Ofsted

Sefton 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: 11 April to 5 May 2016

Report published: 27 June 2016

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

[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's services in Sefton require improvement to be good. Services for children in need of help and protection have not made progress since they were last inspected in 2011 and services for children looked after have deteriorated. Some areas of improvement identified then, such as ensuring that effective management oversight is clearly recorded in case notes, have not been sufficiently addressed.

The director of children's services (DCS), who took up his post in October 2015, and the head of service (HOS), who has been in post since February 2016, both demonstrate a detailed understanding of the service. In a short space of time, the DCS has introduced measures to support more effective practice. These measures include an increase in the establishment of full-time social work posts, the roll out of technology to assist mobile working, and improved quality assurance activity. However, the quality of assessment, planning and review of services for children and families remains inconsistent. This inconsistency is seen in responses to early help, children subject to child in need and child protection plans, children looked after and care leavers.

All work with children and families is undertaken using a casework model. Workers' ability to use the model differs greatly. Generally, it is not used well in assessments and plans.

The local authority has identified that the current structure of services does not support its vision of ensuring that children have as few changes of worker as possible. While the workforce is stable, children experience too many changes of worker at important transition points, making it difficult for them to form consistent and enduring relationships. Despite an increase in social work posts, caseloads are too high in some areas, such as assessment teams, children looked after teams, and the independent reviewing officers' (IRO) service. These issues significantly contribute to the poor quality of some assessments and plans seen, infrequent and insufficiently analytical recording of management oversight and a lack of effective challenge when practice requires improvement by managers and IROs alike.

Although children's needs in relation to their ethnicity are well understood and responded to, other needs, such as those arising from the impact of a child's disability on their identity, are not always sufficiently explored. Diversity is not well considered for some children.

The local authority has not met national minimum standards in relation to private fostering. It did not provide an annual report to the Local Safeguarding Children Board (LSCB) in 2015–16. There has been no active awareness raising with staff for over 12 months and workers' understanding of private fostering is poor.

When young people aged 16 and 17 present as homeless, some good work is undertaken to ensure that those young people who should, do return home, and that others are placed in accommodation that meets their needs. However, arrangements are sometimes made with neither an assessment of whether the young person needs to be looked after, nor a discussion with them about the benefits of becoming or remaining a child looked after. While no young person was seen to be in unsuitable

arrangements as a result of this practice, it is not compliant with case law. In a very small number of cases, young people aged 16 or 17 and care leavers had been placed in bed and breakfast accommodation as emergency measures in the 12 months prior to the inspection, with neither a risk assessment being undertaken nor the young person being provided with additional safeguards. This leaves young people highly vulnerable. The local authority took swift action in response to learning from this inspection and the DCS has issued appropriately revised procedures.

Most children and families benefit from good-quality support services, with appropriate monitoring of their progress from social workers and family support workers. This compensates for some of the deficits in core practice seen in this inspection. No children were found to be in circumstances of unacceptable risk.

The local authority intervenes swiftly and effectively when children need to become looked after. Good use of pre-proceedings agreements result in timely conclusion of court proceedings. The vast majority of children looked after live in stable, good-quality placements and receive effective support for their educational needs. High numbers of young people in Sefton are looked after by their parents, subject to placement with parent regulations. Although no cases of young people being inappropriately placed at home were seen, some young people remain subject to care orders for too long, which exposes them and their families to statutory intervention for longer than is necessary.

Good transition arrangements for care leavers with significant physical or mental health needs ensure that they receive the services that they need as adults without delay. Young people with lesser needs, such as mild anxiety or depression, often do not get the help that they need quickly enough and remain too long in accommodation that is unsuitable or that does not provide them with the level of support that they need. Care leavers receive a wide range of good support to meet their educational and employment needs, and this is preparing many of them for adult life effectively.

The timeliness of children in need of adoption being placed with adoptive parents has significantly improved. Other aspects of the service are weaker, such as the poor contribution of the adoption panel to improving practice and lack of learning from placement disruptions. Adoptive families receive very good adoption support, which mitigates some of the deficits.

Strategic responses and practice when children go missing from home, care or education or are at risk of sexual exploitation are very good and, in some instances, highly innovative.

The local authority has a strong determination to improve services for children in Sefton. Learning from independent and external scrutiny is used to inform improvement planning. Participation of children and young people at a strategic level is a strength. The Children in Care Council known as 'making a difference' (MAD) has made a significant contribution that is improving the services received by children looked after and care leavers. The local authority recognises that the membership of MAD needs to be extended to younger children so that their voices can be heard and make a difference.

Contents

Executive summary 2

The local authority 5

Information about this local authority area 5

Recommendations 8

Summary for children and young people 9

The experiences and progress of children who need help and protection 10

The experiences and progress of children looked after and achieving permanence 17

Leadership, management and governance 30

The Local Safeguarding Children Board (LSCB) 36

Recommendations 37

Inspection findings – the Local Safeguarding Children Board 38

Information about this inspection 43

Ofsted

The local authority

Information about this local authority area[2]

Previous Ofsted inspections

- The local authority operates three children's homes. All three were judged good or outstanding at their most recent Ofsted inspection.
- The previous inspection of the local authority's safeguarding arrangements was in June 2011. The local authority was judged adequate.
- The previous inspection of the local authority's services for children looked after was in June 2011. The local authority was judged good.

Local leadership

- The DCS has been in post since October 2015.
- The DCS is also responsible for adult services and health.
- The chair of the LSCB has been in post since December 2012.

Children living in this area

- Approximately 53,480 children and young people under the age of 18 years live in Sefton. This is 19.6% of the total population in the area.
- Approximately 20% of the local authority's children are living in poverty.
- The proportion of children entitled to free school meals:
  - in primary schools is 15.1% (the national average is 15.6%)
  - in secondary schools is 13.4% (the national average is 13.9 %).
- Children and young people from minority ethnic groups account for 4.3% of all children living in the area, compared with 22% in the country as a whole.
- The largest minority ethnic groups of children and young people in the area are Mixed and Asian/Asian British.
- The proportion of children and young people with English as an additional language:
  - in primary schools is 3.9% (the national average is 19.4%)
  - in secondary schools is 3.0% (the national average is 15%).

[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.

- Sefton has a low proportion of residents from minority ethnic groups compared to both national and regional rates.

Child protection in this area

- At 11 April 2016, 1,285 children had been identified through assessment as being formally in need of a specialist children's service. This is a decrease from 1,720 at 31 March 2015.
- At 11 April 2016, 253 children and young people were the subject of child protection plans. This is the same as at 31 March 2015.
- At 11 April 2016, one child lived in a privately arranged fostering placement. The number as at 31 March 2015 had been suppressed due to small numbers.
- Since the last inspection, five serious incident notifications have been submitted to Ofsted and no serious case reviews have been completed or were ongoing at the time of the inspection.

Children looked after in this area

- At 11 April 2016, 474 children are being looked after by the local authority (a rate of 88.6 per 10,000 children). This is an increase from 450 (85 per 10,000 children) at 31 March 2015. Of this number:
    - 155 (or 32.7%) live outside the local authority area
    - 46 live in residential children's homes, of whom 53% live outside the authority area
    - six live in residential special schools[3], of whom 50% live outside the authority area
    - 302 live with foster families, of whom 34% live outside the authority area
    - 100 live with parents, of whom 13% live outside the authority area
    - four children are unaccompanied asylum-seeking children.
- In the last 12 months:
    - there have been 11 adoptions
    - seven children became subjects of special guardianship orders
    - 132 children ceased to be looked after, of whom 3% subsequently returned to be looked after
    - 35 children and young people ceased to be looked after and moved on to independent living

---

[3] These are residential special schools that look after children for 295 days or less per year.

– no children and young people who ceased to be looked after are now living in houses of multiple occupation.

The casework model used in this area is 'signs of safety'.

Recommendations

1. Ensure that all assessments of children, young people and care leavers are timely, address all areas of risk and need and are updated regularly.

2. Ensure that management oversight and supervision are sufficiently regular and rigorous to oversee the quality and progress of work effectively, and that they are clearly evidenced on case files.

3. Ensure that case and care planning for all children, young people and care leavers, clearly identify desired outcomes, with timescales, responsibilities and measures in order to evaluate progress.

4. Ensure that timescales set for social work assessments and frequency of visits to children are based on individual need and that performance monitoring of social work practice rigorously evaluates quality as well as timeliness.

5. Ensure that for all children issues of diversity are fully considered in assessment, planning, intervention and review.

6. Ensure that statutory requirements are met in relation to private fostering and that training and awareness raising underpin prompt identification, assessment and support for children in private fostering arrangements.

7. Ensure that practice in relation to homeless 16 and 17 year olds is compliant with statutory guidance and case law.

8. Ensure that when children are placed with parents, the arrangements are reviewed and, when necessary, the care order is discharged or other remedial action is taken.

9. Ensure that IROs, social workers and managers have sufficient capacity to undertake their work to a good standard and that those IROs and managers challenge poor practice effectively, to improve outcomes for children and young people. Ensure that all review meetings evaluate progress in achieving outcomes effectively, and consider the effectiveness of interventions so that future work can be appropriately directed.

10. Ensure that the adoption panel works with the agency decision maker to champion good practice and that the adoption service takes swift action to learn from any event that could inform practice, to prevent future placement breakdown and to ensure that statutory requirements are met.

11. Ensure that care leavers get timely support for their mental health and accommodation needs so that they can continue to make progress to become successful adults.

