2 August 2016

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Dear local partnership

Joint targeted area inspection of the multi-agency response to abuse and neglect in Liverpool

Between 20 and 24 June, Ofsted, the Care Quality Commission (CQC), HMI Constabulary (HMIC) and HMI Probation (HMI Prob) undertook a joint inspection of the multi-agency response to abuse and neglect in Liverpool.[1] This inspection included a 'deep dive' focus on the response to child sexual exploitation and those missing from home, care or education.

This letter, to all the service leaders in the area, outlines our findings about the effectiveness of partnership working and of the work of individual agencies in Liverpool.

Multi-agency senior leaders across the partnership in Liverpool share a vision, ambition and commitment to protect and improve the lives of their vulnerable children and young people. Despite the many challenges they face – they operate in a context of increasing demand for services and substantial reduction in resources – we found evidence of strong collaboration between agencies.

However, we also identified serious and widespread deficits across the partnership, which senior managers and the Local Safeguarding Children Board (LSCB) did not know about until this inspection. These include failings to protect some children and young people from harm at the 'front door', including those at risk of being sexually exploited and who are missing from home and care. Ineffective performance management and quality assurance – particularly within children's social care and

[1] This joint inspection was conducted under section 20 of the Children Act 2004.

Merseyside Police – prevent senior managers from understanding and acting on these and other fundamental deficits in frontline practice.

Areas for priority actions

Leadership

- Ineffective management oversight means that statutory child protection enquiries are not consistently undertaken by children's services or jointly investigated by the police. The Careline (front door) contact team refers children at risk of significant harm promptly to the co-located police and social work joint investigation team (JIT). However, these cases are not considered for joint investigations at the point of referral. Instead, JIT social workers undertake the assessment or investigation as a single agency. It is only if there is evidence of an offence that the police will become involved, following a further strategy discussion. Such practice is unacceptable; it is not compliant with 'Working Together' and it contributes to delays in identifying (and so protecting) children and young people at risk of harm. Inspectors identified a small number of cases where the police failed to carry out a joint investigation when children had alleged physical abuse and had visible injuries. In these cases, social workers and their managers failed to make arrangements to have children medically examined, deciding that the injuries did not warrant this. There is limited evidence of the recording of strategy discussions or meetings on police systems. For some children, this means that if further incidents take place, full information is not available to police officers about previous risk or concerns.
- In most cases looked at which involved children who either are or are at risk of being sexually exploited, joint investigations are not routinely undertaken. Risk is not assessed urgently and joint planning to identify actions to safeguard children is delayed. A failure of management in children's social care is resulting in a lack of clarity about section 47 strategy meetings, child sexual exploitation meetings and multi-agency child sexual exploitation meetings (MACSE). Consequently there is duplication and delay in progressing work. Inspectors found some children waiting for weeks before receiving effective interventions to reduce harm. In addition, in some cases we found a lack of urgency in speaking to victims after allegations had been made. This leads to delays in understanding the impact on the victim, building rapport and the gathering of evidence. We also found repeated failures by the police to speak to suspects about specific allegations of sexual exploitation.
- Return home interviews (after children go missing) are not being undertaken consistently. Those completed take place generally after 72 hours and the quality seen is poor. It is not always evident whether the information is passed to the appropriate person or agency to take action. Information sharing across the partnership (including senior management oversight) is weak. Currently, there is

no senior leader multi-agency system for aggregating or cross-referencing information from return home interviews for those children who are at risk of being, or are being, sexually exploited. Inspectors did not see 'missing' strategy meetings being held in the cases tracked for children who regularly go missing and are at risk of sexual exploitation. This is not in keeping with the local authority's own procedures, and means that preventative work around the child may be missed. Inspectors saw a number of cases where the police had failed to identify children at high risk when they were missing from home and significant concerns had been raised.

- A partnership finding following the Ofsted inspection under the single inspection framework published in July 2014 concluded that, 'The local authority needs to work with partner agencies to improve the quality of partnership working in key areas'. These included strategy meetings and the application of statutory thresholds. The required improvements have not occurred. Multi-agency strategy meetings remain a significant cause for concern and thresholds are not embedded or consistently applied. The sporadic use of the multi-agency referral form exemplifies this finding, and leads to too many inappropriate referrals to children's social care. Partners are revising the LSCB levels of needs framework and are in dialogue with the local authority regarding 'risk & demand' analysis; inspectors consider that such actions should be prioritised urgently, as the pace of change is too slow. Confusion regarding thresholds, coupled with issues of capacity, create drift and delay in assessing risk by key partner agencies.
- Performance management and quality assurance within children's social care and Merseyside Police are underdeveloped, with the former being over-reliant on paper generated data until a new children's electronic system is fully implemented. There is no evidence of risk assessment by senior social care managers during this transitional period. Management grip on performance is weak, resulting in inconsistent and poor practice in a number of cases seen at the front door and in the tracked and sampled cases. The multi-agency audit of children at risk of sexual exploitation did not consider the effectiveness of management oversight, or the failure to comply with statutory responsibilities around joint investigations. This demonstrates a lack of critical enquiry by senior managers and leaders, and a failure to recognise and analyse poor practice across the partnership.

