

Liverpool City 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 board¹

Inspection date: 20 May 2014 – 11 June 2014

Report published: 18 July 2014

The overall judgement is **requires improvement**.

There are no widespread or serious failures that create or leave children being harmed or at risk of harm. The welfare of looked after children is safeguarded and promoted. However, the authority is not yet delivering good protection and help and care for children, young people and families.

It is Ofsted's expectation that, as a minimum, all children and young people receive good help, care and protection.

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

The effectiveness of the Local Safeguarding Children Board (LSCB) is **requires improvement**.

The LSCB is not yet demonstrating the characteristics of good.

¹ Ofsted produces this report under its power to combine reports in accordance with section 152 of the Education and Inspections Act 2006. This report includes the report of the inspection of local authority functions carried out under section 136 of the Education and Inspection 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.

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Section 1: the local authority

Summary of key findings

This local authority requires improvement and is not yet good because

1. There is no clear, single 'master plan' across Children's services which allows progress to be tracked or shows how all the changes taking place are helping to improve services for children.
2. "Performance management within Children's Social Care is underdeveloped and relies on manually generated data. This limits the ability of some senior managers in Children's Services to have a good enough window on frontline practice"
3. The turnover of social work staff is high and too many are agency staff. There is no comprehensive workforce competency framework or performance appraisal.
4. The arrangements for early help are not fully embedded across agencies in Liverpool who work with children, young people and their families.
5. The local authority needs to work with partner agencies to improve the quality of partnership working in key areas including strategy discussions, MAPPA arrangements and the embedding of thresholds.
6. Social workers' caseloads are variable and some are too high.
7. Social workers' supervision records are variable in quality, detail and frequency, and do not show reflective practice.
8. The quality of assessment and intervention with children, young people and their families is too variable and children's views are not asked for or taken into account in enough cases.
9. The local authority was unaware that referrals and assessments were unallocated in one safeguarding team. Current arrangements mean that the local authority cannot assure itself that similar unauthorised arrangements will not reoccur.
10. Child protection plans are not consistently outcome-focused and measurable.
11. There is no information-sharing protocol between the local authority and health partners to enable the names of children missing from education to be shared without parental consent. This means that these children are not supported.
12. Not all services are effectively evaluated for their effectiveness, taking into account the views of children and their families and staff.
13. Too many children are placed at home with their parents under Placement with Parents (PwP) regulations; some with no assessment or plan.
14. Some children are not having direct work or life story work when they should.

15. Case recording for looked after children is not consistently of a good enough standard.
16. The independent reviewing officer (IRO) service is not fulfilling all its statutory duties, and caseloads of IROs are too high.
17. There is no monitoring system in place to ensure that return home interviews are always carried out and done well enough after a looked after child has gone missing.
18. The achievement gap between looked after children and all pupils in Liverpool remains too wide and personal education plans contain insufficient information about levels of progress being made.
19. Looked after children with more complex emotional and mental health needs have to wait too long to get specialist help.
20. The fostering service improvement plan lacks timescales by which objectives are to be achieved, making evaluation of progress difficult.
21. It takes the local authority too long to identify a suitable family once the court has agreed that a child should be adopted. Managers are not sure they know about all children where adoption may be a potential option. Some adopters experience too much delay between their initial enquiry and next steps.
22. The majority of pathway plans lack measurable outcomes and are not understood by the young people. Services for care leavers over the age of 18 are insufficient and require review and improvement.
23. Partnerships, including the Children's Trust Board (CTB), the Health and Well-being Board and the Local Safeguarding Children Board (LSCB), do not have sufficient good quality performance information. Their strategic and delivery plans are not sufficiently outcome-focused, specific or measurable.
24. The placement sufficiency statement provides no meaningful information about future patterns of need or supply, and the draft commissioning strategy lacks sufficient detail.