Summary for children and young people

- Inspectors found that many services for children in Sefton could be better. Leaders know what changes need to be made and are working hard to make them as soon as possible.
- A wide range of good early help services means that families get help when they first need it, including when they are experiencing domestic violence. Arrangements to support children missing education are good and children who go missing from home and care or are at risk of sexual exploitation get very good advice and support, which helps them to keep safe.
- Some social workers and IROs have responsibility for too many children and young people and this means that the quality of the work that they do sometimes is not good enough. Managers do not always make sure that children are receiving the right help to meet their needs as often as they should.
- Workers do not always have enough training to know how to give children who are privately fostered a good service. They do not always explain clearly to homeless young people the benefits of becoming a child looked after.
- Some children's plans are not good enough and it is difficult to understand how professionals will support them or how their needs will be met. Some children looked after who live at home continue to receive services when they no longer need them. A few children who are looked after are not visited often enough when their own social worker is off work.
- Children and young people who are looked after are generally doing well at school, and staff make sure that they get all the support that they need to achieve as well as they can and to enjoy what they are doing.
- Children looked after live close to their families and friends with carers who look after them well. When children are adopted, they get good help to settle into their new families quickly.
- Care leavers develop positive and trusting relationships with their support workers, feel safe and get good help with their education and employment. Not all of them live in suitable accommodation and sometimes they wait too long to get specialist help if they are anxious or depressed.
- Although workers are good at making sure that they consider children and young people’s cultures, they do not always think enough about other things that are important to their identities, such as disabilities.
- Leaders in the local authority are good at listening to young people and at responding. Young people help to improve services. They know that they make a difference and that their achievements are well celebrated. However, more work needs to be done to involve younger children.

The experiences and progress of children who need help and protection	Requires improvement

No children have been found in situations of unassessed or unacceptable risk through this inspection. However, the variable quality of core areas of practice means that, while some good-quality work was seen, too many children, young people and families do not receive effective interventions that sustain risk reduction and improve outcomes in a timely way.

Thresholds are generally applied well within the multi-agency safeguarding hub (MASH) and by children's social care. Almost all children and families referred receive services at the appropriate level of intervention. Early help services are well coordinated and meet a range of needs, using evidence-based interventions. The recently established community adolescent service (CAS) is having an emerging positive impact on addressing and reducing risk. Immediate risk is identified and responded to well. Strategy meetings share information effectively, leading to timely proportionate action to protect children.

The majority of assessments, including early help assessments, are not completed within appropriate timescales for the child. Often, assessments do not analyse well how any concerns raised are affecting the child. Assessments are not consistently updated in response to changed circumstances. Although a specific casework model is used, it is not well applied and most plans, including child in need plans and child protection plans, do not prioritise important areas of risk or need, do not set measurable outcomes with clear timescales and lack clear contingency planning. Child protection conferences do not provide sufficient rigour in evaluating progress and the effectiveness of interventions.

Sefton has not met national minimum standards in relation to private fostering, and current practice does not effectively or appropriately identify private fostering arrangements, which potentially leaves vulnerable children in living arrangements that remain unassessed.

Young people aged 16 and 17 who become homeless receive immediate support and, when they are not able to return home, a range of good-quality accommodation is used. Assessments do not routinely specifically address or discuss with a young person whether they need to become or remain looked after. These elements of practice are not compliant with statutory guidance. In the 12 months prior to the inspection, a very small number of young people had been placed in bed and breakfast accommodation without appropriate risk assessment and management.

Good work is undertaken with children and young people who are at risk of child sexual exploitation. This includes highly effective activity to ensure the safety of young people who are placed in Sefton by other local authorities. Children who go missing are promptly identified, and return interviews are of good quality.

Inspection findings

12. The early help strategy, led by the local authority, is well supported by partner agencies. Coordinated services that meet a range of needs are closely aligned to children's social care with one access point into services, leading to more timely early help service responses. Priority groups include children under five, children who have disabilities, children at risk of substance misuse, crime and anti-social behaviour and young carers. All groups have delivery services to support them. The age range is covered effectively by 10 children's centres, four family centres and five youth hubs, with social workers being part of the early help teams and providing therapeutic interventions to families. A wide range of evidence-based practice is used in early help to ensure that families make progress. The multi-agency CAS, established in July 2015, works closely with young people who are at risk due to a range of issues, including child sexual exploitation, gang affiliation and youth offending. The service is having early positive results in reducing risk. Young people's cases sampled clearly show how plans had resulted in improvements in outcomes for the young people and their families. This was particularly evident in relation to youth offending, with some young people responding better to CAS because it is not a statutory service.

13. The local authority monthly data gives a quantitative overview of early help activity and details the outcomes of closed cases. However, it is not yet sufficiently detailed to support a comprehensive analytical view of the quality and outcomes of early help provision. A structured programme of training for partners, including awareness training for early help plans, early help assessment training and lead practitioner training, is supporting an increase in more targeted work. The data shows that parents do not engage with the early help offer in a quarter of the referrals but, as yet, the local authority and partner agencies have not undertaken any analysis of the reasons or identified what action could be taken to address this.

14. Early help assessments and cases that were seen by inspectors were located in early help provision, consent had been gained and children and families received a timely offer of help. A good range of services were supporting children and families and regular team around the family (TAF) meetings were evident in the majority of cases. The assessments identified areas of concern, but the quality and method of recording was too variable and did not support effective information sharing. The majority of plans did not identify responsibility, timescales for completing actions or detail measures for successful outcomes (Recommendation).

15. Thresholds are understood and applied well in the MASH. The MASH contact officers consider contacts made from agencies, promptly pursuing additional information when the contact was not sufficiently detailed. Decisions on next steps are made by qualified social workers, and contacts are suitably re-directed if they do not meet the threshold for children's social care in a timely

way. Protocols for ensuring that consent has been obtained for referrals and information sharing across the MASH have been recently implemented, and in the majority of cases seen had been appropriately used. When the decision is for no further action to be taken, letters are routinely sent out to families.

16. More children are receiving help at the right level at the right time and, in some cases, the early help given is successful in preventing the need for statutory intervention at a later date. Contacts that do not meet the criteria for social care are promptly passed to the early help gateway, and, at the time of the inspection, this constituted 36% of all contacts. The contacts to early help have contributed to a reduction in the percentage of referrals to social care that require no further action and to a reduction in the percentage of re-referrals: from 26.8% in 2014–15 to 17.6% in 2015–16.

17. Case management and transfer of cases between early help and social care operate effectively in the vast majority of cases seen. Cases that step up to social care do so due to significant changes in circumstances, including clear escalation of risk. Early help services are suitably maintained to ensure consistent support for families during and beyond the transition, depending on the identified need. Cases that step down from social care are well coordinated, with early help service attendance at meetings, to support a coherent transfer.

18. Child protection concerns are appropriately prioritised, and, when there is a risk of significant harm, prompt multi-agency responses ensure that the immediate risk is identified, assessed and managed in a timely way. The vast majority of strategy meetings are multi-agency and are well recorded with clear actions. Child protection enquiries are timely and result in proportionate subsequent actions. In cases seen that resulted in an initial child protection conference, decisions to place a child on a child protection plan were appropriate.

19. When risk is less immediate, the majority of assessments do not explore all potential areas of risk or need and are not consistently updated in response to changing circumstances, for example, the impact of a parent’s new partner on the family or relationships within the wider community. Children’s lived experiences are often not evident. The local authority does not set timescales for assessment based on the needs of the individual child, and timeliness is measured at the maximum of 45 days. Current reported performance for completion within this timescale is 73%. This means that the outcomes of assessments and decisions on future actions are often not timely and lead to a delay in children receiving help when they need it. However, services are provided as soon as they are identified in the assessment process (Recommendation).

20. The quality of pre-birth assessments seen was a strength. They were almost all of good quality, prompt and thorough. This informed timely planning prior to the birth, reducing uncertainty for parents. In some cases, this helped them

to engage with services more effectively and in others ensured that there was no delay in court proceedings when no progress had been made.

21. The variability seen in the quality of assessments is replicated in plans. The large majority of plans do not sufficiently focus on important areas of risk and need, and do not set measurable outcomes with clear timescales. Contingency planning is absent or not sufficiently clear in too many cases. This means that plans are not an effective mechanism to elicit change and do not result in effective evaluations of intervention or support prompt alternative courses of action (Recommendation).

22. Child protection conferences are well attended by partner agencies but do not yet provide sufficient rigour when evaluating progress and the effectiveness of interventions.

23. Visiting frequency for social workers is not defined in line with the child's needs in the majority of child protection cases, but is measured at a 28-day frequency. Although, in cases seen, social workers and family support workers generally visited more often and increased their monitoring and oversight of children in line with changing need, this is too dependent on the professional judgement of the individuals involved. This, combined with irregular managerial oversight, means that the local authority cannot be certain that its current performance of 98% of child protection visits within timescales ensures that all children are seen as often as they should be (Recommendation).

24. Core groups with good partner agency attendance are held regularly, but, in the majority of cases seen, updated information is shared without sufficient reference to the plan and ongoing evaluation of risk. The views of children and young people are evident on records from social workers or other services, such as family support, but these are not consistently used to inform planning and the reviewing and evaluation of work. Advocacy services, while available to children who are subject to child protection plans in Sefton, are not promoted well and take-up is low.

25. At the time of the inspection, 253 children were subject to a child protection plan. Of those, 63% were subject to a plan due to emotional abuse and 16% due to neglect. The local authority is working closely with the Sefton Safeguarding Children Board (SSCB) to understand this. The SSCB has delivered training across the partnership in the use of the graded care profile, which is a tool used for measuring neglect to assist with early identification. This tool has been incorporated into the social care electronic system. When children are subject to a child protection plan for over 12 months, there is a multi-agency challenge meeting for professionals involved, chaired by an advanced practitioner. In contrast to most others, these meetings provide rigorous scrutiny and challenge and provide clear direction for future work. The local authority performance data shows that, as a result, the number of

children who have been subject to a plan for more than 15 months has reduced from 10 in March 2015 to five in March 2016.

26. Workers do not always fully consider issues of diversity in their work with children and families. For example, the effect of a child's disability on their identity was not addressed in the majority of cases seen in which this was relevant. More positive work was evident in relation to children's cultural heritage, including clear planning for consideration of contact with family and linking them to community groups when appropriate. Interpreters were used when necessary and important documents such as court reports and child protection plans were translated to assist understanding (Recommendation).

