and therefore the information within them becomes increasingly outdated. For example, they do not reflect changes in children's and young people's families, such as births of brothers or sisters, or parents separating. This is particularly significant for children and young people who have not yet achieved permanence and whose needs are changing, or for those children and young people whose parents are requesting their return home (Recommendation).

42. A few assessments seen do not explore crucial issues thoroughly enough. This includes issues such as the impact of parental ill health on children and young people and the views of significant family members, such as birth fathers and grandparents. Diversity, religion and culture are not consistently considered in assessments for all children and young people (Recommendation).

43. The lack of up-to-date information and assessment of children's and young people's needs reduces the quality of planning for them. Although plans are refreshed regularly, and the better ones reflect current information and circumstances, some sections of plans are not routinely updated. These include information about children's and young people's developmental needs, which will inevitably change as they get older. Plans include targets for the future, but are not always specific enough. Responsibility for undertaking tasks is not clearly ascribed, and the lack of timescales makes it difficult to monitor progress (Recommendation).

44. The quality of some children's and young people's case records does a disservice to the knowledge and understanding of children and young people, as reflected by the social workers during discussions with inspectors. The vast majority could describe children and young people in detail, including their histories, key events, current needs and circumstances, and what the future plans are for them. Most social workers had clearly spent time with the children and young people and understood their wishes and feelings. Creative examples were seen of direct work with children and young people to help them to express themselves. The views of children and young people are recorded on files, but the written records of these are too brief and do not reflect the good work that is being done to listen to children and young people.

45. Contact between children and young people and their families is well facilitated at the local authority's children and family centre, which creates a relaxed, informal, child-centred atmosphere. Comprehensive reports of contact sessions are shared with parents and social workers, and these usefully inform plans.

46. Statutory visits are carried out within timescales and are recorded on children's and young people's files. Social workers note when children and young people have been seen alone. However, the purpose of some visits to children and young people is not always clear and records are sometimes too brief to see what has been achieved by the visit.

47. Decisions about what actions to take for children and young people looked after are not always recorded well enough and do not set out the reasoning behind the decisions being made. In tracked cases, decision-making in the cases of children and young people looked after was found to require improvement in 12 out of 15 cases.

48. Despite the relatively stable workforce seen across other parts of the service, some children and young people looked after have had several social workers, so that they do not get the opportunity to build trusting, meaningful relationships with them. This makes progress on plans more difficult to maintain, and parents, children and young people told us that they found it difficult when they had to get to know and share information with different workers (Recommendation).

49. Timeliness of initial health assessments for children and young people looked after is improving, but needs further work to ensure that their health issues and needs are identified and addressed as early as possible.

50. Dedicated, responsive child and adolescent mental health services (CAMHS) meet the emotional and mental well-being needs of children and young people looked after promptly and effectively. Many examples were seen of highly effective interventions from this team: for example' in helping children and young people to understand and cope with the difficult things that they had experienced. The provision of individual consultation to carers and staff enables them to increase their skills and confidence to support children and young people with more complex needs. The emotional health and well-being coordinator works closely with the virtual school team to provide a continuum of care and support in school for children and young people looked after.

51. The virtual school is well managed and all children and young people looked after, of whom 201 are of school age, are tracked. Their progress is monitored closely and is well understood. Individual children and young people are provided with a learning mentor, through pupil premium funding, if they need one. The PEPs of children and young people looked after set out clearly what pupil premium funding is being applied for and what it is expected to achieve. Ten high level learners receive extra financial support and all Year 11 pupils are allocated £1,000 to ensure that they are prepared for Year 12. The virtual school team provides good support for children and young people who are placed in Bury by other local authorities and pays equally careful attention to their educational progress, supported by good liaison with the placing authorities.

52. PEP completion is now over 90%, and the virtual school is actively assessing the quality of these documents to support all children and young people to achieve educationally. Learning from these audits is not maximised because feedback on the strengths and weaknesses of a PEP is not routinely provided to the authors, and not enough social care staff are accessing training offered by the virtual school. Therefore, PEPs remain variable in quality, and the input of the child or young person in the process is not always obvious. Target setting is not always specific enough to assist the child or young person to progress swiftly.

53. Outcomes at key stage 2 are poor, but progress for children from a low starting point is good. At key stage 4, 12% of young people gained five GCSEs at A* to C grade, including English and mathematics last year, which is a 1% increase on the previous year's results. The virtual school monitors every child or young person individually, which allows for a more personalised approach (Recommendation).

54. At the present time, 27% of young people looked after aged 16 to 18 are NEET, and this figure is too high (Recommendation).

55. Very few children or young people looked after (4%) attend a secondary school that is judged inadequate. Children and young people are not precipitously removed from schools judged inadequate. Rather, careful consideration is given to all of a child's or young person's circumstances before a decision is made. Attendance of children and young people looked after at school is good at 94.4%.

56. Good arrangements are in place to monitor the six children looked after who are not in receipt of 25 hours' education. Each child has a clearly recorded action plan with timescales for their return to full-time education, and their progress is tracked. This ensures that they are integrated into full-time education at the earliest opportunity.

57. Effective processes are in place to identify and promote the safety of children and young people looked after who go missing or who are at risk of sexual exploitation. All children and young people who go missing are risk assessed to consider the possibility of sexual exploitation. Return interviews take place within 72 hours of a missing episode, and information from these is recorded and considered alongside information provided from other return interviews, to check for patterns, trends and any other links that might cause concern.

58. Although the local authority does not have any children's homes of its own, it facilitates a regular forum, which successfully brings together the private home providers in the borough. This is valued and provides an excellent means of ensuring that all the providers are aware of local arrangements to safeguard children and young people and promote their welfare, including what to do when children and young people from other local authority areas run away or are at risk by other means.

