Liverpool City Council

Inspection of local authority children's services

Inspection dates: 14 May 2018 to 25 May 2018

Lead inspector: Shabana Abasi HMI

Judgement	Grade
The impact of leaders on social work practice with children and families	Requires improvement to be good
The experiences and progress of children who need help and protection	Requires improvement to be good
The experiences and progress of children in care and care leavers	Requires improvement to be good
Overall effectiveness	Requires improvement to be good

Since the joint targeted inspection (JTAI) in 2016, and the subsequent four monitoring visits, senior leaders have made purposeful and targeted progress in strengthening arrangements in the multi-agency safeguarding hub (MASH) and early help services. However, insufficient progress has been made in other aspects of the service, and weaknesses found during this inspection mirror many of those identified in the single inspection framework (SIF) inspection carried out by Ofsted in 2014. The new senior management team has a very clear understanding of issues and improvements needed, and this is reflected in an honest and accurate self-assessment.

Children at immediate risk of harm receive a prompt and effective response, which ensures that they are safeguarded. Children's needs are not always well considered through assessments and plans. This means that, for some children, there is delay in having their needs met and risks reduced.

Most children come into care appropriately, and the majority of children, including those waiting for adoption, and care leavers experience improved outcomes as a result of having been in care. However, some children continue to be looked after when they do not need this level of protection and too many children who are not being adopted wait too long to be matched with their permanent placement. Too many care leavers are not in employment, education or training.

What needs to improve

- Social work capacity and allocation of caseloads.
- The quality, consistency and child-centeredness of assessments and plans.
- Permanence planning for all children in care.
- Timeliness of transition planning for children in care.
- Comprehensive needs assessment and commissioning strategy for sufficiency of placements, including foster care.
- Quality and consistency of oversight and challenge by first line managers, child protection conference chairs and independent reviewing officers.

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

1. Children and families who need additional support benefit from access to a comprehensive range of early help services and well-coordinated packages of intervention. Early help teams are based in children's centres and this provides easy access for parents and supports good partnership working. Creative direct work undertaken with children and their families is helping to reduce the likelihood of statutory intervention.

2. When needs or risks increase, cases are stepped up appropriately from early help to children's social care. This escalation is timely and ensures that children receive more specialist support when needed. When professionals have concerns about children, they make appropriate contacts to children's social care.

3. A small number of multi-agency referral forms are rejected or redirected because they do not meet the threshold for children's services, lack sufficient detail, or because parental consent is missing. This results in delays in assessing risks, determining needs and in the provision of intervention to these children and families. The local authority has plans in place to address this.

4. Detailed screening decision-making is undertaken in Careline (the single point of contact for adult and children services) and the multi-agency safeguarding hub (MASH). The majority of contacts and referrals are progressed within 24 hours. Management oversight of these front door teams is effective, although it is not always consistently well-recorded. MASH, which was relaunched in November 2017, ensures that prompt information sharing and decision-making are undertaken to safeguard children. Children at immediate risk of significant harm are identified swiftly, and action is taken to safeguard and protect them. The vast majority of children in need of help and protection receive a proportionate response. Careline operates 24 hours each day, which means that there is a consistent response to children who require help and protection out of hours.

5. Screening of domestic abuse notifications by the police within the MASH has also improved since the last inspection. These notifications are triaged effectively to collate information and identify the level of priority. This leads to relevant onward referral to either Careline or early help hubs. The local authority is appropriately planning to introduce a domestic abuse risk assessment tool to improve consistency of decision-making.

6. Initial strategy meetings in Careline usually only involve MASH-based police, probation, health, education and school staff, rather than those who have first-hand knowledge of the child. This limits the richness of the information-sharing process. Plans are in place to enable the professionals who made the referral to participate in strategy meetings in the future.

7. The majority of subsequent strategy meetings are timely, and information sharing from relevant partners is considered carefully. This leads to appropriate decisions and actions to protect children. When child protection enquires are initiated, joint investigations with the police are comprehensive. This was an area of concern identified during the JTAI and which the local authority addressed quickly, and has sustained progress since the monitoring visits. Written records of strategy meetings and investigations are not of a consistently good quality.

8. The quality of social work assessments has not improved since the JTAI. Assessments are not routinely updated when children's circumstances change. Children's lived experiences, including their needs, family dynamics, culture and identity, are not consistently at the centre of assessments. Although risk is identified, it is not rigorously analysed, and the impact on the child is not fully considered. This lack of sharpness in assessments results in child in need and child protection plans that are not as clearly child-focused or clear as they need to be, which in turn dilutes the impact and effectiveness of child in need meetings and core groups. The weaknesses in planning for children also means that it is difficult for parents and professionals to hold each other to account for follow-through of actions.