27. Social workers feel supported by their managers, but management oversight of casework is not sufficiently evidenced or recorded to ensure timely and detailed monitoring of the quality of work or to ensure swift case progression. There is significant variation in social work caseloads, and, when caseloads are high, this can affect the social worker's ability to work effectively. The current service structure results in several changes of social worker. This makes it more difficult for families to develop effective working relationships and is exacerbated when joint visits are not undertaken as part of the handover between workers. Nevertheless, some positive examples were seen in which consistent social work support has been important in achieving positive outcomes for children and families (Recommendation).

28. Clear, holistic and effective partnership working is evident for children at risk of child sexual exploitation and who go missing. A clear pathway ensures timely referral and access to services through the MASH. The missing and child sexual exploitation group (MACSE) ensures timely information sharing, case planning and risk management at an individual case level when children are identified as at risk. Creative direct work that engages young people was evident from case sampling and was seen to be making a positive difference for some children. Sefton has developed an innovative approach to ensuring risk management for children looked after who are placed in Sefton from other local authorities. Return interviews for children who go missing are tenaciously pursued and comprehensively completed by the 'developing choices' team. Information is shared appropriately among agencies and subsequent actions are undertaken in line with identified risk and need.

29. The local authority has established effective links and prompt information sharing with education partners. A multi-agency monitoring placement group meets fortnightly to ensure that the whereabouts of all children are confirmed and appropriate actions taken if they are not. The children missing education (CME) coordinator is part of the MACSE, ensuring that additional vulnerabilities as a result of children missing education are fully considered.

30. Currently, 88 children are registered with the local authority as being electively home educated, and 54 children are being educated in medical facilities or at home due to ongoing medical conditions. The arrangements to support these

families are thorough. All families who are registered receive an annual welfare visit from staff, and the authority offers a range of additional support, including online curriculum resources and exam venues.

31. Constructive partnership work in relation to children who are affected by parental mental health, domestic abuse and alcohol and substance misuse is evident in Sefton. The prevalence of issues affecting children known to services is understood, and a range of services are available from statutory and voluntary organisations. These services include some innovative work in Sefton and the wider Merseyside area. For example, a pan-Merseyside pilot is identifying and working with a small cohort of families based on the family drug and alcohol (FDAC) court model. The local authority and statutory partner agencies have a clear understanding of areas of practice that need to improve, including planning, a focus on the impact on the child, and evaluating effectiveness. They are fully engaged in action planning to improve practice.

32. The multi-agency risk assessment conference (MARAC) meets fortnightly and appropriately considers cases in which domestic abuse is a significant risk. MARAC ensures that information is shared, children and young people's needs prioritised and actions directed that contribute to the safeguarding of children. The current reported performance of 20% repeat referrals is better than the national average of 25%. Recording of MARAC activity is minimal. Actions are not outcome-focused and are not always fully recorded on the children's social care file. This does not assist communication, as workers are not always fully informed of actions taken by other agencies.

33. Awareness-raising events in relation to prevention and identification of extremism have been held in Sefton. No cases of concern had been identified at the time of the inspection. Updated advice in relation to female genital mutilation is available on the SSCB website, but no current cases relating to this area of work were identified in the inspection.

34. Allegations management processes evidence appropriate referrals from a wide range of agencies, including those from the private and voluntary sectors. The post is located in the MASH, supporting timely information sharing and coordination. An experienced, knowledgeable officer has developed clear systems for receiving referrals, offering appropriate advice and ensuring that appropriate actions are taken when needed. The database used allows for continued monitoring and tracking of cases. Evidence was seen of effective case management, with referrals to the disclosure and barring service made when required.

35. Sefton has not met national minimum standards in relation to private fostering, and current practice does not accurately identify private fostering arrangements in all cases. An annual report was not presented to the SSCB in 2014–15. An audit of private fostering cases was presented to the board in November 2014, and the local authority accepts that this does not meet the

requirement of an annual report. Awareness raising among staff has not been undertaken recently, and, although the authority does have a private fostering champion, the role is largely dependent on staff contacting her for advice. This, combined with the lack of frequency with which workers are required to undertake private fostering assessments, means that there is no specialised expertise developed and that understanding is variable. This is illustrated in one case deemed as private fostering, although the parent was clearly not in agreement with the placement, and in a second case in which a potential private fostering arrangement was missed. The authority has put together an action plan to address these deficits. This will be presented to the SSCB in May 2016, but, at the point of the inspection, the identification and assessment of the suitability of arrangements for this vulnerable group of children have been insufficiently prioritised (Recommendation).

36. In the vast majority of cases when young people age 16 and 17 present as homeless, concerted efforts are made to mediate with family members and the young person, which result in the young people appropriately returning home. When this is not immediately possible, a range of alternatives are used, including respite care and short-term accommodation under section 20 of the Children Act 1989. In cases sampled, the young person then moved on to supported living arrangements, but these arrangements were made without an assessment of whether the young person needed or wished to be looked after. While no young person was seen to be in unsuitable arrangements as a result of this practice, it is not compliant with statutory guidance or case law. In a very small number of cases prior to July 2015, young people aged 16 or 17 were placed in bed and breakfast accommodation as an emergency measure, without a risk assessment being undertaken or additional safeguards such as spot checks and support out of hours being in place. This leaves young people highly vulnerable. The DCS is clear that bed and breakfast accommodation should not be used, unless in exceptional circumstances and only then for very short periods of time, and had instructed staff to this effect upon his appointment in October 2015. As a result of learning from this inspection, he has given a written undertaking that revised procedures will be issued, ensuring that no young person is placed in bed and breakfast accommodation, other than as a last resort following detailed risk assessment and agreement of a senior manager (Recommendation).

37. No children were found to be in circumstances of unacceptable risk during this inspection. Despite the deficits in some areas of core practice, many children and families benefit from the range of support that they receive, and outcomes improve for them as a result.

Ofsted

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

Summary

The Community Adolescent Service (CAS) is successful in helping some young people on 'the edge of care' remain with their families. When children become looked after, decisions are timely and appropriate. Public Law Outline (PLO) processes are used effectively. However, too many children are placed at home with parents without a thorough evaluation of the appropriateness of the placement.

The overall quality of case recording is not good enough and does not always reflect children's lived experience. Assessments lack analysis of some issues and neither risks, such as identity, nor plans always prioritise important issues for children. Often, children have too many changes of social worker, which makes it difficult for workers to form consistent positive relationships with them. Social workers' caseloads are high and a small number of statutory visits have been significantly delayed or missed.

IROs have caseloads that are significantly higher than is recommended in statutory guidance. Although timeliness of children looked after reviews is good, the service is not rigorous in challenging the quality of social work practice and quality of planning.

Initial and annual health reviews are not always timely, and there are delays for some children in receiving child and adolescent mental health services (CAMHS). The education of children looked after is good. Their attainment and progress are effectively supported by a well-led and suitably resourced virtual school. The attainment gap between children looked after and their peers is reducing.

Responses to children and young people who are at risk of child sexual exploitation and/or who go missing from care or from education are timely and effective.

Timeliness for children placed for adoption has improved and adoption support is a strength. However, learning from placement disruptions has not been used to improve practice. Life storybooks and later life letters are not given to children in a timely way.

Care leavers enjoy positive and trusting relationships with their workers. However, pathway plans are poor, some young people wait too long to have their mental health needs assessed, and too many care leavers are currently in unsuitable accommodation.

The Sefton children in care and care leaver council, making a difference (MAD), is effective and influential but does not have any members under the age of 13.

Inspection findings

38. In instances when children have recently become looked after, the decisions were appropriate and, in the majority of instances, timely. The PLO is used well with families to address areas of concern. The number of children looked after in Sefton at the time of the inspection was 473, a rate of 88 per 10,000 population. This is an increase from 450 in 2014–15, which was a rate of 85 compared with statistical neighbours at 77 and England averages of 60.

39. The local authority has a clear strategy on using preventative services to reduce the number of children becoming looked after. The multi-agency CAS was established in July 2015. The service works with children and young people who may be on 'the edge of care' due to a variety of reasons. For example, they may be at risk of or involved in offending behaviour, including gang membership and gun crime, at risk of child sexual exploitation or domestic abuse, or may not be in education employment or training (NEET). Although the service is quite new, there are already good indications that it is having a positive impact, especially for children and young people involved in offending or risk-taking behaviours.

40. When children and young people become looked after, the local authority effectively prioritises permanence for children before their second looked after review. Court proceedings are timely at less than 26 weeks.

41. When considering plans for permanence, social workers are good at considering a range of options. The quality and timeliness of assessments for court, including Regulation 24 placements with connected persons and special guardianship orders, are good, with clear outcomes and recommendations.

42. A high proportion (21%) of children looked after in Sefton are currently placed with parents. As a result of a recent audit by the local authority, additional training has been provided for staff, and decisions for placement with parents are subject to careful scrutiny by managers and legal staff to ensure that the placement is the right one. However, for many children already placed with parents, decisive action has not yet been taken to discharge care orders or to take alternative action. Only three care orders for placement with parents have been discharged since the end of December 2015, and 12 children have remained placed with parents for more than five years. Although no young people were found by inspectors to be living with parents inappropriately, it does mean that some children and families remained subject to statutory intervention needlessly, which is potentially intrusive to them and adds to the already large workload of social workers and IROs (Recommendation).

43. The structure of social work teams in Sefton means that children have had too many changes in social worker by the time they have a permanent plan to be looked after. This, combined with high caseloads for some social workers, means that too often children are unable to develop longstanding relationships

with adults and, in part, this contributes to the poor quality of casework across services (Recommendation).