59. The majority of children and young people looked after live in families. Foster carers spoken to say that they are well supported and were well prepared for the role. There are currently 160 foster carers approved for 258 children and young people. Family and friend carers look after a further 56 children and young people. The campaign to recruit more in-house foster carers has been very successful, leading to more children and young people living locally. There is a clear process in place to match children and young people with carers to minimise the risk of breakdown and to ensure that children and young people experience better choice as part of the process.

60. Good efforts are made to place brothers and sisters together. Currently 51 children and young people from 20 families are placed together, with only one family of two children being placed separately. The reasons for this are clear and appropriate to the needs of the children.

61. Well-established needs analyses, supported by effective local and regional commissioning and contractual arrangements, ensure that future demand for placements with foster carers and children's homes is anticipated and planned. There is a good range of foster carers who can care for children and young people with complex needs, babies and older young people. Commissioners visit establishments so that they are assured of quality and value for money.

62. Children and young people placed outside of the borough are visited by their social workers. The borough is geographically small, however, and the vast majority of children and young people placed outside it are within close travelling distance of their home of origin. Their education and health needs are identified and met, and they make appropriate progress. Children and young people placed outside of the borough are well supported to maintain links with family and friends through visits. This includes providing overnight accommodation for parents when necessary, to promote contact.

63. The fostering panel chair is suitably independent, qualified and experienced for the role. Panel membership has recently been strengthened by the addition of a mix of professionals and foster carers, providing a more diverse and independent panel. The panel has been proactive in driving up the quality of assessments and providing effective challenge to ensure that reports are good enough to assist the panel in making the right decisions. The panel chair has not been meeting regularly with the agency decision maker, attributed to changes in managers within children's social care, and this is a missed opportunity to improve communication and coordination. Plans are in place to remedy this.

64. The local authority works hard to secure permanency for children and young people when adoption is not appropriate. A strong focus is placed on providing long-term foster placements, special guardianships and placements with family members. Examples were seen of social workers helping to achieve permanence and stability for children and young people in very difficult circumstances, such as following a placement breakdown. Inspectors saw good sensitive work to prepare children and young people for new placements.

65. When children and young people looked after return to the care of their parents, placement with parents regulations are not fully met and endorsed by a sufficiently senior manager within children's social care. Not all families are prepared well enough for the impact of children and young people returning to their care, and parents are not always supported through the transition. Very good support is available for families who attend the children and family centre with, for example, parenting courses and activities to help children and young people to re-establish their relationship with parents. More families in similar circumstances would benefit from these services.

66. IROs ensure that children's plans are reviewed regularly and that children, young people, parents and carers are spoken to before the review. Relevant professionals attend, and reports are provided to inform the review and subsequent plans. Although plans are reviewed in a timely way, IRO caseloads are high, and IROs undertake the dual role of IRO and child protection conference chair. IROs acknowledge that child protection work often takes precedence over the added attention that they would like to give to children and young people looked after, such as checking on their progress and meeting with them in between reviews (Recommendation).

67. Challenge from IROs when there is any drift or delay in progressing plans for children and young people looked after is not recorded well, and it is difficult to see their footprint on children's and young people's files. The IRO service is clear that it does offer challenge and raises concerns when it has them and this is confirmed by senior managers. However, challenges are not routinely recorded; so it is difficult to confirm how often this happens or to see what impact challenges have had (Recommendation).

68. Occasionally, to prevent reviews from going out of timescale, IROs hold a series of single meetings with professionals and then collate the information later to form a review. This is not good practice and means that the rich discussion, debate and participation of families is lost from the review process. The local authority responded promptly when this was brought to senior managers' attention during the inspection, and steps are already in place to cease this practice and to monitor compliance.

69. Children and young people looked after are helped to meet together, supported by a dedicated children's rights service, which includes a youth participation apprentice. The two age-banded Children in Care Council (CiCC) groups meet regularly and are reasonably well attended, with an average attendance of approximately 10 children and young people, who are encouraged to help to shape the services that they receive. The CiCC is able to publicise its existence and work through its own website. The local authority has invested in Total Respect training which encourages youth participation across services. Representatives from the CiCC attend the corporate parenting board and youth cabinet. The local authority was successful in meeting independent national standards for the participation of children and young people looked after, and has been awarded maximum Leading Improvement for Children in Care (LILAC) accreditation in recognition of this.

70. Children aged six to ten years in the CiCC told inspectors that they felt safe at school and at home. They said that they can talk to their social workers and would tell them if they felt unsafe. They know that they have a right to complain and could give examples of changes made because they had asked, such as contact with pets and having more photographs. They have good opportunities to develop hobbies, interests and friendships outside of school, such as attending cubs and brownies, football and drama groups.

71. Advocates are available for all children and young people looked after who want them. The service is commissioned from an independent provider and is well used, supporting 123 children and young people in the past year. Positive feedback from children and young people about the service indicates that they feel listened to and responded to.

72. Social workers benefit from regular supervision from their managers. In a small number of instances, supervision had not taken place on time. Supervision files do not generally evidence supervision that is reflective or challenging. A few good examples were seen but most workers wanted supervision to be more reflective to inform casework practice. Social workers say that they feel well supported by their managers.

The graded judgement for adoption performance is that it is good

73. The local authority gives high priority to promoting permanence for all children and young people that is underpinned by an integrated strategy and clear routes to permanence. The local authority was quick to respond to national guidance on fostering to adopt with 11 children benefiting from this type of placement since 2014. The recruitment of adopters is highly effective, with the number of prospective adopters increasing year on year, resulting in more adopters than are required locally. This has enabled the local authority to refer 27 adopters to the National Adoption Register since 2013. Currently there are 13 adopters without a match and only two children waiting for a match. This has supported the improvement in the number of children adopted over the last three years. The local authority has used the National Adoption Register to achieve adoption for children with complex needs in 21 cases since 2013, which is good.

74. Adopters say that they are attracted through personal recommendations of adopters or in response to recruitment campaigns. Information and guidance for adopters give a realistic picture so that their expectations are well managed. Adopters report that they have continuity in assigned workers who are proactive, supportive and helpful.