9. When children in need, including those in need of protection, are identified as being at increased need or risk, they are appropriately stepped up to higher levels of intervention. However, in some cases, there is a delay in reaching this decision due to social workers and managers over-estimating parents' capacity to change. Inspectors also saw evidence of over-optimism by social workers and managers, with decisions to step down cases based on perceptions of improved compliance, rather than any real change for the child.

10. Children are seen regularly and seen alone. While social workers and family support workers are increasingly undertaking direct work with children, this is not always clearly noted in case records. The impact of the children's participation in, and influence on, the planning process is therefore limited.

11. Management oversight of front-line practice is not consistently effective. It is often too focused on compliance, with little evidence of added value in improving the quality of social work with children and their families. While the majority of social workers receive regular supervision, this is not always sufficiently analytical or reflective. Decisions taken or actions agreed in supervision are not always followed up. This has led to drift for some children and families.

12. The quality of help and protection offered to children by the disabled children's team is a strength. Workers are highly skilled, experienced and know the children they are working with exceptionally well. Assessments are updated regularly and provide good evaluation of the needs of children. This leads to strong planning and bespoke packages of support for children and their families.

13. Children at home or in care who go missing, or who are at risk of exploitation, receive well-coordinated strategic and operational multi-agency responses that

reduce risk and help to protect them. This is another area of sustained progress since the JTAI and through the monitoring visits. Daily operational multi-agency child exploitation meetings are used to coordinate effective intelligence sharing, which enables swift identification of young people at risk of different types of child exploitation. Children at risk of sexual exploitation receive support from skilled workers in the protect team. Multi-agency completion of the child exploitation risk tool informs thorough safety planning.

14. Return home interviews for children who go missing from home or care are detailed, child-focused and timely. Children's views and experiences are carefully considered, including the 'pull and push factors' that led to them going missing, and these are used to inform their safety planning. A multi-agency approach ensures that all intelligence is shared and that links to other vulnerable young people are made to enhance support planning and risk management.

15. Tracking of children missing education (CME) is detailed and effective. Leaders have developed robust systems for assessing the risk of each CME. Well-developed multi-agency working enables prompt information sharing to identify the whereabouts of CME. The elective home education service is conscientious and develops supportive relationships with parents. These positive relationships are helpful, both when assessing the quality of the education and also when taking appropriate action to address poor quality education.

16. Public law outline processes are used increasingly effectively with families to address areas of concern. The children and family court advisory and support services (Cafcass) and the designated family judge commented positively on the improving quality and timeliness of court work. Inspectors also found an improvement in the quality of papers for court.

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

17. When risks increase, and children are no longer able to live safely at home, the local authority makes good use of its legal powers to safeguard and protect children. The use of parental agreement to accommodate children is appropriately applied. However, a small number of children have remained subject to these arrangements for too long and this has resulted in significant delays in securing their permanence. The local authority has relevant plans to address this.

18. Children in care are seen regularly and alone by their social workers, both where they live and in school. Social workers take time to get to know the children who they work with and can clearly articulate their needs, identify their risks and vulnerabilities and describe their personalities. However, this is not always

sufficiently considered or recorded in assessments and plans, where the voice of the child is not strong.

19. When children are placed with parents under a care order, assessments and support plans are appropriate, but, in some cases, children have remained subject to care orders at home for too long. In these cases, there has been delay in progressing the discharge of orders. Senior leaders have already identified this issue and targeted work is being undertaken to address it.

20. The immediacy of the intensive family support, including edge of care support, provided to families by the multi-agency instant response team is impressive. Children and families benefit from this support and this includes improvement in children's outcomes, risks reducing due to effective response and, for some children, support to return home safely.

21. The quality of assessments and care plans is not good enough. Assessments are not routinely updated to reflect changes in children's circumstances, and needs are not fully informing care planning. The majority of care plans are too general and do not include consideration of the specific needs of the child. Therefore, it is not clear how children's needs will be met or their progress measured. In a small number of cases, there is also a lack of clarity regarding contingency planning. Challenge by independent reviewing officers (IROs) is not consistently effective. It does not provide the level of critical evaluation and action planning required to progress children's cases with clarity and pace.