44. The quality of case recording, assessments and care plans is not good enough. Assessments and plans submitted for court proceedings are generally good, but others are not. Assessments include detailed information and consideration of children’s views and those of family and others. Ethnicity and identity details are recorded. Historical information is considered well. However, overall assessments lacked analysis of many of these important factors. Chronologies are not used effectively, risks are not always fully considered and contingency planning is poor. Assessments are not updated when children’s and young people’s needs change. Consequently, children’s plans arising from the assessments do not emphasise the important issues and risks. Management oversight and supervision of the quality of assessments and plans lack rigour. As assessments are not routinely updated when the circumstances and needs of children change, plans do not contribute strongly enough to improvement in outcomes for children looked after in Sefton (Recommendation).

45. Unusually high levels of sickness in some teams have led to a decline in the frequency and quality of recording of statutory visits to children and young people. This has resulted in insufficient consideration of some children’s experiences. While in the majority of instances children and young people have had contact with other professionals, it was only recently that managers took effective action, in accordance with statutory guidance, to ensure that their living circumstances had been reviewed and recorded by a qualified, experienced social worker. In children’s cases, no young person was found to be unsafe because of these deficits.

46. Caseloads for IROs are too high. At 30 September 2015, IROs had, on average, responsibility for 65 children looked after and 33 children on a child protection plan. Despite these excessive workloads, the completion of children looked after reviews for this same reporting period was 98%, and 98% of children over the age of four years provided their views for their review. Compliance, therefore, is good. IROs prioritise well and ensure that they see the most vulnerable children between reviews. This is good practice. However, high caseloads impair the quality of some aspects of the service that IROs provide. Critically, informal and formal escalation procedures are not used often enough when concerns about children’s cases are identified, and challenge is not always rigorous or effective, for example, in considering the quality of children’s plans (Recommendation).

47. Placement stability in Sefton is improving for children and young people with three or more moves. Long-term stability has remained relatively consistent for several years, at around 69%.

48. The sufficiency strategy includes suitable regional and local responses to the recruitment of foster carers. Shortages of foster carers within the local

authority have resulted in targeted recruitment and close working with regional partners. Initiatives include targeting potential carers online and commissioning through regional networks, such as 'fostering front door'. Recruitment of carers, however, remains a challenge regionally and nationally, particularly for older young people with challenging behaviours and for children in larger families.

49. Children are carefully matched to carers, and their views and wishes are considered well. Brothers and sisters are consistently placed together unless their plans identify that it would not be in their best interests. Good support arrangements contribute to the stability of placements. For example, children and young people receive support at a Sefton children's home where staff work to help them to build resilience and self-esteem to enable them to live with foster families.

50. The fostering service is managed well to meet the needs of children and young people as effectively as possible. Foster carers are positive about the support that they receive, and training opportunities for all foster carers are very good. This helps them to provide good care for children and young people**.** The annual training calendar is comprehensive, and the training coordinator is tenacious in ensuring that carers know what is on offer and are encouraged to attend. Foster carers' completion of the training and skills development workbook has improved from 7% in 2014–15 to 69% in 2015–16 for mainstream carers, and to 15% for kinship carers. While this demonstrates significant improvement, it is from a very low baseline. The local authority recognises that more needs to be done, in particular, to improve kinship carers' engagement with training and has developed a tailored training package for them to try to improve on this performance.

51. When a placement cannot be provided by Sefton, the commissioning team explores placements with independent fostering agencies (IFAs) or independent children's homes. Placements are only considered within services that are judged as good or better by Ofsted. If judgements decline, the service is reviewed and decisions to continue the placement risk assessed and considered in the best interest of the child. The only instances when children or young people are not placed in accordance with their care plan is when they have complex needs that cannot be met, for example, when they would benefit from placement with foster carers, but their needs are such that they can only be met in a residential setting.

52. Case tracking of children and young people placed out of area showed appropriate access to health services and education. However, given the complex needs of some of these children, it is often difficult to sustain their education, and alternative home support is provided. The health reviews for children living out of area are monitored, with clear expectations for the quality of these reviews communicated and quality assured. Case tracking highlighted a lack of communication between some out-of-area children's homes and the local authority, which resulted in some poor planning and/or

slow responses to issues of concern, exacerbated by changes in social workers.

53. The attainment and progress of children looked after in Sefton is effectively supported by a well-led and suitably resourced virtual school with firmly established governance arrangements. Currently, pupils at key stage 1 to key stage 2 are generally making expected levels of progress given their starting points. However, levels of progress from key stage 2 to key stage 4 continue to be a challenge, and a number of pupils are not yet making good progress. The use and close monitoring of the pupil premium, including ongoing one-to-one support, is beginning to have an impact on closing the attainment gap for this group of pupils.

54. For the 40 pupils who were eligible to sit GCSEs in 2015, 21% achieved five GCSEs at A*to C grades, which is above the national rate of 18% for children looked after. They also achieve one percentage point above the national rate of 14% when English and mathematics are included.

55. At the time of the inspection, 22 children looked after were receiving alternative education. In all cases, the authority make careful checks into the quality and suitability of the provision, and all provision is registered.

56. Personal education plans are generally fit for purpose and identify effectively barriers to learning and the teaching strategies to overcome these barriers. Of particular note is the detail in relation to the use of pupil premium, which in most cases carefully identifies how additional money will be spent in supporting the current progress of pupils, including one-to-one tuition, therapeutic intervention, accessing the wider curriculum and providing laptops.

57. Children and young people enjoy a wide range of leisure activities that support their wider emotional and social development, both at home and in school. Within school, children can enjoy music lessons and horse riding. At home, carers support children and young people well to become involved in social, recreational and friendship building activities. Passes are provided to enable them to use local authority leisure services.

58. Arrangements for supervised contact are provided through the family support workers or by social workers. Reports are completed by workers and used to inform planning and assessments. However, although the contact reports sampled included detailed information of observations, they lacked analysis to inform ongoing work fully.

59. Well-coordinated systems and procedures for children who are at risk of child sexual exploitation and/or who go missing ensure timely and effective responses. When children and young people are reported missing from care, prompt action is taken. The ‘developing choices’ team persists in contacting children to undertake return home interviews. These are not always

completed or completed within timescales. This is not because of a lack of capacity within the team, but because of refusals and difficulties in engaging young people. When children go missing on a regular basis, appropriate action is taken, including strategy discussions and, when necessary, referrals are made to the child sexual exploitation team for review and action.

60. Sefton has well-established and comprehensive arrangements to report, track and locate any children missing from education. A children missing education coordinator works effectively across all groups and the MASH for those missing, including children missing from care, to ensure prompt communication and effective action across agencies and the MASH. This means that the vast majority of children missing education are located and that they remain on the school roll until they are found.

61. Children and young people looked after who are at risk because of substance and alcohol misuse benefit from timely intervention, support and advice from the Sefton multi-agency substance misuse hub (SMASH) service worker, who is co-located within the corporate parenting team. Responses to ending gang and youth violence are effective, using innovative work to target children vulnerable to bullying and intimidation.

62. The timeliness of initial and annual health assessments is not good enough. In 2014–15, Sefton reported that 75% of the children who had been looked after continuously for at least 12 months had received an annual health assessment. Current data shows that this is now improved to 85%. This is still below the statistical neighbour average of 92% for 2014–15 and below the England figure of 90% for the same year. The timeliness of initial health assessments is currently 54.7% within the 28-day timescale. Action is being taken to improve the timeliness of these, including plans to enable nurses to use the local authority electronic recording system to improve communication.

63. CAMHS for children and young people who are looked after are currently coordinated through Alder Hey hospital via a single point of access. All children and young people who are looked after are guaranteed an assessment, and initial triage and screening determines the urgency of referrals. Access for children looked after to CAMHS follows a consultation model, in recognition of their increased vulnerability, and children will usually be seen within two weeks. It is acknowledged by health and children’s services that waiting times for some children are too long, and better ways of working are being rolled out through development and coordination between health and children’s social care of a therapeutic support service. Foster carers who have had experience of this service are uniformly positive and report overall that when children need some specific help or input is was made available.

64. Older children and care leavers in Sefton are very well represented by MAD. The group is highly influential in shaping services for children looked after. Members of the group highlighted issues with entitlements to benefits for care

leavers, which resulted in Sefton pioneering a protocol with the Department for Work and Pensions to ease the transition for care leavers applying for benefits and seeking work following their 18th birthdays. This has subsequently been rolled out nationally as an exemplar of good practice. The Sefton pledge to children in care and care leavers is given to all children when they first come into care and is also re-distributed on a regular basis with the annual survey. This ensures that children looked after are made aware of their rights and entitlements, including how to complain. Despite the significant achievements of MAD, there is insufficient representation of the wider children looked after population and no representation for children under the age of 13.

The graded judgement for adoption performance is that it requires improvement

65. Sefton's adoption service was made the subject of an improvement notice between December 2012 and June 2014 due to its poor performance in placing children with adopters quickly. Since that time, effective tracking systems that ensure that children's plans consider permanence at an early stage and monitor their progress through care proceedings have been routinely used, and unnecessary delay is avoided. Oversight of progress by a dedicated family finder and senior managers through adoption permanence panels ensures that plans do not drift. Good communication with the family finder enables the adoption team to give early consideration to the adopters already approved and those who are in the assessment process as potential matches for children.

66. The authority's performance against the Department for Education's adoption scorecard shows a year-on-year improvement in timeliness performance. In 2012–15, scorecard data shows an average time of 631 days, between entering into care and moving into an adoptive placement. This is an improvement from the previous period of 2011–14, when the average time was 54 days longer. Unvalidated data provided by the local authority for children adopted in the past 12 months shows a further reduction to 305 days, which is significantly better performance than the target of 487 days set by the Department for Education.

67. In the last year, there has been a reduction in the numbers of children adopted. Eleven children were adopted in 2015–16, which is 8% of the children looked after population. In the previous year, 20 children were adopted, 13% of the children looked after population, and seven children were made subject to special guardianship orders. The reasons for the reduction in the number of adoptions are not fully understood by the local authority. Inspectors saw no cases in which children who should have been considered for adoption had not been.