75. Once children have a placement order, permanence is achieved through adoption in nearly all cases. There have been no revocations since 1 April 2015. The proportion of children who leave care through adoption is good: 20% of children looked after who left care did so through adoption in 2014–15, better than the national proportion of 17%. Data from 2013–14 shows that 52% of children wait less than 18 months from entering care to moving in with their adopters, which is better than statistical neighbours and the national proportion of 51%. Scrutiny of cases in which children experience delay confirmed that this was because of factors that could not be anticipated or controlled, such as unexpected bereavements. At the time of the inspection, 18 children have a plan for adoption. Only two children are currently waiting for a placement order.

76. The local authority has given high priority to tackling the poor performance on adoption reported at the previous inspection. The local authority's data for 2014–15 shows that timeliness is much improved. However, the poor performance in 2012 continues to have a negative impact on the three-year performance for 2012–15. The three-year average time between a child entering care and moving in with their adoptive family has improved to 529 days. This is 42 days longer than the national threshold, but the gap is closing. Performance on the three-year average of the number of days between authority to place a child and the match to an adoptive family has also improved to 244 days. However, this rate of improvement has not closed the gap, and it remains a challenge, with current performance 123 days longer than the national threshold of 121 days.

77. There is strong performance in other key areas: for example, matching children from a minority ethnic background for adoption and placing brothers and sisters together wherever possible.

78. There is a wide range and good take-up of pre- and post-adoption support, training and events. Adopters benefit from the local authority's commitment to providing post-adoption support for as long as they want it. Training for adopters on the use of letterbox contact and how to deliver life story work is making a demonstrable difference to improving outcomes for adopted children and young people. The quality of this work is outstanding. The activity-based support provided for adopted children and young people who attend the young people's group is making a difference, and is highly valued both by adopters and by children and young people.

79. Individual support tailored to each family is readily provided. For example, referral to a genetic counsellor, and support provided by the nurture group that is age banded and needs led. Examples were seen of creative and proactive responses to assist adopters as part of the matching process.

80. The adoption panel is effective. All prospective adopters are approved without delay, and decisions are signed off by an appropriately senior agency decision maker. The adoption panel chair is suitably experienced, qualified and independent of the local authority. The panel is diverse, featuring a wide range of expertise, including representatives from non-social work professions and adopters, and is sufficiently diverse with regard to ethnicity and gender. Reports for the panel are consistently good. Adopters report that assessments are thorough and fair. Life story work is consistently timely and of good quality. Although the quality of later life letters seen is consistently good, too many of the children's and young people's cases sampled do not have a later life letter completed in a timely manner.

81. There are robust systems in place for suitability checks, including medical assessments as part of the adoption approval process. The minutes from adoption panels set out clear decisions and recommendations. Although processes are rigorously adhered to, in a small number of cases the rationale for decisions is not clear from the minutes seen, and this impacts on the agency decision maker's ability to make fully informed decisions.

82. The adoption panel chair reports on the quality of social work reports, and this is shared with the corporate parenting board, keeping elected members informed. Standards are already high, but the panel's plan to improve continuously is exemplified by its careful consideration of the limited number of disruptions that have occurred, to see if any lessons can be learned. No families have experienced a placement breakdown since 1 April 2015.

83. The adoption support fund is used effectively to support children and young people with special needs. Panel members make sure that new adopters are aware of this fund to promote equality of access for children and young people.

The graded judgement about the experience and progress of care leavers is that it requires improvement

84. The return of the leaving care service to local authority control in 2015, having previously been outsourced for many years, was in recognition that the service had some strengths but required improvement overall. Plans and costings have been approved and are being progressed to improve the services provided to care leavers.

85. The local authority makes strenuous efforts to keep in touch with care leavers through phone calls, drop-in facilities, face-to-face visits and working with other professionals. As a result, it is in touch with the vast majority of care leavers.

86. Care leavers spoken with by inspectors value the leaving care service and described different ways in which they have been supported. They are positive about the help that they receive from their PAs and are confident that they will continue to receive the support that they need.

87. Too many care leavers are NEET. This accounts for 27% of 16 to 18-year-olds, rising to 51% (year to date) for those young people aged 19 to 21. This represents a slightly worsening picture from 2014–15. The local authority lacks a focus on the progress being made by young people who are over the age of 18 years, and outcomes for many of these young people are poor as a result (Recommendation).

88. This is in sharp contrast to those care leavers who do well, and there are currently 14 young people at university, with many graduates achieving highly.

89. Pathway plans are too variable in quality. In many cases, the young person is not involved adequately in the process to make it a valuable or meaningful experience for them. Staff complete too many plans without the young person being present. Educational plans are not always realistic for the young person or specific enough for them to move forward in their career. PAs update pathway plans in a timely way and review the plan with the young person wherever possible, but do not involve other agencies and services. This means that some care leavers experience disjointed services, and different professionals working with a young person do not always know what everyone else is doing to help the young person. Pathway plans for young people over the age of 18 are not independently overseen by, for example, IROs (Recommendation).

90. Detailed information about the practical support available to young people demonstrates the considerable work done by the PAs to help young people as they mature. This was the strongest element in most plans seen by inspectors. PAs are good at recognising those young people who are at risk of sexual exploitation and at ensuring that appropriate specialist services are put in place to reduce the risk.

91. The local authority apprenticeship scheme did not recruit any care leavers last year as the requirements for applicants to have A* to C grades in English and mathematics excluded many young people looked after and care leavers. The timing of the apprenticeships also meant that many young people had already made plans for their future. The local authority is currently reviewing its processes, and in conjunction with adult education provision will be offering traineeships from September 2016. This will offer placements to young people while supporting them to improve their English and mathematics grades in preparation for an apprenticeship or other further education or training. At the present time, the local authority only has four care leavers in apprenticeships and traineeships.