The local authority has the following strengths

25. The local authority knows itself well and is working on a range of improvements.
26. Inspectors saw individual examples of good social work practice where interventions were having an impact and making a difference to children's lives.
27. The early intervention team works well with a variety of partners to deliver good support for children and families. This often results in positive, sustained change.
28. Effective liaison between CAF co-ordinators means that children and families who move across local authority borders are provided with help and support.
29. Good awareness-raising activities regarding private fostering have taken place, resulting in increased enquiries from partner agencies, including 12 advance notifications from a local language school.
30. The Director of Children's Services' efforts to raise awareness of child sexual exploitation with schools has had a positive impact and there has been an increase in disclosures from young people of sexual exploitation, particularly since the roll out of a powerful theatre production to secondary schools.
31. Children who are missing education are tracked and followed up quickly. Schools report children missing promptly. The local authority provides good support for children who are known to be receiving elective home education (EHE).
32. Children are benefitting from the local authority's positive and improving performance in achieving legal orders for children more swiftly.
33. The local authority is successful in placing the vast majority of looked after children within the city or in neighbouring authorities, enabling most looked after children to have continuity of support from professional staff who know them.
34. Some looked after young people co-chair or take the minutes of their reviews.
35. The majority of children live in stable foster placements that meet their needs.
36. There is good consideration of children moving to live with their extended family and friends instead of strangers, when they cannot remain at home. The use of Special Guardianship Orders (SGOs) is increasing.
37. Looked after children make satisfactory or better educational progress for their age. Their progress is carefully tracked.
38. Good guidance is given to schools about how the pupil premium should support looked after children. Initiatives to raise the attainment of looked after children are successful, for example, the reading project which starts at reception age has resulted in this group improving their reading levels significantly.

39. The looked after children education service (LACES) provides training for school staff about the trauma and attachment issues experienced by looked after children. This helps school staff to better support looked after children.
40. No looked after child has been permanently excluded for over three years and the number receiving fixed term exclusions continues to decrease. Nearly all children attend good or better schools and no child is attending inadequate provision. Attendance of looked after children in primary and secondary schools is high and better than the Liverpool average.
41. The regular Children in Care scrutiny meeting allows care leavers to influence service development through regular access to senior council officers who attend the meetings and progress pan-council initiatives.
42. The adoption service is working hard to recruit carers from diverse parts of the community. For example, there are currently nine same-sex couples at different stages of the approval and matching process. Feedback on the adoption support team confirms it is well regarded by families and meets their needs.
43. A conference held in 2014 was successful in increasing awareness in Liverpool's schools of the needs of adopted children.
44. There is a good variety of trainee, apprenticeship and work preparation programmes for care leavers, supported by information, advice and guidance workers up to their 19th birthday. Care leavers who attend university are well supported financially and practically.

What does the local authority need to improve?

Priority and immediate action

The inspection did not find any areas for priority and immediate action.

Areas for improvement

45. Improve the triage and timeliness of notifications of domestic abuse made by the police to Careline and improve Children's Services attendance at MAPPA meetings.
46. Strategy discussions should always include relevant partner agencies to ensure that key information held by those agencies is fully taken into account when deciding on next steps. All section 47 enquiries and their outcomes must be clearly recorded on the child's electronic record.
47. Ensure that all social workers, including agency social workers, have manageable caseloads, in line with their experience and role.
48. Review the impact and effectiveness of the pilot duty system to ensure it meets its aims of reducing caseloads, enabling good quality social work practice, and improving workflow across the service.
49. Improve all assessments of children so that they take full account of their needs and of risks, take the child's experience into account, and result in clear, evidence-based plans to meet those needs.
50. The quality assurance role of the Safeguarding Unit staff, child protection conference chairs and IROs, and managers, should be developed to utilise and aggregate their knowledge of practice to contribute to improving standards of practice.
51. The child protection advocacy service should be publicised so that all staff and managers are clear about its offer and its eligibility criteria. Children and young people should be aware of this service and encouraged to use it.
52. The local authority and its statutory partners should agree legal means by which information can be shared in relation to children known to health services but who may not be on a school roll.
53. Improve the quality of the adoption service and the scrutiny of its progress, for example by providing the adoption panel with aggregated data on performance, including the quality of reports, timeliness of life story work, and the views of adopters about the adoption process; and systematically track all looked after children once they have had their second statutory review to ensure that drift and delay in permanency planning are minimised.
54. Ensure that all children who would benefit from life story work receive this, and where children are placed for adoption, that their life story book is available to them and their adopters when they are placed.