68. The local authority's average number of days between receiving the court authority to place a child to be adopted and the authority deciding on a match to an adoptive family in 2012–15 was 253 days, which is an improvement on the 282 days for 2011–2014. This is still 132 days outside the national scorecard threshold of 121 days. However, in the last year, despite having five children over the target number of days, the average for all 11 children was 107 days, which again demonstrates positive progress, and below the national target.

69. In the last year, seven out of the 11 children adopted were placed outside of the local authority. One reason for this is that the adopters recruited and approved by the local authority did not match the needs of the children with a plan of adoption. The local authority does not target recruitment to the needs of children waiting or projected future need. Recruitment is limited to general advertising and a campaign on social media. Currently, there is no strategy for 'fostering to adopt' placements, and only one such placement was made in the last year. The effectiveness of recruitment has not been analysed, nor the means of attracting adopters able to meet a diverse range of needs explored. Despite its lack of targeted recruitment in 2015–16, Sefton placed more brother and sister groups together than the national average.

70. Adopters are positive about the quality of information and the welcome that they receive when making an enquiry to become adopters. This includes relevant literature and research findings, and adopters are asked to complete a comprehensive workbook at stage one. They attend a three-day preparation group, which is alternately hosted by the local authority and a neighbouring local authority. The service does not receive timely feedback from the other local authority when they have run the preparation group, which can delay progression to the next stage. However, regular visits to the families throughout this time to support the pre-approval process mean that few drop out. The majority of assessments are timely and comprehensive, and delays are due to factors outside of the control of the service. Adopters in the last year have been from a suitably diverse range of backgrounds and family composition, and include people from ethnic minorities, single people and same-sex couples. The prospective adopter reports seen by inspectors were comprehensive and thorough. However, in the past year, a number of assessments that were not of the same quality were completed by a contracted agency, and had to be deferred by panel while missing information was added. This has slowed the approval process for some adopters. Once adopters are approved and when there is not a match within the local authority, family finding is promptly extended regionally and nationally.

71. The dedicated family finder is proactive in pursuing options and links for children through a range of contacts, such as the national adoption register and exchange days. Currently, there are five children waiting for a suitable match. Child permanence reports (CPRs) are rarely updated following the court process, and, therefore, information provided is not current, at this early stage. This means that for some children potential carers may be ruled in or

ruled out inappropriately, based on analysis of children's needs that is no longer accurate as they grow and develop.

72. In the year 2015–16, none of the 11 Sefton children placed for adoption both with Sefton adopters and adopters from other local authorities experienced a disruption of the placement. However, Sefton adopters experienced unusually high levels of placement disruptions. Altogether, over half of the children placed with Sefton adopters by other local authorities in that year suffered a disruption. No formal consideration of learning or identification of themes has happened and, consequently, no actions have been taken to prevent further disruptions in the future. In one case, the report of the child's disruption review undertaken in October 2015 was not received by the adoption service until requested by an inspector. This does not demonstrate sufficient urgency to learn from these children's and adopters' experiences in order to prevent future breakdowns, and is very poor practice (Recommendation).

73. Due to changes at a senior management level, there have been three agency decision makers in the last year. This has inevitably led to a lack of continuity, and there has been no formal meeting between the agency decision maker and the adoption panel chair in the last 12 months. The chair's performance reporting lacks rigour. Essential information, such as the ages and ethnicities of children, is not included and reporting fails to reference the disruptions that have taken place. Areas for development in relation to the panel identified in 2014–15 have not been addressed. These include a panel development plan and use of regional comparative data to benchmark performance (Recommendation).

74. The panel's membership is too narrow. Although recruitment is ongoing, a skills gap analysis has not been undertaken and recruitment has not been targeted. The panel currently lacks expertise in the field of education, and there is a gender imbalance. A panel member who has experienced adoption has recently been recruited. This is a positive step. The panel seeks feedback from those who attend. Some applicants reported that the panel had been a negative experience. The panel has changed its questioning process in response to this feedback, although it is too early to measure whether applicants now have a more positive experience.

75. The panel provides individual feedback on the quality of the CPRs and prospective adopters' reports. However, it has made no challenge to the agency decision maker (ADM) or agency adviser when poor or incomplete assessments are presented, resulting in delays in decision-making. This, combined with changes of ADM, means that senior managers were not fully aware of areas for development in relation to the effectiveness of the panel and the adoption service as a whole (Recommendation).

76. Once children have been matched, adopters report that the matching process and introductions were completed at the child's pace. The adopters felt that they had enough information and if they had any questions, they were always

Ofsted

provided with the answers. 'Moving on' meetings are held to ensure that professionals and carers have a shared understanding of processes and timescales. A comprehensive children's guide is available in three different versions, to support children of different ages. However, in the last year there has been no service statement of purpose available, which is a statutory requirement of an adoption service.

77. Adoption support is an area of strength. Effective support is available to birth families, children and adopters. A wide range of support is available, including direct work with families, letterbox contact, direct contact supervision and general advice giving. A range of therapeutic services are available through the use of the adoption support fund. Following a social work assessment, appropriate support is provided. Support packages are available to all adoptive families, regardless of the length of the placement. The support offered is timely and responsive. The service also offers a range of activities to adopted children, such as bowling, walking and residential trips as well as direct work.

78. The service-produced life storybooks are of a good standard. However, to date, children have not received them soon enough. Due to a backlog, books were commissioned from an external provider, but this caused a further delay due to more work being required before they met the service's appropriately high standards. Later life letters are of a good standard but too often delayed, with only three out of the 11 children adopted last year having received them.

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

79. The local authority is in touch with all but three of the 287 care leavers. Two of these care leavers have returned home and do not want to engage with the service, and a third care leaver is out of touch. Personal advisers are highly experienced and provide a very supportive and effective service. However, a recent restructure of the leaving care service means that their work with care leavers often starts after the care leavers are 18. This means that there is only a short time to engage with and equip young people for independence. Increasing workloads in the leaving care team are further affecting the ability of workers to meet the presenting needs of care leavers.

80. The vast majority of care leavers feel well supported by their personal advisers and build helpful and trusting relationships with them. Staff are particularly skilled at helping young people to understand the potential outcomes of their behaviour, especially in relation to risks, including those that might affect their sexual, emotional and physical health. As a consequence, almost all care leavers spoken to by inspectors have a good understanding of how to keep themselves safe and say that they feel safe.

81. Pathway plans are not effective planning tools. The majority are too descriptive, and are insufficiently analytical of the reasons behind the lack of progress that some care leavers make. This results in targets for remedial action not being specific or memorable enough for care leavers to understand what needs to happen. None of the care leavers spoken to for the inspection remember completing a pathway plan and therefore could not comment on its usefulness or otherwise.

82. Of particular concern is the consistently poorly completed education section of the pathway plan, with few identified actions or options to ensure that young people are appropriately advised and guided to secure employment or training as part of the recorded plan. The local authority recognises that the current pathway plan requires improvement and, as a result, a new plan is currently being reviewed by young people to ensure that it is fit for purpose (Recommendation).

83. Despite pathway plans not being sufficiently focused on education, other useful work is being done to support young people into education, training and employment. A well-established corporate apprenticeship scheme has been running since 2010 and has successfully supported over 30 care leavers into apprenticeship or employment. As a result, a number of care leavers are now employed by the authority and two ex-care leavers are employed by a local charity that supports care leavers.

84. For those care leavers who choose not to stay on in school beyond Year 11 and who are not quite ready for an apprenticeship scheme, there are opportunities for structured appropriate work experience that supports them to develop good employability skills. This helps young people to improve their confidence and to develop independence. The programme was developed in 2011 as a direct result of feedback from care leavers. Care leavers who are at risk of disengaging are well supported back into training, and 35 care leavers have benefited from the scheme since it started.

85. The current numbers of care leavers who are NEET is 25%. This figure is lower than the most recently published figures for comparators. However, the figure rises considerably, to over 40%, for those care leavers aged over 19 years. A thorough tracking system is used to monitor employment and training destinations for this group, and targeted interventions are made to engage young people in education or training. Examples include one-to-one advice and guidance sessions, introductions to potential work placements and support to attend college courses. A useful protocol has been established with the Department for Work and Pensions that prevents delays in care leavers applying for benefits and seeking work following their 18th birthday. As a result of the above initiatives, the numbers of older care leavers who are entering training or employment is steadily rising, but this is still lower than the number of young adults in the general population who are entering training or employment.

86. Long-standing and purposeful relationships with two local colleges support effectively the 53 care leavers who are currently attending further education programmes. For the 11 care leavers who are in higher education, a good package of support, including financial and emotional support, is helping them to achieve. One young person has successfully completed an undergraduate degree and the authority is now supporting them to complete a Master's programme.

87. The transition arrangements for those care leavers with an identified and long-standing disability are good, and they are well supported to access adult social care services in a timely way. However, when an assessment is required to establish whether care leavers meet the criteria for adult social care, the wait is sometimes too long and there is consequently a delay in their receiving all the services that they need as adults. For example, a small number of care leavers have waited for adult social care assessments for over a year. This has resulted in these young people remaining in circumstances that have not necessarily met their changing needs, for example, remaining in a residential children's home. In another case, a care leaver remained in supported lodgings, which were never meant to be a long-term placement (Recommendation).

88. Care leavers are routinely provided with helpful health information and health passports. In 2015–16, 21 health passports were issued. Nurses are available to provide support, advice and written information. As a result, care leavers are well supported in relation to their physical health. This is not the case for their oral health, as very few of them attend the dentist regularly.

89. All those spoken to recognise the need to take responsibility for their own health needs. However, a significant number of care leavers expressed concern about their mental health needs not being well addressed. This is because of the long wait to access appropriate mental health services. Some of the tracked and sampled cases evaluated by inspectors also identified and confirmed this concern.