92. Although the local authority is working to improve the offer to care leavers, other opportunities are currently provided, such as work experience being made available for young people looked after and care leavers, to encourage them into employment. Young people with learning difficulties benefit from good supported placements within the council.

93. The care leavers' charter is too general and is not specific to Bury. The charter is not written in young person-friendly language and it has little impact on care leavers. Despite this, care leavers do clearly understand their entitlements and receive a booklet setting out financial arrangements and benefits. Care leavers were confident that their PAs would be able to help with securing entitlements or other resources that they might require, so did not see the charter as significant.

94. PAs start supporting young people from the age of 16 years, alongside their social worker, to help to prepare them for independence. Care leavers receive support from PAs until they are 21 or, if they are in further or higher education, up to the age of 25. When young people move into semi-independent or supported accommodation, PAs teach them independence skills. PAs are responsive to young people's individual needs and celebrate key events such as birthdays. Care leavers report good access to their PAs and are positive about the support that they receive, including help with transport to health appointments, interview practice and help with finances. Care leavers make good use of the drop-in facility at the care leavers' team base.

95. The number of 16 to 17-year-old care leavers who are in supported or semi-independent accommodation is too high. Currently, 28% of care leavers aged 16 to 18 years are in supported or semi-independent accommodation, including five young people who are 16, and 17 young people who are 17 years old. This is a high figure and, while this type of accommodation may be appropriate for a few young people in this age range, it is unlikely to be the most suitable accommodation for many who require a more nurturing family-type environment (Recommendation).

96. The staying put policy is used well, with 18 young people currently remaining with their foster carers. Young people who have sufficient independence skills are given priority to bid for a tenancy from the local social housing provider. Currently, 25 care leavers aged 18 years and over have their own tenancy. Most (92%) of the 19 to 21-year-olds are in suitable accommodation with a few recorded as living in houses in multiple occupancy. This latter category includes some semi-independent accommodation and young people attending university.

97. Care leavers benefit from a dedicated CAMHS outreach team co-located with the children looked after social work teams. The children looked after nurse also supports care leavers and provides weekly drop-in sessions at the care leavers' team base. A wide range of health needs is met and advice is provided. Care leavers are provided with personal health passports which include good health information and advice. Care leavers spoken to understood their health histories. Specialist health services, such as sexual health and substance misuse services, are accessible, young-person friendly and deliver improved health outcomes to young people.

98. All young people about to leave care at 18 years of age receive a transitional health assessment, and those young people with complex health needs are the subject of transitional planning from 16 years of age. The children looked after nurse contributes well from that point to support the young people into independence or adult services.

99. The local authority has an annual presentation event to celebrate the achievements of the young people in their care and care leavers. Last year, two separate parties were organised for the younger and older children. These were successful, with the CiCC helping to organise the event. There is a separate care leavers' forum that meets regularly, supported by the care leavers' team. These young people are encouraged and enabled to influence service design and delivery, and have influenced, for example, the design of sexual health services for all young people in Bury.

100. Bury is part of the north-west cluster of local authorities taking forward the development of services for care leavers. The action plan is comprehensive and encompasses all areas of key importance to care leavers. Progress has been made in all areas of the plan. The local authority expects this to result in improved services and outcomes for care leavers in the north-west, but it is too early to see the impact of this yet.

Leadership, management and governance	Good

Summary

Leaders, managers and politicians have worked purposefully to improve the quality of social work provided to children, young people and families over the past two years. A permanent senior team has a strong track record of redesigning and improving services as swiftly and sustainably as possible. Important services have been developed and implemented, including a robust and effective MASH, a multi-agency child sexual exploitation team and a strong, targeted early help service. All are achieving very good outcomes for children, young people and families. Previously outsourced services, such as the care leaving service, have been brought back in house over the past 12 months to accelerate improvement, and work is under way to achieve this.

The majority of practice seen during the inspection was robust, resulting in children's and young people's outcomes being improved. Children and young people who require statutory intervention are effectively safeguarded through consistently high-quality assessments, plans, interventions, and reviews. Partner agencies work together well to promote children's and young people's outcomes. The senior leadership team knows the strengths and weaknesses of its services very well and appropriately prioritises weaker areas, particularly strengthening the IRO service, services for care leavers, and services for children and young people with complex and varied disabilities. Although improvements are required, inspectors saw good work leading to positive outcomes for some children and young people, for example a good number of care leavers being supported to attend university.

The senior leadership team, well supported by elected members, promotes a culture of openness and learning, regularly inviting scrutiny from, for example, external peers and the Bury Safeguarding Children Board (BSCB). Feedback from these exercises, and feedback from service users, inform continuous service improvement. Internal quality assurance processes continue to be strengthened. Senior managers are highly visible to front-line staff, which the staff value. Senior managers regularly consider the quality of front-line practice in detail and use their learning to make improvements where the need is identified.

There are coherent and effective strategic relationships between the children's trust, the BSCB and key partner agencies, such as health services and the police. These enable senior managers to effect positive influence and change at decision-making forums, such as the local clinical commissioning group and the community safety partnership. Children's services are prioritised by the council, exemplified by additional financial investment to increase the number of social work posts and to provide a good offer to newly qualified workers. Because of this, the stability of the workforce has significantly improved, morale is high and turnover is low. Staff are well supported in their learning and continuous professional development.

Inspection findings

101. Political oversight, corporate parenting and the governance, management and performance of children's services have strengthened markedly since the last inspection in 2012. Strategic links, responsibilities and accountabilities between the children's trust, the Health and Well-being board (HWB), the BSCB and the CPB are clear and coherent. Engagement across the partnership is good, with good attendance from senior partner representatives at the children's trust board. Priorities are sharp and clearly set out in an up-to-date children and young people's plan. This plan includes the BSCB's priorities and challenges. The HWB formally assesses the progress of the plan twice a year as well as undertaking additional deeper periodic progress assessments. This ensures that progress is continuously scrutinised, and any structural difficulties benefit from partner agencies jointly overcoming them.