Case study: area for priority action

Arrangements to manage child protection referrals from Careline to the multi-agency safeguarding hub (MASH) and the JIT are fragmented. Information sharing is ineffective in high-risk cases, with partners not always represented at strategy discussions, leading to an incomplete picture of children's lived experiences or the risks they might be exposed to. Cases involving children at higher levels of risk are passed promptly to the JIT, but without the benefit of input from the MASH. This is leading to duplication and delay within the JIT, with social workers having to hold additional meetings to gather information.

Areas for improvement

Leadership and management

- There are delays in the MASH process as a result of the high volume of referrals. There is no triage process in place, except for domestic abuse referrals. This leads to delays in children accessing services. Urgent referrals are appropriately referred to the JIT team, but multi-agency checks are not completed by agencies in the MASH on these cases. This is a missed opportunity to use the expertise, shared intelligence and knowledge of health and probation practitioners. There is a large backlog in the MASH of notifications of police incidents, at various stages of completion. At the time of inspection, there were 481 incidents that had been initially assessed but were awaiting further information prior to referring to Careline. The oldest of these was from the first week in June 2016. There were also: 44 requests for strategy discussions (with one from April 2016); 143 requests for police information and 18 unprocessed MASH cases. There is a lack of quality assurance processes for police work in the MASH to support effective service.
- The health landscape across Liverpool is complex and is not clearly articulated or understood by multi-agency partners. The clinical commissioning croup (CCG) recognises that there is more to do to promote the benefits of information held across multi-disciplinary health teams to partner agencies, and to consider how this important information could be used to inform the safeguarding process to better protect vulnerable children and young people. There are longstanding concerns about school nurses, health visitors and midwifery not taking on the lead professional role or completing early help assessments. This has been escalated by the LSCB chair but action by senior health and public health leaders to address concerns is too slow.
- Management arrangements for the safeguarding of children and young people when they are assessed at adult emergency departments (EDs) in Liverpool are

inconsistent and not robust. Aintree ED uses separate casualty assessment cards for attendees aged under 18 years. These clearly prompt practitioners to request important information pertaining to risks to children and young people. This helps practitioners recognise and consider the additional needs and risks to children from, for example child sexual exploitation, female genital mutilation and honour-based violence, ensuring that escalation to other agencies is completed in a timely manner. However, this is not the practice at Royal Liverpool, where there are no separate ED cards or documentation. For example, inspectors saw records of a 16-year-old child who had been classified as an adult.

- School nurses do not currently provide sexual health services at their school drop-in sessions. This is a missed opportunity for school nurses to be more involved in the safeguarding process, by being able to better develop proactive working relationships with young people in their care. School drop-in sessions are currently underused by Liverpool children.
- There is active cooperation and involvement of senior leaders across Liverpool in raising awareness and in the development of processes regarding child sexual exploitation, supported and informed by the Pan-Merseyside joint procedures. Before the inspection, managers identified that more work was required to ensure that all practitioners on the ground understand the referral pathways into the multi-agency child sexual exploitation (MACSE) and pre-MACSE meetings. Currently, the MACSE meeting does not work effectively to support timely, coordinated, frontline safeguarding activity. Actions are not monitored by managers or completed, and in some cases the same actions are repeated again in the subsequent monthly meetings.
- Although there is clear evidence of strategic leadership and direction within the police, this has not yet been translated into consistent improvements in operational delivery. This has resulted in a clear gap between strategy and operational activity. As a consequence, and despite the intent to improve, the police are not yet consistently making effective decisions to protect children.
- Social care managers at Careline do not have access to reliable performance data to support effective management of the service. Service managers report little data about the volume of work, the sources of referral or the outcomes. As a result, managers cannot effectively monitor performance and so cannot be assured that children receive timely interventions.

Identification and managing risk of harm at the 'front door'

- Referrals to social care from partner agencies are not of consistently good quality, with the majority being made as a result of telephone contact. There is an agreed multi-agency referral form (MARF) which should be used as a referral tool. However, most agencies do not comply with this requirement. As a result, vital information to inform decision making is not captured. In most cases, it is not clear if consent has been obtained from families prior to the referral. This creates

additional unnecessary work in a system which is already under stress, and is causing further delay for children. Managers in social care have escalated this issue to the LSCB, but this has not resulted in improvement.