90. Care leavers are generally well supported to develop their independence and self-help skills by access to a charity-run care leavers' centre, 'Our Place'. The centre works effectively in partnership with the local authority. Staff at the centre, two of whom are former care leavers, provide useful and bespoke support, helping young people to develop the skills that they need to live independently, for example, budgeting and cooking. They also provide pre-tenancy and tenancy support, and counselling and well-being sessions. At present, the number of care leavers regularly accessing the centre is small. However, attendance is growing steadily, particularly since personal advisers are now working out of the centre.

91. The majority of care leavers live in appropriate housing and are safely and well accommodated. The growing numbers of care leavers who are 'staying put' with former foster carers is increasing slowly, and currently 11 care

leavers are benefiting from these arrangements. Three care leavers have been in bed and breakfast accommodation recently, including one care leaver at the start of the inspection. In all cases, this was in response to an emergency. In all three cases, no risk assessments were completed, despite some of the young people having significant vulnerabilities. A small number of other care leavers remain in unsuitable accommodation, with four care leavers in family situations that are unstable and 11 in custody. Personal advisers maintain strong links with care leavers while they are detained and collaborate well with other agencies to achieve stability for them on their release, which reduces the risk of re-offending.

92. A wide range of accommodation is made available to care leavers, including supported lodgings, and support with gaining their own tenancies is provided. While care leavers are given some priority on the local housing waiting list, they are not included in the highest band. A shortage of social housing, particularly in the north of the borough, combined with greater priority given to other groups, such as ex-army personnel, means that some care leavers wait too long for housing in their preferred area. The local authority recognises that young people from the north have a very different, distinct cultural identity from those in the south and is forging links with private providers to increase the range of choices, but this does not offer the security of social housing. Some staff spoken to for the inspection reported reservations regarding the quality of some provision. Issues of concern included the lack of structured support for young people, poor communication with the leaving care service, and limited help in preparing young people well for their future independence. Managers have responded effectively to these concerns, and a recent re-tender process has been undertaken, focusing on the quality of provision, and on reducing the number of providers from 57 to 18. The local authority anticipates that this will bring about the necessary improvements to the service (Recommendation).

93. Many of the care leavers spoken to by inspectors are justifiably proud of their achievements, including becoming successful parents. They all agreed that their achievements are well celebrated by the service through well-attended annual events that a number of them help to organise, but also by the ongoing and continual encouragement from staff. All care leavers spoken to by inspectors know their rights. This is particularly well disseminated by the MAD group, which ensures that care leavers have a good understanding of their entitlements, including ongoing financial support if they remain in or return to education or training.

Leadership, management and governance	Requires improvement

Although the local authority has taken action to improve services since the last inspection, progress has been erratic and has not yet resulted in consistently good services for children, with some recommendations still not addressed. A highly effective multi-agency strategy in relation to children at risk of child sexual exploitation has resulted in some innovative practice, and some good practice was also seen in other areas. However, some core social work services require improvement, and responses to some vulnerable groups of young people, such as those who are privately fostered and homeless 16 and 17 year olds, have not been rigorous enough.

There is a clear alignment between strategic partnerships in terms of priorities that are well informed by the joint strategic needs analysis (JSNA). The children's trust arrangements have recently been subsumed into the Health and Wellbeing Board (HWBB) in recognition that the HWBB's consideration of children's issues was too limited. It is too soon to determine the effectiveness of these changes. The DCS demonstrates strong leadership and is well supported by the chief executive and elected members who have a realistic overview of the service, and the pace of change is now increasing. While leadership is strong and governance arrangements are sound overall, there are important areas of management that are weak and need attention in order for this area to be judged good overall.

Caseloads are excessive in some areas, and workers do not always have sufficient time to provide a good service. Management oversight and supervision are insufficiently regular or challenging. Although the local authority has taken action to improve the quality of supervision and challenge to practice by managers and IROs, this is not yet evident in casework, and the quality of social work practice remains too variable even within teams in which caseloads are low. The local authority has identified that structure and transfer of work across services contribute to this unequal distribution of work and does not achieve its vision of consistent relationships for children and young people. Currently, too many children and young people experience changes of worker at important transition points when they would benefit most from continuity.

Performance management has been an area of significant development in the last year and there has been a vast improvement in the quality of data. Monthly performance meetings help to identify deficiencies in practice, but action planning has been limited. The local authority improvement board, for example, has not set targets to measure success. Audit and quality assurance activity have been significantly improved. The recently refreshed quality assurance framework is rigorous and includes targeted quality assurance in important areas. Findings are used well to influence workforce development.

Ofsted

Inspection findings

94. The local authority has a clear determination to improve services for children in Sefton. Senior leaders have high aspirations demonstrated by the introduction of an improvement board three years ago, chaired by the chief executive. While this has ensured that the chief executive and the lead member receive regular updates on action taken to improve practice, the impact of the board has been limited. In recent months, with the benefit of external review, the board has recognised that progress has not been as significant as it needed to be. While some of the issues identified during the previous inspection in 2011 have been addressed, others, such as poor case recording and insufficient management oversight, continue to have a negative impact on the quality of service that most children receive.

95. The recently appointed DCS and even more recent head of service demonstrate an impressive and detailed understanding of the quality and impact of frontline practice. They are both highly visible, and the DCS has undertaken direct observations with social workers to help him to understand the challenges. They have quickly identified some important strategic priorities, including introducing technology to support mobile working and reducing caseloads. Almost all of the areas of development highlighted in this inspection had been identified and actions had been planned or were underway to support better social work practice.

96. The DCS also has strategic statutory responsibility for adult social care services and health. Although this is a wide span of control, it gives him oversight of the interface between services. An appropriate statement of assurance has been undertaken to ensure that he has the capacity to fulfil these statutory responsibilities.

97. Sefton children's services benefit from the strong involvement of the chief executive, elected members and an appropriately challenging lead member. The regular sharing of information via a variety of methods means that they have a realistic overview of the strengths and weaknesses of the service and understand the improvement journey. Children's services have not been subject to wholesale reductions in resources and have benefited from additional investment to improve service development.

98. Governance arrangements across the strategic partnerships are clear, with joint priorities through all of the strategic plans, informed by the JSNA. The HWB has not prioritised children's issues sufficiently. This has been recognised by the local authority and partner agencies, and proposed changes to the structure and governance of HWB to include the children's trust arrangements provide a much-needed opportunity to give broader consideration of the children and young people's plan and wider safeguarding issues. The board, however, has not yet met under the new arrangements, and its effectiveness is yet to be tested. Mental health and emotional well-being are clear priorities

across all the boards and partnerships identified from the strategic needs analysis. This has led to a formal agreed strategy but, as yet, some children and young people continue to wait too long to access appropriate services to address their emotional and mental health needs.

99. The overview and scrutiny committee meets regularly, with good attendance from elected members. It considers a wide range of information, including national and local issues. The value of the committee's oversight of performance is limited because it does not receive routine performance information and has not undertaken any formal scrutiny reviews in the last year.

100. The DCS meets regularly with the chair of the SSCB and was instrumental in championing the need for an independent review of the board concluded in January 2016. This resulted in a number of recommendations to improve the functioning of the board and to ensure that it meets its statutory responsibilities. The lack of follow up or challenge has left the local authority vulnerable as multi-agency policies and procedures do not meet statutory requirements. However, there were no cases seen in this inspection in which children had not received an appropriate service as a result of the board's failure to update procedures.

101. The corporate parenting board has appropriate oversight of important issues and the work of the board contributes to the improvement of outcomes for children looked after in Sefton. Chaired by the lead member and with membership from across the council and wider partnerships, including care leavers, it has been instrumental in setting up effective systems for monitoring children and young people looked after placed in Sefton and those from other areas, ensuring that they are safe and receiving appropriate services. Strong challenge from board members and especially the MAD group is evident. The annual survey in relation to the pledge for children who are looked after is an example of good practice because it is clear that children and young people are listened to and that action is taken as a result. An example is the development of an action plan to promote advocacy to children and young people after increasing numbers reported that they did not know about the service.

102. The commissioning strategy describes the commissioning cycle well, but it does not have an associated commissioning plan to identify the important priorities for children. The commissioning arrangements are closely linked to local need, with priorities aligned with the JSNA and shared strategic objectives across the HWB. Joint commissioning arrangements are evident, and a review of substance misuse services has led to a streamlining of providers and a more family-orientated service provision. The regional review and recommission of services for children leaving care has not yet been fully implemented, but the aim is to provide a more flexible approach to commissioning services so that these meet the bespoke needs of each young

person. Only those services that meet the identified quality standards will be considered.

103. The local authority sufficiency strategy meets statutory requirements. It provides a detailed overview of service demands, and there is an appropriate prioritisation to reduce the numbers of children who need to become looked after. To support this, the authority successfully bid for a social work innovation fund grant and has used this to establish the CAS, which is demonstrating some early indications of potential success. Sefton uses a number of purchasing frameworks to increase placement choice and these frameworks support better market management and performance monitoring through effective quality assurance standards and processes.

104. Social workers spoken to by inspectors were very positive about working for Sefton. Recruitment and retention is a strength. Sefton benefits from a relatively stable workforce, with low sickness (6%), and low turnover rates (6.85%). Use of agency staff is minimal and mainly to cover maternity leave and sickness when needed. A number of these workers are recruited to permanent posts when they become available. This stability should contribute to social workers being able to build effective and meaningful relationships with children and families, which is a priority for the service. This is not, however, supported by the current structure, where there is the potential for children to have three or four changes of social worker at important transition points, which is when they need consistency most. The local authority has appropriately identified that a review of the structure is required and the need for swift effective contingency planning in the event of future unplanned staff absence.

105. Caseloads are very variable across the service and too many social workers have in excess of 30 children, which is not reflective of the caseload management policy. Visiting children within timescales is a clear priority but not always achieved in periods of high demand within the children looked after service. High caseloads contribute to the variable quality of assessments and direct work completed with children and young people. The increased use of mobile working is having a positive impact but it is not yet available to all social workers (Recommendation).