102. Clear political scrutiny is evident through a children's safeguarding scrutiny board and strong cross-party political attendance at the CPB. There are sufficient checks and balances in the governance system holding the leadership of children's services to account, providing coherent political and strategic oversight. Frequent meetings are held between the chief executive, the director of children's services (DCS), the assistant director, and the lead and deputy lead members for children. These provide a forum where close and well-informed oversight of plans and priorities is reviewed and feedback from staff is considered. The BSCB and CPB both include the DCS and lead member, and this supports good information sharing and progressing of actions.

103. Senior managers are highly visible to front-line staff, who report that they value this and find all levels of managers approachable. Engagement is substantial with, for example, the DCS holding regular detailed case discussions with social workers and observing child protection conferences each month. This personal engagement style is complemented by other frequent and good-quality methods of communication with staff, including weekly written briefings, regular open house sessions and lunchtime briefings.

104. The many staff who spoke with inspectors confirmed their positive engagement with senior managers, their clear understanding of priority areas for children's services, and conveyed a sense of being valued. Loyalty to the local authority and children's services was expressed strongly and repeatedly. This emphasis on the importance of good communication and staff participation is mirrored in the careful attention given to the involvement and engagement of children, young people and their carers. There is a range of active and influential bodies, including a well-attended youth parliament, schools' councils, CiCC and a care leavers' forum. Participation leads to tangible and demonstrable influence. For example, the children and young people's network has reviewed proposals for revised services, such as the CAMHS transformation programme, early help offer and sexual health services. Their views have influenced service design. Interviews for managers in children's social care do not proceed unless children and young people are available to participate in the recruitment process. The council actively promotes participation by children and young people across partner agencies, with a clear strategy and action plan underpinned by accessible resources. This helps partner agencies to take account of their users' views regularly.

105. A needs analysis drawn from a variety of sources, such as the joint strategic needs analysis, and prevalence data on domestic violence and young people's substance misuse, informs the commissioning of services. There is recognition that the current joint strategic needs analysis provides high-level data at a point in time, and deeper dives are required to improve understanding of need in order to commission services accordingly. Active efforts are in progress to introduce a more detailed joint needs analysis which can be easily updated. While this is in progress, alternative approaches ensure that services are commissioned to meet need.

106. Joint effective services are in place to support children, young people and families affected by the compounded difficulties of parental substance misuse, domestic abuse and mental ill health. Partner agencies all recognise the importance of identifying children and young people living in these home environments, and careful screening of all referrals where these factors are prevalent ensures that risk assessments and interventions are comprehensive. A recent exercise identified 57 children most seriously affected by these difficulties, and a subsequent audit of plans and interventions was undertaken to ensure that responses were sufficiently robust.

107. The sufficiency duty in respect of children and young people looked after is well met through membership of the regional commissioning consortium for independent fostering and residential placements. Additional oversight of contract compliance is undertaken by the local authority's children's commissioning unit. Effective application of an Invest to Save model resulted in the successful recruitment of 13 new carers in the last year. Placement stability is comparatively good, with the majority of children and young people looked after placed close to their family homes, even those who are placed outside of the borough. While there is an issue relating to the young age at which some care leavers move into supported housing, the actual quality of the provision is good.

108. An ambitious, comprehensive transformation of CAMHS over a four-year period is currently under way. The developments have demonstrably been informed by the involvement of children, young people and their families. Pooled funding between the local authority and the clinical commissioning group will incrementally increase financial resources over the four years. CAMHS for children and young people looked after and care leavers are already accessible and effective. This transformation plan will further enhance access to emotional well-being services for more vulnerable children and young people.

109. Indicative of the senior leadership team's capacity to plan and develop services based on evidence and local needs, is a service in development to reduce the number of teenage young people coming into care. Successful securing of corporate investment has enabled this to proceed, despite continuing fiscal pressures. Inspectors saw advanced development of this service, which will benefit from bespoke premises providing respite care, mediation and family work. This illustrates that the local authority is responsive to evidence-based arguments that support improving services and reducing longer-term costs, and is prioritising children's services.

110. The CPB is well attended by senior managers from partner agencies and by elected members. Four CPB sub-groups scrutinise progress against identified priorities, including the quality of placements and the health and education of children and young people looked after. Remedial actions are instigated where targets are not being met, and these are refined to ensure that actions achieve the desired outcomes. The CPB, as the governing body for the virtual school, designates one sub-group to concentrate on care leavers' engagement in EET for those aged 16 to 18 and 19 to 21 years. Despite this scrutiny, performance is not good enough. CPB minutes confirm that partners are aware of the volume of young people not engaged in EET, but more work is needed to close the gap, as some care leavers do very well while others are not engaged in positive activity. The CPB's field of vision regarding children and young people looked after is suitably broad, but its effectiveness would benefit from tighter priorities and more qualitative information on the experiences of children and young people (Recommendation).

111. Clear, well-established arrangements through the community safety partnership and the Bury Resilience Forum provide effective governance of the Channel Panel and 'Prevent' steering group, including advising the BSCB of their work. Effective activities are undertaken regarding the potential radicalisation of young people, including awareness raising, responding to agencies' concerns, and assessing individual risks. Bury is not a Home Office priority area, but because it borders local authorities which are, there is careful liaison regarding children and young people of concern crossing local authority boundaries. Work with local communities is effectively and sensitively undertaken by the council's community cohesion officer in partnership with a voluntary organisation specialising in work with local minority ethnic communities.

112. Accurate and detailed quantitative performance data is regularly analysed by senior managers in children's social care to ensure that priority targets are being met. The datasets predominantly comprise information on early help, child protection and child-in-need performance. There is little information regarding the outcomes for children and young people looked after, and none on the experiences and outcomes of care leavers, which is a shortfall. Evaluative written commentaries are not routinely provided alongside the datasets, and this inhibits understanding of the data and what it means over time (Recommendation).