- Work is ongoing to ensure that health practitioners within the MASH have better access to information across health providers, including GPs, so that they can better inform the safeguarding process. The GP lead for digital within the CCG is reviewing electronic systems and considering ways that MASH health practitioners can gain access to that information. However, in the interim, it is recognised that the diversity of systems used across the health agencies hinders the accessibility and use of information when assessing risk to children.
- Frontline assessment teams have high caseloads, with many staff seen having between 30 and 39 cases each. As a result, workers have backlogs of cases needing to be written up for closure or transfer. Inevitably, this is causing delay for some children. This is as a result of a six-month period when work could not be transferred from the assessment teams to court care planning teams because of staff shortages. Senior managers have recently established an extra children in need team and, as a result, caseloads are beginning to reduce, enabling social workers to improve the quality of their assessments.

Responses to children missing and at risk of sexual exploitation

- Ineffective management means that the processes for the identification, referral and assessment of risk – particularly those associated with child sexual exploitation – are confused, and this creates delays in making decisions and implementing protective plans. Professional activity is often focused on the delivery and maintenance of a process, either MACSE or associated child sexual exploitation safeguarding enquiries, rather than the delivery of timely interventions that improve outcomes for children.
- Communication from MACSE to frontline staff across agencies is not timely and does not encapsulate all details and actions from the meeting, and therefore it does not underpin coordinated multi-agency planning with the young person. Practitioners working with young people are not invited to MACSE meetings. Adult health practitioners, for example, often hold information pertaining to adults who have parental or caring responsibilities for vulnerable young people, but they are rarely invited to inform or attend MACSE meetings. This is a missed opportunity to gain important information about adults who often lead chaotic lifestyles, which are known to have a detrimental effect on children in their care and those 'hidden from view'.
- There was no evidence of liaison by health practitioners with GPs regarding child sexual exploitation cases. It has not been possible to ascertain whether GPs are aware of young people known to the local authority and police as being at risk of sexual exploitation, as this information is not collated.

- Recently improved systems are in place to monitor children who are missing from home or care. All children missing are assessed by police using the pan-Merseyside criteria. Police review cases daily. Careline receives information on all missing episodes and enters them into the electronic system. Careline staff risk-assess all episodes and grade the priority. Episodes on previously closed cases or unknown children are reviewed by the child sexual abuse coordinator. All episodes about children known to the child in care service or who are children in need are sent to the allocated social worker or the targeted support services to complete return home interviews. However, this is not resulting in an effective approach to managing risks or in the routine completion of return home interviews.

Key strengths

- There is a strategic commitment and clear ambition to improving services for children across the partnership. This is evidenced well in overarching joint strategic priorities and plans.
- Members work well together cross-party to prioritise children's services. Resources are being protected, with an additional £6 million from council reserves. There is evidence of strong partnership working. For example, subject to a decision by the board, the CCG may commit £1 million to support children's centres. All members have been briefed on child sexual exploitation and they informed inspectors that they expected the same standard of response applied to all vulnerable children in Liverpool.
- The police have good working relationships with local authority partners and other services that operate across the area. There is substantial investment in the child sexual exploitation teams and coordinators. Inspectors saw some examples of the effective engagement with young people to deliver improved outcomes.
- The sophisticated analysis of the child sexual exploitation problem profile by Merseyside Police has improved senior leaders' ability to assess the nature and extent of sexual exploitation risk across the force area. It has also ensured that suitable multi-agency resources are commissioned and targeted appropriately.
- Members of the Local Safeguarding Children Board demonstrate a whole systems approach to safeguarding, with activities and subgroups linked in to strategic priorities. Awareness raising activity with practitioners, elected members, children and young people and key members of the community, such as taxi drivers and hoteliers, has recently been strengthened.
- The availability and quality of multi-agency training are generally good and linked to board priorities. Financial commitment by key partner agencies has ensured that this training is also accessible to the third sector, encouraging take-up and leading to opportunities to improve practice in the approach to assessment reported by those agencies.