106. Although staff report regular informal discussions with managers, frontline management oversight is often poorly recorded across all areas of the service. This means that that no audit trail is provided and risks miscommunication of what has been agreed. Staff supervision is not always regular enough and, in most cases, it is either not recorded in a timely manner or the quality of the recording is poor. As a result, neither line management endorsement of practice nor challenge are consistently evident. Senior managers are aware of these weaknesses and are taking authoritative action to improve supervision practice. This is recent and has not yet resulted in discernible improvement on the ground (Recommendation).

107. The workforce development strategy clearly sets out the local authority's aspirations for the workforce and the actions needed to achieve them. The workforce development team has undertaken a recent training needs analysis and works closely with operational teams to understand the training requirements of social care staff. This results in an extensive training offer, which complements that offered by the SSCB. Learning from audit activity has been used well to identify staff's developmental needs. For example, practice weaknesses, identified through audit, have led to the commissioning of specific training and development programmes, such as that on promoting the child's voice.

108. The principal social worker role has not yet been influential in helping the service to understand and improve social work practice nor offered any challenge in relation to significant issues, such as high caseloads. Until recently, the role was undertaken by the head of service. Prior to this inspection, the local authority changed arrangements in recognition that an important function of the role is independent challenge. It is now undertaken by an advanced practitioner in each part of the service. This is very new, and the effectiveness of these arrangements is yet to be determined.

109. Clear strategic arrangements provide strong and effective oversight of children at risk of child sexual exploitation and those who go missing from home, care or education. These arrangements underpin information and intelligence sharing and support proactive work on the ground. The DCS maintains a clear understanding of need and risk in this area through chairing the SSCB child sexual exploitation and missing subgroup. The provision of services for children who are at risk of child sexual exploitation or who go missing are effective overall. Partners and senior and political leaders work well together to understand the prevalence of child sexual exploitation and to establish effective ways of overseeing and reducing local need and risk.

110. The local authority has improved the quality of performance management information over the last year. The range of data available within the service is now much more accurate. Monthly performance meetings help to identify deficiencies but, until recently, did not set clear actions with timescales to measure success. Further development of the performance dashboard would be beneficial as the lack of data for important areas such as care leavers and adoption means that there is not a consistently presented overview of all areas. The dashboard uses regional and national benchmarking to help the understanding of progress, but lacks specific targets for measuring success in Sefton.

111. The quality assurance framework and audit cycle have been revised and improved. The recently refreshed audit cycle ensures that regular and independent case audits are undertaken across the service. The senior leadership team and the performance and planning group receive summary reports that help to identify how the important findings can be cascaded to relevant staff. Seven-minute briefings to impart the feedback from audits

highlight good practice and ensure that staff get consistent messages about development areas. The SSCB does not receive the findings from these audits, and this is a missed opportunity to inform the SSCB about the quality of practice.

112. The DCS and the head of service have been proactive in meeting with the family judge and the Child and Family Court Advisory and Support Service (Cafcass) to address areas for improvement. Good strategic engagement with the local family justice board is evident. The social work service benefits from the support of a strong legal team and a child progression officer who monitors compliance. These factors are ensuring that timescales meet the national 26-week target.

113. Learning from complaints is not effective. Although exploration and analysis of the outcomes of complaints is carried out, this does not result in action plans, or inform or prioritise lessons to be learned to enable practice to improve. Despite a reported increase, the numbers of children looked after accessing an advocate are still low (18 during 2015−2016). Advocacy is primarily taken up by children looked after. The service is not routinely promoted to children in need or those subject to protection plans. According to the annual pledge survey, the numbers of children looked after who know how to make a complaint or how to access an advocate have reduced, and this is now subject to an action plan to increase awareness.

114. The strategic oversight of private fostering is insufficiently rigorous, and awareness raising is not routine or targeted. As a result, this is likely to lead to under-reporting of potential private fostering situations by the public and professionals, evidenced by the fact that Sefton is only aware of one such arrangement. The local authority has developed an action plan to address the deficits and this will be presented to the SSCB in May 2016, but at the time of this inspection, the identification and assessment of this vulnerable group of children had not been effectively prioritised (Recommendation).

115. Participation and involvement of young people is a strength in Sefton and this is creating meaningful opportunities for young people to engage in strategic thinking and planning. The MAD group has strongly influenced actions in important areas and the group provides a range of training to foster carers and elected members. It exerts influence in most important strategic groups and planning forums. Moreover, its contribution is highly valued by senior leaders, staff and elected members. The local authority would benefit from widening the representation of young people so that younger children can be more actively involved and their views can influence service development.

Ofsted

The Local Safeguarding Children Board (LSCB)

The Local Safeguarding Children Board is inadequate

Executive summary

The Sefton Safeguarding Children Board (SSCB) is inadequate because it is not discharging all of its statutory functions as set out in national guidance published in March 2015. However, much of the work it does is good and some very good.

At the time of this inspection, not all of the SSCB's policies and procedures had been updated. Some, including the multi-agency threshold guidance, had not been updated since 2013, despite significant national and local changes in practice. The SSCB website providing information to external agencies was out of date. This included guidance on the role of the designated officer and on what action to take if a serious incident should occur. Prior to an independent review of the work of the SSCB, reporting in January 2016, the board had not recognised these deficits and, at the point of the inspection, planning to address them remained at an early stage.

The SSCB's provision of monitoring and evaluation of multi-agency training have not included some groups specified in the guidance such as young carers. Privately fostered children who have been identified in the guidance as requiring oversight by LSCBs, have not been prioritised by the board.

The current board structure has not ensured sufficient delivery of the work programme. This was recognised by the SSCB prior to the inspection, and recent decisions have been taken to increase the capacity to address this. Audits and individual case reviews are not sufficiently focussed on monitoring frontline child protection practice to identify what needs to change and to ensure that this results in improvement. The challenges by the SSCB to safeguarding practice, including section 11 and section 175 audits, are insufficiently well recorded.

Action taken to publicise the SSCB's work is not yet fully effective. Some social workers, whom inspectors spoke to, had limited knowledge of the range of the SSCB's work. The last annual report did not include a separate summary or a children's and young people's report, to disseminate important messages across the children's workforce and to the wider community.

The SSCB has undertaken good work with health partners to ensure that they remain integral to safeguarding. Effective links with schools are leading to improved awareness of issues such as bullying and e-safety. Under the board's strategic leadership, responses to address child sexual exploitation are strong. Actions to safeguard children looked after inappropriately placed in Sefton by other authorities demonstrate outstanding rigour and effectiveness.

Recommendations

116. Ensure that the SSCB urgently reviews all of its policies, procedures and work programmes to ensure that these are fully compliant with guidance and legislation. This should include ensuring that they are updated regularly to reflect any future changes to statutory guidance.

117. Urgently ensure that the SSCB has oversight of how well the needs of children and young people who are privately fostered and those who are young carers are being met in Sefton.

118. Ensure that the SSCB's case reviews, audits and performance management examine the full range of safeguarding activity, including identification of good practice.

119. Ensure that the SSCB's action planning is specific and measurable, with clear achievable timescales, that this is integral to its work programme and that the results are reported regularly to the board and to stakeholder agencies.

120. Ensure that the SSCB records individual casework, thematic and agency challenges and monitors that these have been resolved.

121. Ensure that the SSCB improves its communications with the children's workforce and wider communities, and that its website is up to date, that there is a regular newsletter, and that the annual report has a separate summary and children's and young people's version.

122. Ensure that the board thoroughly evaluates the quality and the impact of training on improving practice.

Inspection findings – the Local Safeguarding Children Board

123. The SSCB is judged to be inadequate as it has not been discharging its statutory functions as set out in 'Working Together to Safeguard Children 2015', the Children Act 2004 and the LSCB regulations 2006 (Recommendation).

124. Despite some good work by partner agencies, the SSCB has not fully updated its policies, procedures and work programme to take into account major revisions to the national guidance for LSCBs published 15 months ago. Its website is also not up to date. As a result, external agencies have not been given current advice and guidance. Most importantly, two groups of children, young people and their families who had been identified as a priority for LSCBs, that is, young carers and privately fostered children, have not benefited from the leadership of the board to ensure that they receive at least appropriate, if not good, services.

125. The governance of the board needs improvement. The SSCB chair has regular one-to-one sessions with the chief executive and the DCS. They also meet regularly in a wider group that includes the lead member and the HOS, to scrutinise the work of the local authority and the SSCB. These meetings benefit from the attendance of a chief executive from another local authority to provide independent challenge. However, these arrangements have not ensured that the board is working to the national framework for LSCBs. Following the appointment of the new DCS in October 2015, a review of the work of the SSCB by an independent consultant was jointly commissioned by the DCS and the chair. This concluded in January 2016 and identified that there were issues that needed to be addressed, including that policies, procedures and the work programme were not fully compliant with the national guidance. At the point of the inspection, this issue had still not been fully addressed, meaning that some policies and procedures had been out of date for over 12 months. This is unacceptable. The SSCB's action planning has not ensured that the issues identified in the review were addressed in a timely manner. This has been further compromised by recent staffing difficulties.

126. The current structure of the board includes the business partnership group, which coordinates the work of the subgroups, the child sexual exploitation/missing subgroup, the joint children's and adults' training group, the critical incident panel, the pan-Merseyside child death overview panel (CDOP), the joint Sefton/Liverpool health agencies subgroup, and the bullying/cyberbullying subgroup. There are also task and finish groups on neglect, early help and a subgroup on the locally used casework model concluded in February 2016. The board is well attended by an appropriate range of local agencies. There are two lay members, one of whom has been involved for over three years and has provided a significant range of challenge to the agencies on the board. This structure has not ensured sufficient

delivery of the work programme. This has been recognised by the SSCB, with a recent decision taken to create a new subgroup to look at auditing and performance management and to separate the neglect and early help task and finish group. Work on policies and procedures, and on communications, are subsumed in the work of the other subgroups, and this has resulted in a lack of prioritisation of these vital areas of the LSCB's workload.