113. Evidence of performance management improving practice is clearly apparent in some areas, but is under-developed in others. Positive impacts can be seen in the uniformly good quality of assessments, effectively reducing delays in management decision-making in the MASH from an average of four days to one, and in redesigning services to increase the number of children leaving care via special guardianship orders. Under-developed areas include the IRO service, the children with disabilities social work service and EET provision for care leavers, but the local authority was already aware of these and has plans to improve all areas, currently at different stages of maturity. For example, senior managers are committed to supporting the IRO service to improve its offer to children and young people looked after and enable them to scrutinise the progress that children and young people make between their reviews.

114. Quality auditing of children's and young people's case files is a more recent development, with the delay in progressing this attributed to difficulties in recruiting sufficiently good senior managers to oversee this work and its development. Themed audits undertaken are leading to tangible practice improvements in tackling child sexual exploitation, neglect and working with families where parents have multiple difficulties. Audits commissioned by the BSCB have generated learning which has also been applied and has improved practice across the partnership, including in children's social care. Learning from recent SCRs is disseminated widely and in very accessible formats. Staff spoken to confirmed that they understood messages from SCRs and could describe how these influence their practice. Routine case auditing would further help to identify strengths and weaknesses of current social work practice, and help to drive continuous improvement.

115. Regular supervision and case management of social workers were evident in the majority of cases seen by inspectors. However, there is variability across the teams, with supervision being insufficiently frequent or effective in the children with disabilities and the leaving care teams. This contrasts with management oversight, decision-making and direction being effective in the MASH, early help and child protection services. Supervision and management oversight are present but less consistent in the children looked after teams. Records do not routinely include evidence of reflection and challenge, but social workers told inspectors that reflective discussions are held and are complemented by the availability of managerial advice.

116. Children's social care services have a strong learning and improvement culture. Staff benefit from a comprehensive workforce training and development strategy. Bury is an active member of numerous Greater Manchester learning alliances, featuring partnerships with local universities and the pan-Manchester social work academy. Newly qualified social workers receive enhanced support and protection. Training is thoughtfully commissioned, using high calibre trainers, and is linked to learning priorities such as disguised compliance and peer-on-peer abuse. Social workers confirmed good access to diverse learning opportunities, and the pathways for career progression are well understood. The numbers of complaints received about services for children and young people are relatively low, with the large majority promptly resolved, averting escalation to formal, adversarial investigations. There are no common themes arising from complaints, although they are carefully scrutinised for themes and trends, but individual learning points are succinctly captured.

117. Children, young people and families benefit from a stable, permanent social worker workforce with low turnover rates. Despite this, too many children and young people looked after have had multiple changes of social worker. A permanent group of experienced team managers is now providing a consistent environment, enabling social workers to flourish and develop. Caseloads have substantially reduced, partly through an investment in an additional 22 social workers, the majority of whom are recently qualified but well supported. Small pockets of higher caseload pressures remain, but these are not widespread. The use of locum social workers is minimal, and they are primarily used to cover short-term leave periods rather than long-term vacancies. Alongside this significant and positive investment in attracting and professionally developing new social workers, the workforce is sufficiently experienced, with the majority of social workers having five or more years of experience.

118. A cogent child sexual exploitation strategy and local action plan is diligently overseen by the BSCB sub-group. Operational activity is closely monitored by the child sexual exploitation and MASH steering group which meets regularly, chaired by a senior manager. This group reviews risks, progress and outcomes for individual young people. Regional child sexual exploitation tactical meetings, convened by the police, enable effective cross-border information sharing and working. Direct work undertaken in the multi-disciplinary child sexual exploitation team is particularly effective in reducing the risks to children and young people. Strategic and operational responses to missing children and young people are also effective with all children and young people offered a return interview. Return interviews for children and young people missing from care seen by inspectors were thorough.

119. Cafcass and the Family Justice Board report sound and timely preparation of assessments and evidence for children and young people who are the subject of care proceedings. Bury progresses cases promptly, with an average of 27 weeks in the year to date. However, in the most recent quarter, proceedings had further improved, reducing to an average of 23 weeks.

The Local Safeguarding Children Board (LSCB)

The Local Safeguarding Children Board is good

Executive summary

Bury Local Safeguarding Children Board (BSCB) meets its statutory responsibilities, and strong links are in place with other strategic bodies, such as the children's trust. The board's structure is well established and effective. The business plan is up to date, and focuses on three appropriate priorities. Partners from a range of agencies chair sub-groups that make good progress on their work programmes. Board members are sufficiently senior to implement changes recommended by the board.

Records demonstrate useful challenge from the board, resulting in improved services and outcomes for children and young people. The board informs and influences local services in relation to emerging trends, recommendations from serious case reviews (SCRs) and findings from its audits.

The board is independently chaired and efficiently run. Accountability would be improved by minuting the regular meetings between the chief executive of the council and the DCS. Handover arrangements for the incoming chair are in place and have been well planned.

Safeguarding procedures are up to date, comprehensive and reflect local and national priorities. The threshold document is also clear and up to date. It supports professionals' and the public's understanding of when a child or young person may require additional help or protection.

The board evaluates the effectiveness of early help services and provides challenge where necessary. The board has a good understanding of the effectiveness of frontline services and checks this in a variety of ways. This knowledge would be strengthened by a clearer picture of single-agency auditing activity and findings in partner agencies. There is good oversight of strategic and operational responses to child sexual exploitation and children and young people who go missing. Private fostering requires improvement. The police do not attend all initial child protection conferences, and not all domestic abuse notifications are promptly dispatched to the MASH.

The board regularly scrutinises performance data. However, the multi-agency data set adopted in June 2015 is not yet supporting scrutiny of performance across all agencies. The board facilitates a wide range of relevant training, which is positively received across the partnership, and practitioners report that there has been a good impact on practice.