55. The quality of case recording must be improved so that the child's experience and views are clear. This should include improvements in identifying, recording and responding to children's diverse backgrounds so that their identity becomes more central to understanding, identifying and meeting their needs.
56. Management oversight of social work practice, including formal supervision, must be consistent, robust, properly recorded on both the worker's supervision file and the child's file and include evidence of reflective practice. This should include informal supervision and case direction.
57. Develop effective monitoring systems to capture and build up intelligence and themes regarding children and young people who have gone missing from home and care. This should include compliance monitoring of return interview completion and quality.
58. All children living with their parents under the Placement with Parents Regulations should be supported by full risk assessments and clear support plans to ensure that they are thriving and their needs are being met. Care orders should be discharged where the local authority considers it no longer needs to share parental responsibility.
59. The local authority, in partnership with commissioners and providers, should ensure that all looked after children are provided with timely specialist mental health services when this has been assessed as being required.
60. Improve the attainment at Key Stage 4 and the progress in closing the wide gap in achievement between looked after children and all pupils in Liverpool in primary and secondary schools.
61. Improve services for care leavers including: better pathways plans which young people understand and find useful, informed by up-to-date assessments; good access to independence preparation programmes; accessible information about their entitlements; more suitable accommodation, with sufficient support where required, including the option to remain living with their foster carers; and an increased leaving care grant.
62. Develop targeted plans and interventions to decrease the number of 18 to 20 year-old care leavers who are NEET and increase the number of 16 and 17 year-olds attending further education courses. Ensure that the most vulnerable care leavers over the age of 18 years are known and provided with targeted services, including swift access to emotional and mental health services and addressing their high levels of being NEET.
63. Ensure that all strategic plans are informed by needs assessments and take account of future projected demands. This includes the Children and Young People's Plan and the Sufficiency Plan for looked after children. Plans must be outcome focused, specific and measurable to drive forward improvements.
64. Implement the new electronic recording system for children's social care and at the earliest opportunity.

65. Ensure the new quality assurance framework in children's social care is informed by performance management information which is accurate and up-to-date and provides insight into the activities of children's social care. It should focus on ensuring that children receive a minimum standard of social work service and that practice developments are informed by the experiences of children, young people and families, including learning from complaints.
66. Devolved decision-making should be supported by clear written accountabilities and responsibilities so that staff and managers at all levels within children's social care understand their respective responsibilities and what they are accountable for.
67. Workforce development plans should include recruitment and retention arrangements that deliver a stable workforce which reflects the diversity of the local population, and should include an effective workforce competency. Account should be taken of the need to support managers at all levels by building their capacity.

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 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 six of Her Majesty's Inspectors (HMI) and two Additional Inspectors from Ofsted.

The inspection team

Lead inspector: Sheena Doyle

Team inspectors: Nigel Parkes, Janet Fraser, Judith Nelson, Debora Barazetti-Scott, Stella Butler, Nick Stacey and Dominic Porter-Moore.