- Evidence of significant work with school leaders in partnership with 'School Improvement Liverpool' is raising awareness of child sexual exploitation effectively in many schools. Twenty-two of 24 secondary schools have used 'Chelsea's Choice' training materials successfully and, as a result, have increased referrals to children's social care. Headteachers are clear about referral pathways, and articulated clearly their involvement in pre-MACSE and MACSE meetings, leading to greater confidence in identifying children at risk of exploitation.
- The implementation of an integrated early help strategy is a partnership priority. While progress has been slow, it is beginning to have an impact; in the last two quarters there has been a 7% reduction in referrals to social care. Quality assurance processes are being embedded to ensure that children at risk are receiving the requisite level of support.
- Children missing from education is an area for strategic priority action. The director of children's services wrote to all parents in the city regarding persistent absence, and setting out the minimum attendance expectation of 97%. This led to a partnership action plan to identify persistent absentees and correlate across to other known areas of need. A pilot scheme currently in place in some schools identifies children if attendance drops below 90%, when children are referred to the education welfare service. More work is required to ensure that information on children absent from school is cross-referenced with those at risk of exploitation and abuse.
- Careline's 24-hour service provides good continuity and communication between daytime and out-of-hours services. Staff work on 'shifts' in both parts of service, so they have sufficient resources available to undertake home visits and write up brief assessments. This enables children to be seen on the same day, even if their referrals were made at the end of office hours.
- Within the youth offending team there is a good understanding of child sexual exploitation and effective management oversight of this work at an operational level. Partnership working is strong and decisions on who should lead on particular areas of work with young people are based on need. The Community Rehabilitation Company (CRC) demonstrates a high level of commitment to partnership working and is well represented on partnership groups. The National Probation Service (NPS) is represented on both strategic and operational partnership groups. The service participates in joint audit and other service improvement activity.
- The NPS manages high-risk perpetrators of child sexual exploitation and multi-agency public protection arrangements (MAPPA) are used effectively for the very high risk cases. There are high levels of awareness of child sexual exploitation within NPS and staff have been trained to identify and respond effectively. NPS is represented at MACSE meetings and provides information on adult offenders linked to young people. It also ensures that information related to vulnerable children is disseminated to offender managers when necessary. Information from

children's services is logged on NPS case management systems and taken into account in supervision decisions, although in some cases new information is not sufficiently reflected in assessments. The CRC displays high levels of commitment to reducing child sexual exploitation and its staff are trained to recognise and respond to indicators of child sexual exploitation.

- The integrated sexual health and genito-urinary medicine (GUM) service at Royal Liverpool Hospital hosts a twice-weekly lesbian, gay, bisexual and transsexual clinic, with a key objective of encouraging young gay and bisexual people to have sexually-transmitted infection screening. This facilitates engagement by a group of young people who might otherwise find such engagement difficult and thereby enhances the opportunity to identify risks.
- The Brook sexual health service practitioners use a comprehensive risk assessment tool to determine the risk of sexual exploitation to children under 18. This 'professional curiosity' was evident in cases seen by inspectors, resulting in key information about risks being obtained from young people who are difficult to engage. An effective system to monitor or escalate cases of concern prevents drift.
- The 'Protect' targeted youth support team and the youth offending team are successfully engaging with young people experiencing sexual exploitation and other forms of abuse. Young people spoken to gave an articulate and consistent view of how services were helping them to make positive changes. There is evidence of persistent relationship-based work, reducing risks and building resilience.

Case study: highly effective practice

The local authority provides targeted youth support groups for girls and young women who have been subject to sexual exploitation in Liverpool.

Inspectors met with five young people, all of whom spoke positively about their experiences of support provided by youth workers who ran the group. All of them said that if it were not for this initiative, their personal circumstances would be much worse.

One young person talked about not being able to recognise that she was in an abusive relationship: 'The group taught me about abuse in relationships, I thought I was in love and... I realised that it was not love, I was being controlled.'

These girls and young women are now safer and the risk of further exploitation is reduced. They are more able to recognise the signs of abuse and their lives have changed for the better. They feel more confident in being able to identify potential signs of sexual exploitation and feel that they can recognise and avoid risky situations in the future.

Group members have been recruited as paid advisers by the LSCB and form part of a group that will help shape the future of services for young people in Liverpool. This role is having a positive impact not only on their levels of confidence, but also in their self-belief and self-esteem.

During the time that the group has been in existence, girls have been removed from abusive situations, gained employment, returned to education, developed parenting skills and rebuilt family relationships. They described feeling happy and that they could see a positive outlook for themselves. One girl told us 'My youth worker never gave up and I am so glad she didn't, otherwise I don't know where I would be.'

Next steps

The local authority should prepare a written statement of proposed action responding to the findings outlined in this letter. This should be a multi-agency response involving the LSCB partnership and, specifically, the police, children's social care, and health services. The response should set out the actions for the partnership and, where appropriate, individual agencies.[2]

[2] The Children Act 2004 (Joint Area Reviews) Regulations 2015 www.legislation.gov.uk/uksi/2015/1792/contents/made enable Ofsted's chief inspector to determine which agency should make the written statement and which other agencies should cooperate in its writing.

The local authority should send the written statement of action to protectionofchildren@ofsted.gov.uk by 8 November 2016. This statement will inform the lines of enquiry at any future joint or single agency activity by the inspectorates.

Yours sincerely

Ofsted	**Care Quality Commission**
Chris Russell Regional Director	Sue McMillan Deputy Chief Inspector
HMI Constabulary	**HMI Probation**
Wendy Williams Her Majesty's Inspector of Constabulary	Chief Inspector