127. The SSCB has a clear memorandum of understanding and links with corporate parenting and community safety boards. However, partnership work between the strategic boards requires improvement overall. Recent changes to the Health and Well-being Board (HWB) have been introduced to respond to its limited consideration of children and safeguarding, but it has yet to meet and it is still too early to judge whether the SSCB will have an improved and sufficient influence on the HWB in the future.

128. Multi-agency child protection procedures that are out of date include advice on the serious case review process and the role of the designated officer, who should be contacted when there are concerns about adults in positons of trust potentially abusing children. This is a concern, as some non-statutory organisations may be reliant on the multi-agency procedures for advice and guidance. More up-to-date advice on female genital mutilation is included, due to a pan-Merseyside police procedure, and the child sexual exploitation section makes appropriate reference to 'Working together 2015'. Children who are young carers and those who are privately fostered, both identified as priority groups in the updated guidance published in March 2015, are not included at all. The current threshold document, used by all agencies, on identifying when they should be making referrals to children's services, was updated in 2013 and is not fully compliant with national guidance. The SSCB therefore cannot be certain that these gaps have not prevented any agencies, including the large number of local private and voluntary children's homes in Sefton, from taking appropriate action to safeguard children and young people (Recommendation).

129. The SSCB has not commissioned any serious case reviews (SCRs) this year. Two cases have been appropriately considered and, on the information available, it was appropriate to look at other means of gaining the learning. The SSCB learning and improvement framework describes the approach to looking at practice-based issues. It is clearer in describing SCRs than, for instance, audits. Overall, the framework does not sufficiently concentrate activity on action planning for what has been identified as requiring change. The critical incident panel has looked appropriately at a number of cases and has undertaken 'systems reviews'. However, the recommendations from these reviews have not been specific or measurable and lack timescales. It is therefore unclear what will happen as a result. The panel has concentrated on poorer-quality work. It has not sufficiently looked at good work, so that learning from good practice can be communicated to the children's services workforce. This is a missed opportunity. These issues were identified in the independent review of the SSCB (Recommendation).

130. The SSCB has an established programme of multi-agency themed audits and those completed to date include neglect, child sexual exploitation, vulnerable children and substance misuse. The methodology has been good, with cases looked at in great detail by a wide selection of other agency representatives. However, none of the audits has clear conclusions and action plans. Audit activity has not concentrated specifically on frontline child protection work. Learning from auditing has not been collated or disseminated to enable the SSCB to advise all agencies on ways to improve. The data dashboard used by the board is comprehensive, with performance management provided from the partner agencies. However, this has been insufficiently analysed. The SSCB has acknowledged the weakness of its performance management and its inability to progress actions to improve practice, based on learning from its audit activity. Prior to this inspection, plans were underway to launch a new subgroup to focus on improvements in these specific areas (Recommendation).

131. The SSCB records when it challenges other agencies to improve their services through an action plan tracker. Clearly, work has been done to ensure that partner agencies are fully involved in safeguarding. This includes resolving issues regarding CDOP, ensuring that safeguarding self-audit reporting occurs, involving agencies in multi-agency audits and addressing concerns about the children's homes with out-of-borough placements. However, there is a lack of recording of case-level or thematic challenge. This does not demonstrate that the board has been concentrating activity sufficiently on improving practice. Similarly, section 175 audits covering the academic year 2014-15 were completed by September 2015, section 11 audits were last completed three years ago, and agencies were asked to update their action plans in 2014. However, the recording does not sufficiently evidence that the SSCB vigorously challenged the findings (Recommendation).

132. Despite the significant structural weaknesses of the SSCB, the board has provided strong leadership in some areas in Sefton. Good strategic work underpinned by strong partnership working with other agencies, such as police and health, has resulted in a whole-systems approach to child sexual exploitation. This includes a multi-agency child sexual exploitation SSCB subgroup chaired by the DCS, a public health ongoing child sexual exploitation health needs assessment, the child sexual exploitation victim/offender location map and analysis, and the child sexual exploitation awareness day, which involved a number of events and 300 students from Southport College. Some of the outstanding operational work in relation to prevention of child sexual exploitation seen in this inspection has clearly benefited from the strategic management of the board.

133. The SSCB has maintained a clear oversight of the needs of over 200 children looked after placed by other authorities in Sefton. Due to the mixed and sometimes poor quality of services, this is a priority for the SSCB this year. Work has included the involvement of the providers of children's homes in training, work with Ofsted to address poor-quality residential provision and

visits to the children's homes by a commissioned service to raise awareness of the dangers of child sexual exploitation. The links with independent fostering agencies, however, are not as strong and they do not benefit from the same level of scrutiny or support offered to the independent children's homes.

134. The SSCB has undertaken good work on awareness raising and safeguarding in relation to e-safety and bullying. Initiatives include 'bullybusters', which has a local helpline, organises an anti-bullying conference and supports peer mentoring across schools. It has recently received an award as an anti-bullying special educational needs champion from the Department for Education. A quarterly report is produced specifically for e-safety. A young adviser is looking at how to gather further involvement by young people, and a service has been commissioned to work in local schools to raise awareness.

135. Partner agencies contribute well to the work of the SSCB. Primary and secondary schools are actively involved. Twilight sessions have been held every term over the last two years, with all schools invited. The board has provided good, targeted safeguarding training for all headteachers and safeguarding leads. In Sefton, 99% of schools have completed section 175 audits. Two representative headteachers from the primary and secondary sectors are members of the SSCB. A joint Liverpool/ Sefton health sub-group ensures that the health community (commissioners and providers) is supporting the work of the SSCB. This includes consideration of neglect, out-of-area health support and the MASH. The voluntary, community and faith sectors are highly involved in the work of the board and the representatives ensure participation in the full range of safeguarding training.

136. Significant issues in the functioning of Merseyside CDOP that resulted in a backlog of cases being presented to the panel have been addressed. A new temporary CDOP chair was appointed six months ago, and the work is now being completed to a good standard. The CDOP chair reported that the SSCB's compliance with CDOP procedures was 'extremely good' , that there were good connections between the issues raised at the panel and that the community education programmes, such as 'Safe sleeping' run across Merseyside. In the last business year, CDOP looked at 113 cases, of which 20 related to Sefton. Of these, four had 'modifiable factors'. Positively, there were no issues involving practitioners' learning.

137. The SSCB commissions and provides a wide range of training courses. Last year, 964 individuals attended 16 different courses and this is good. Most attendees were from Sefton council (27%). However, probation and the police only formed 6% of attendees. The training programme was developed following a workforce analysis conducted across the statutory and voluntary sectors. Courses include effective engagement with families, safer recruitment, managing allegations against adults, e-safety for schools and issues about child sexual exploitation. Further work by the board is needed to evaluate the quality of the courses and the impact of the training on improving practice (Recommendation).

138. While board members have met with frontline staff in key partner agencies, including children's social care, the SSCB is not yet fully effective in publicising its work. Social workers spoken to by inspectors had a limited knowledge and understanding of the SSCB. Some did not understand its role and function nor recall any training or learning events such as from SCRs (Recommendation).

139. Learning is widely disseminated through '7-minute briefings'. So far, these have included briefings on child sexual exploitation, missing children and young people and safe sleeping. Following the briefings, referrals from some agencies increased, for example sexual health staff and general practitioners.

140. The annual report 2014–15 is too descriptive. It could be improved by greater analysis of the outcomes of the board's work (such as the audits, reviews, performance management, section 11 and section 175) and what this means for children, young people and families in Sefton (Recommendation).

Ofsted

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 who 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 10 of Her Majesty's Inspectors (HMI) from Ofsted.

The inspection team

Lead inspector: Shirley Bailey

Deputy lead inspector: Cath McEvoy

Team inspectors: Peter McEntee, Graham Reiter, Fiona Milnns, Rachel Holden, Pam Blackman, Neil Penswick

Shadow inspectors: Caroline Walsh, Julia Toller

Senior data analyst: Clare Atkinson

Quality assurance manager: Christine Williams

Ofsted

Any complaints about the inspection or the report should be made following the procedures set out in the guidance 'Raising concerns and making complaints about Ofsted', which is available from Ofsted's website: www.gov.uk/government/publications/complaints-about-ofsted. If you would like Ofsted to send you a copy of the guidance, please telephone 0300123 4234, or email enquiries@ofsted.gov.uk.

The Office for Standards in Education, Children's Services and Skills (Ofsted) regulates and inspects to achieve excellence in the care of children and young people, and in education and skills for learners of all ages. It regulates and inspects childcare and children's social care, and inspects the Children and Family Court Advisory and Support Service (Cafcass), schools, colleges, initial teacher training, further education and skills, adult and community learning, and education and training in prisons and other secure establishments. It assesses council children's services, and inspects services for children looked after, safeguarding and child protection.
If you would like a copy of this document in a different format, such as large print or Braille, please telephone 0300 123 1231, or email enquiries@ofsted.gov.uk.
You may reuse this information (not including logos) free of charge in any format or medium, under the terms of the Open Government Licence. To view this licence, visit www.nationalarchives.gov.uk/doc/open-government-licence, write to the Information Policy Team, The National Archives, Kew, London TW9 4DU, or email: psi@nationalarchives.gsi.gov.uk.
This publication is available at www.gov.uk/government/organisations/ofsted.
Interested in our work? You can subscribe to our monthly newsletter for more information and updates: http://eepurl.com/iTrDn.

Piccadilly Gate
Store St
Manchester
M1 2WD
T: 0300 123 4234
Textphone: 0161 618 8524
E: enquiries@ofsted.gov.uk
W: www.ofsted.gov.uk
© Crown copyright 2016