The board's annual report is detailed but lacks analysis and does not fully reflect some of the positive work done by the board in the preceding year.

Recommendations

120. Single-agency audits of practice should be regularly presented to the board to facilitate a broader understanding of strengths and weaknesses of practice across partner services.

121. The board should ensure that strategic leaders understand the impact of the limitations of police resources on practice and safeguarding children and young people, and seek reassurance from the police that these are being addressed.

122. The board should ensure that its multi-agency dataset is sufficiently comprehensive and analytical, in order to inform the board of performance across agencies, including outcomes for children and young people looked after and care leavers.

123. The board should promote awareness of private fostering arrangements across Bury as a priority and ensure that action to improve awareness and practice is scrutinised by the board.

124. The board should ensure that the annual report clearly reflects the work of the board and its partners, including providing clarity on areas for development and actions being taken to address them.

Inspection findings – the Local Safeguarding Children Board

125. BSCB is meeting its statutory responsibilities. It has clear protocols in place with both the Health and Well-being Board and the children's trust, which set out their respective responsibilities and reporting arrangements. The board is influential in informing and influencing local services in relation to emerging trends or recommendations from SCRs. Examples include changes to the referral pathway for children at risk of female genital mutilation, and challenging the children's trust in relation to gaps in the accessibility of parenting support.

126. The board is well chaired by an independent chair who maintains links with other independent chairs though regional and national organisations. A full-time business manager supports the efficient running of the board. The independent chair has regular meetings with both the chief executive of the council and the DCS. As these meetings are not recorded, it is not possible to assess their impact. The chair also conducts annual individual reviews with board members. These are a useful opportunity for members to share their views on the board's strengths, challenges and their own contribution to the effectiveness of the board. The chair's term of office was extended by one year to support continuity when the chief executive of the council left his post. A new independent chair has been appointed and suitable arrangements have been made for a smooth handover. Lay members initially recruited to the board have completed their term of office. Recruitment undertaken in 2015 has led to the appointment of one new lay member, and a further recruitment campaign is planned to fill the second post.

127. The board's structure is well established, with clear links between the main board, the business group and sub-groups. Minutes demonstrate transparency and thoroughness. Partners from a range of agencies chair sub-groups, which are governed by terms of reference, and clearly progress their individual work programmes. Board members are sufficiently senior to implement changes recommended by the board. For example, in response to findings from a multi-agency audit on neglect, the assistant director of children's social care issued an instruction that the graded care profile should be used in all cases where children and young people are subject to a child protection plan for neglect. The board has challenged the failure of some partners to contribute financially to the board. This has resulted in one partner providing a significant contribution in kind through collecting and analysing data. Consequently, the board has sufficient financial resources to progress its work. Unused contingency funds set aside for potential SCRs are now being utilised to fund a part-time data analyst. An up-to-date business plan focuses on three appropriate priorities: safeguarding vulnerable groups, strengthening the voice of the child or young person in core activities, and improving the quality assurance capability of the board.

128. The board is a signatory to the Greater Manchester safeguarding procedures that apply across the region. They are detailed and up to date: for example, in relation to changes in legislation regarding female genital mutilation. Local guidance supplements these procedures, such as that on suicide and self-harm developed in response to a local SCR. The local threshold document is clear and supports professionals' and the public's understanding of when a child or young person may require additional help or protection. The board reviews this document to ensure that it remains relevant, up to date and in line with statutory guidance. Application of thresholds is tested by the review of data and audit. For example, a recent audit of contacts to MASH by GPs found that the large majority were appropriate, sufficiently detailed, and met the threshold for intervention by children's social care.

129. The board has received regular detailed reports to support its evaluation of the effectiveness of early help services since July 2013. This has enabled the board to challenge the children's trust when necessary: for example, in relation to the integration of the family nurse partnership with the early help offer and regarding some gaps in parenting programmes. This was effective.

130. Partners report strong working relationships within a culture of constructive challenge. Board meeting minutes, a challenge log and risk register demonstrate examples of challenge from the board that have been effective in improving services and outcomes for children and young people. The board has worked constructively with the designated officer to raise concerns, at a national level, about a private adolescent mental health hospital resulting in a visit from the Children's Commissioner and an inspection by the Care Quality Commission. Scrutiny by the board of the experience of young people from Bury detained in one of Her Majesty's young offender institutions (YOIs) resulted in improved communication between Bury's youth offending service (YOS), the YOI staff, and greater scrutiny of the application of restraint. The board has recommended that YOS officer presence at the YOI increases from two to five days to support the safeguarding of young people. Funding for this is currently being pursued. Delays in producing a domestic abuse strategy were escalated by the chair of the board to the chair of the community safety partnership.

131. The board has mechanisms in place to ensure that there is a good understanding of the effectiveness and quality of frontline services in Bury. These include annual reports, information on allegations management, children and young people who are electively home educated, and private fostering. Multi-agency themed audits, results of inspections, and a range of other regular or requested reports, alongside performance data, underpin the board's assessment of the effectiveness of services. Regular reporting on agency caseloads led to the board questioning high caseloads in safeguarding and children in care teams. A report on police attendance at child protection case conferences identified that the police public protection team was struggling to meet demand due to the high volume of child protection conferences across Greater Manchester, and that Greater Manchester police do not have a protocol for attendance. As a result, the chair raised this issue at the Greater Manchester LSCB group. Police administrative resource limitations are cited as the reason why domestic abuse notifications are received in 'batches' at the MASH. Although serious incidents are fast tracked, instances which appear to the attending officer as less serious may not be triaged at the MASH for many days after the event, and therefore do not benefit from a comprehensive analysis of agency involvement and historical information. This is an area for improvement (Recommendation).