22. The vast majority of children in care live in stable placements that meet their needs effectively and improve their outcomes. This includes children in specialist provision and those in out-of-area placements. Almost all children in care have good access to primary health services and their educational attainment is monitored by the virtual school. Although children have access to a good range of commissioned therapeutic and specialist services to support their mental health and well-being, strengths and difficulties questionnaires are not completed regularly. This means that some children's emotional well-being needs are not fully understood and do not inform health assessments.

23. When there is a breakdown in placement, disruption meetings are not held. This is a missed opportunity to review the circumstances and to inform future learning. Brothers and sisters are placed together, unless their plans identify that this would not be in their best interests. Children have well-planned contact with their families, including with their brothers and sisters, which is supported by a dedicated contact service.

24. Family group conferences are increasingly being used to explore family-based solutions, including alternative care arrangements for children, but not all children have benefited from this service. Most viability assessments are of an acceptable standard and are completed promptly, enabling timely identification

of kinship carers. This means that children remain living with people who they know and who understand their needs.

25. The fostering team devotes most of its time to court-directed assessments of connected carers. Consequently, the time available to commit to the recruitment and assessment of mainstream foster carers is limited and leads to a reduction of in-house placement choice for children. Senior managers recognise the pressure that staff have been under and have agreed to increase the capacity within the service. Assessments of mainstream foster carers are being undertaken by independent assessors; the timescales for completion are achieved but the quality is variable. Foster carers speak positively about the support they receive from the fostering service. Training expectations are not included in the foster care agreements and this makes it difficult for the local authority to hold carers to account for their development.

26. The local authority's approach to permanence planning is not sufficiently rigorous. Systems for monitoring and tracking permanency planning are either not yet fully embedded or are yet to be implemented. Some children who do not have a plan for adoption experience drift and delay in securing permanence. There are too many children living with uncertainty. At the time of the inspection, 80 children who have been living with foster carers for two years are still waiting to be formally matched. There was very little evidence of life-story work being completed with children in long-term foster care. Children are therefore not satisfactorily supported to understand the changes and transitions they have experienced and will experience.

27. For most children whose plan is adoption, permanence is achieved in a timely manner. Child permanence reports are of variable quality, some contain too much narrative and are over-lengthy, while others provide concise analysis. Parents' views are captured and reports highlight the impact of children's experience. Family finding and matching are strong. Post-adoption support is accessible for children and families, and this is underpinned by detailed and relevant support plans. Decision-making for adoption is extremely thorough and well documented. The increasing use of fostering-to-adopt placements is enabling children to be settled with their adoptive families as soon as possible, promoting earlier attachment. Life-story work for children adopted and later-life letters are child-centred and of good quality.

28. Investment in the education of children in care is a priority for leaders. Although children in care benefit from a strengthening focus on their educational attainment, the local authority is aware that it needs to further support better educational outcomes. Attainment for children in care who are placed with their own parents is below that of all children in care across all subjects. This is significant given the relatively high numbers of children living at home on care orders in Liverpool. While the vast majority of children have personal education plans, these are not consistently good and do not effectively support educational planning. Schools consistently use the pupil premium plus funding to good effect for additional classroom support and for enrichment opportunities that support

personal and social group development. Children's achievements are celebrated at an annual awards ceremony.

29. Care leavers benefit from experienced and proactive personal advisers, who tenaciously work to keep and maintain relationships with them. This is resulting in improved outcomes for many care leavers. Not all care leavers live in suitable accommodation and the local authority has an appropriate plan in place to extend the range of housing options. There is a strong staying put offer for care leavers in in-house and independent agency fostering placements. This has enabled an increasing number of care leavers to maintain stability and security through staying in their foster placement.

30. The quality of the pathway plans which the 18+ service inherits from the permanence teams is not good enough. Some are comprehensive, clear and specific. Others lack specificity and do not address all the key issues, such as how young people will be prepared for independence. Young people's health, including mental health, and emotional well-being needs are supported effectively through a variety of health professionals and services. Less than half of care leavers are in employment, education or training (EET). The range of opportunities available to care leavers is not sufficient, therefore limiting their ability to reach their potential. The local authority is seeking to improve this.

31. For some young people, particularly those who are not staying put with former foster carers, the transition from the permanence teams to the 18+ service shortly before their 18th birthdays happens too late. This gives them little time to prepare for, and explore options about, their future needs and aspirations. High caseloads in the 18+ service impact on the timeliness of independence planning.