132. Recent multi-agency audits have included neglect, the children with disabilities service, reflective supervision and the conduct of child protection case conferences. Good use has been made of observation and discussion with practitioners, as well as the review of case records and policies. Action plans are developed as a result of the audit findings, and the board monitors the progress of these. An independent audit of the children with disabilities service, commissioned by the board, identified shortfalls in practice, including the failure to use chronologies consistently, limited information on children's and young people's case files and a lack of planning in some cases. A service improvement plan is in place in response to these findings. The board's ability to understand the quality of frontline practice could be further strengthened by the scrutiny of agencies' own auditing activity (Recommendation).

133. The monitoring and evaluation sub-group of the board receives quarterly performance reports in relation to children's social care. Recent scrutiny of the high numbers of children and young people on a child protection plan led to a sampling exercise being commissioned, to test the hypothesis that partners may be reluctant to step down from child protection plans to child-in-need plans. Board members have also observed child protection conferences to assess the effectiveness of child protection conference chairs and the decision-making process. A multi-agency dataset adopted in June 2015 is not yet supporting the board's scrutiny of performance across all agencies. The board is aware of this and is addressing this through the monitoring and evaluation sub-group (Recommendation).

134. The board, through the learning and development sub-group, facilitates a wide range of training linked to local priorities and a training needs analysis. Take up of training is good, with a wide range of agencies represented, including practitioners from the voluntary sector. Workshops on self-harm, facilitated by CAMHS, in response to findings from an SCR, have been well received and, as a result, more have been scheduled. The board's trainer post has been vacant for some months. During this period, training has been commissioned from independent trainers. This has ensured that all planned courses have taken place. The board has developed its evaluation of the impact of training on staff practice. In addition to providing immediate feedback, course participants are contacted three months after attending training. Feedback has been positive, with practitioners reporting changes to their practice. The trainer vacancy has recently been filled.

135. Effective arrangements, shared with two neighbouring authorities, are in place to review child and young person deaths. The child death overview panel (CDOP), chaired by Bury's director of public health, also works with the Greater Manchester CDOP to consider themes or trends relevant across the region. Work has been completed in relation to a small number of suicides by young people. However, no common theme was identified.

136. In conjunction with a neighbouring board, the board has invested in an online audit tool to conduct section 11 audits. The tool was used for the first time in 2013–14, with all statutory partners completing the audit. A voluntary organisation that provides advice and support to young people on drug and alcohol misuse completed an audit specifically designed for voluntary organisations. The result of this audit was reported to the board, an action plan developed, and progress monitored by the monitoring and evaluation sub-group. An example of improvement resulting from the audit is a change to the child protection element of the induction programme for local authority adult services' social workers. Although arrangements to challenge partners' self-assessments are in place, these could be further strengthened. The board recognises this, and plans are in place to introduce challenge sessions into the next audit round.

137. Child sexual exploitation is a key priority of the BSCB business plan, and the board has a detailed understanding of local activities to tackle child sexual exploitation, to help children and young people, and to disrupt perpetrators. The board has endorsed the local authority's child sexual exploitation strategy. The child sexual exploitation sub-group has recently re-established its role as the strategic body to monitor performance after initial difficulties in receiving data from the pan-Greater Manchester child sexual exploitation team (the Phoenix team). The board has ensured swift progress on the action plan, following a peer review conducted by the Phoenix team in November 2015. The board has ensured that the revised threshold document includes child sexual exploitation and children and young people who go missing, to enable a wide understanding of the public protection response in Bury. Training for practitioners has been rolled out, with participants reporting positively on its impact on their practice. Strengths are the provision of advice for parents on the website and making training accessible to them.

138. Proactive work, through six-monthly meetings with private residential providers, affords opportunities to share good practice, lessons learned from SCRs and to raise awareness of issues such as child sexual exploitation. The board has been less effective in raising awareness of those children and young people living in private fostering arrangements, and there has been delay in implementing the recommendations arising from the most recent annual report on private fostering (Recommendation).

139. Learning from SCRs and critical case reviews is given high priority in Bury. The board, through the case review and learning sub-group, has effective processes to identify when the threshold for an SCR has been met. If the threshold is not met, consideration is given to whether a critical case review should be completed. The board is persistent in seeking assurance from agencies that action plans resulting from SCRs are completed. Examples of such actions include children's social care increasing their capacity to undertake specialist assessment of young people who have committed sexual offences, and the redesign of the CAMHS Asperger syndrome referral pathway. Learning from SCRs and critical case reviews is disseminated widely within agencies, through roadshows and the board's website. Lessons learned are incorporated into training, and specialist courses commissioned in response to SCR findings. A total of 130 practitioners attended seven roadshows in 2014, and training delivered by a national expert on disguised compliance in 2014 was recommissioned in November 2015. Practitioners who spoke to inspectors during this inspection were able to describe learning from SCRs and BSCB training that they had attended.

140. In line with statutory guidance, the board produces an annual report. The report is detailed and supported by a number of appendices. However, the report is insufficiently analytical and does not fully reflect some of the positive work done by the board in the preceding year (Recommendation).

Information about this inspection

Inspectors have looked closely at the experiences of children and young people who have needed or still need help and/or protection. This also includes children and young people who are looked after and young people who are leaving care and starting their lives as young adults.

Inspectors considered the quality of work and the difference that adults make to the lives of children, young people and families. They read case files, watched how professional staff work with families and each other, and discussed the effectiveness of help and care given to children and young people. Wherever possible, they talked to children, young people and their families. In addition the inspectors have tried to understand what the local authority knows about how well it is performing, how well it is doing and what difference it is making for the people whom it is trying to help, protect and look after.

The inspection of the local authority was carried out under section 136 of the Education and Inspections Act 2006.

The review of the Local Safeguarding Children Board was carried out under section 15A of the Children Act 2004.

Ofsted produces this report of the inspection of local authority functions and the review of the Local Safeguarding Children Board under its power to combine reports in accordance with section 152 of the Education and Inspections Act 2006.

The inspection team consisted of seven of Her Majesty's Inspectors (HMIs) from Ofsted and one additional inspector.

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