32. When inspectors met with a group of young people in care and care leavers, they all said that they feel safe and well supported. Those living independently described their accommodation as appropriate and others reported that they are in good placements. Care leavers know about their entitlement to services and they receive good support to access information about their health history, legal rights, and the benefits and financial help that they can receive.

33. The children in care council is influential. It provides a platform for children in care to give their views and provide feedback on important issues via attendance at the corporate parenting panel. The children in care council provides a positive place for children to meet, socialise and exchange views. It has produced the 'Great 8 Mandate' pledge, although the children in care council members are not confident that all workers are aware of the pledge.

34. The local authority has responded effectively to the challenges posed by a steady increase in the number of unaccompanied asylum-seeking children. Immediate action is taken to safeguard and protect them. Arrangements to assess and accommodate them, identify their unmet needs and organise initial health assessments are well-managed. Unaccompanied asylum-seeking children

receive sensitive and holistic support, which is resulting in improved outcomes for the majority.

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

35. Following the JTAI in 2016, local councillors increased their support for improving children's services. Ofsted's monitoring visits following the JTAI found that the local authority had made some improvements. However, the pace of improvement was insufficient. Since the appointment of the new DCS and recent appointment of the assistant director, there has been a notable increase in the rate of progress.

36. There are a number of areas for improvement from the SIF inspection in 2014 that still require attention. The areas still to be addressed include the quality of assessments and plans, tracking of permanency planning, life-story work, management oversight, recruitment and retention and manageable caseloads.

37. Capacity across children's services has been, and continues to be, a critical issue. The late development of early help services means that the local authority has struggled to manage the level of demand for children's social care services. High caseloads have compromised the quality of social work practice. Due to capacity issues and delays in onward transfer of children's cases, some social work teams are carrying additional work. For example, the assessment teams are holding children's cases that should be with the permanence teams, so some children are not benefiting from the expertise and knowledge of permanence workers.

38. Commissioning and sufficiency are underdeveloped. In the absence of effective commissioning and sufficiency strategies, the needs of children, including children in care and care leavers, are not fully understood. The local authority does not have the right mix and volume of foster placements or the right range of accommodation options for care leavers. In addition, senior leaders do not know what placements are needed because a detailed analysis of sufficiency is lacking. The impact of these deficits is minimised for children through the purchase of external placements to meet their needs.

39. The new senior management team has a clear understanding of the strengths and weaknesses of frontline practice. They understand the scale of the challenges they face and have adopted a systematic approach to raising practice standards and improving outcomes for children. The local authority knows itself well and had already recognised most of the strengths and areas for improvement identified by inspectors during this inspection.

40. The new DCS has made a significant impact in a short space of time. He has successfully made the case for additional resources to address long-standing

issues associated with capacity. This has meant that a new assistant director post for education has been created, and 16 additional social work posts have been put in place, some of which have been recruited to. He has improved the level of communication between senior leaders and frontline managers and staff and this is leading to a mood of cautious optimism. He has also appointed a senior data analyst, who has already improved the quality of performance management information, and has recruited an experienced assistant director for social care, who is starting to make a real difference.

41. A recruitment, retention and progression framework has been recently developed. This has led to a much sharper focus on workforce recruitment and retention and, as part of this, several agency staff have been encouraged to accept permanent contracts. Action has been taken by the DCS to address the long-standing problem of newly qualified social workers lacking a programme of support. Staff understand the plans of the local authority and acknowledge the impact that the new senior management team has had over the past few months. There is a strong sense that 'things are moving on'.

42. Performance management is a developing area for the local authority, with several recent initiatives showing early indications of improvement. The local authority has revised the audit framework and, while this is yet to fully embed, the audits reviewed during this inspection were found to be evaluative and accurate. This indicates that the local authority knows what good practice looks like. The new performance and quality assurance framework was launched in March 2018, and a practice learning group has been established to use learning from audits to improve practice. A performance and quality assurance board has also been established to provide monitoring and challenge in driving improvement. The quality of performance information is also improving following a period of it not being sufficiently reliable. The gradual introduction of performance dashboards with live data has improved the direct oversight and understanding that senior and frontline managers have of performance and outcomes.

43. While there are signs that the workforce is starting to stabilise, caseloads are still too high in most teams. The quality of practice is still far too variable. The quality of frontline management oversight is not consistently strong, well-recorded or challenging. The quality of critical challenge provided by IROs is not consistently effective. Children experience too many changes of social worker and some delay due to the number of transfer points across children's social care. Leaders have been diligent in establishing effective systems and processes, and their impact on improving social work practice is at the earliest stages.

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