Information about this local authority area²

Children living in this area

- Approximately 88,911 children and young people under the age of 18 years live in Liverpool. This is 19% of the total population in the area.
- Approximately 33% of the local authority's children are living in poverty (the national average is 20%).
- The proportion of children entitled to free school meals:
 - in primary schools is 29% (the national average is 18%)
 - in secondary schools is 27% (the national average is 15%).
- Children and young people from minority ethnic groups account for 16% of all children living in the area, compared with 21% in the country as a whole.
- The largest minority ethnic groups of children and young people in the area are 'Asian or Asian British', 'Black or Black British' and 'Mixed'.
- The proportion of children and young people with English as an additional language:
 - in primary schools is 11% (the national average is 18%)
 - in secondary schools is 7% (the national average is 14%).
- Levels of deprivation in Liverpool are particularly high and many wards are ranked as being in the most deprived 1% to 10% nationally. Household income during 2012 was the second lowest of the eight core cities in England and fell by over £700 between 2011 and 2012. Almost 40% of households are living at or close to the poverty line. Child poverty is significantly higher than the national average, with approximately one in three children living in poverty, whereas the national figure is one in five.
- 82% of Liverpool Schools have been judged by Ofsted to be good or outstanding and attainment at the end of the Key Stage Four is above the national average. In school inspections, pupil safety and safeguarding are judged as at least good in the majority of cases.

Child protection in this area

- At 21 May 2014, 4,277 children had been identified through assessment as being formally in need of a specialist children's service. This is an increase from 4,079 at 31 March 2013.
- At 21 May 2014, 431 children and young people were the subject of a child protection plan. This is an increase from 342 at 31 March 2013.

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.

- At 21 May 2014, five children lived in a privately arranged fostering placement. This figure is similar to the 31 March 2013 figure, when the data was suppressed (five or less).

Children looked after in this area

- At 21st May 2014, 1,000 children are being looked after by the local authority (a rate of 111 per 10,000 children). This is an increase from 957 (108 per 10,000 children) at 31 March 2013. Of this number:
 - 340 (or 34%) live outside the local authority area
 - 33 live in residential children’s homes, of whom 58% live out the authority area
 - 3 live in residential special schools³, of whom 2 live out of the authority area
 - 698 live with foster families, of whom 36% live out of the authority area
 - 188 live with parents, of whom 18% live out of the authority area
 - 5 children are unaccompanied asylum-seeking children.
- In the last 12 months:
 - there have been 48 adoptions
 - 25 children became subjects of special guardianship orders
 - 361 children have ceased to be looked after, of whom 2.5% subsequently returned to be looked after
 - 96 children and young people have ceased to be looked after and moved on to independent living
 - 2 children and young people have ceased to be looked after and are now living in houses of multiple occupation.

Other Ofsted inspections

- The local authority operates three children’s homes. Two were judged to be good or outstanding in their most recent Ofsted inspection.
- The previous inspection of Liverpool’s safeguarding arrangements was in April 2011. The local authority was judged to be good.
- The previous inspection of Liverpool’s services for looked after children was in April 2011. The local authority was judged to be good.

Other information about this area

- The Director of Children’s Services has been in post since August 2012.

³ These are residential special schools that look after children for fewer than 295 days.

- The chair of the LSCB has been in post since January 2014.

Inspection judgements about the local authority

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

68. The early intervention team provides a wide range of services and resources to support children and families at times of significant stress or crisis. There is good partnership working with, for example, disabled children's services, housing staff, police and health partners. This enables individualised, multi-disciplinary packages of support for children and families that often result in positive and sustainable changes for them. Parents, children and professionals value the support provided, and parents who spoke to inspectors said of the service: 'our lives have turned around', 'it stopped things from getting completely out of control', and 'helped me find my confidence again'. Feedback about the newly formed family support 'team around the schools' is positive, but this service is too new to see its impact.
69. The number of common assessments (CAFs) completed has increased significantly over the last two years. After a slow take up by partner agencies, most are now using the CAF effectively to ensure the right level of help is provided quickly. The quality of plans has also improved. In most instances cases are closed appropriately when outcomes have been successfully achieved or 'stepped up' for more intensive interventions or to statutory services when necessary. Effective liaison between the Merseyside CAF co-ordinators ensures continuity of support for children and their families who move across local authorities.
70. Lead professionals are keen to implement the new early help assessment tool (EHAT) which will replace the CAF from September 2014. 41 EHATs have been completed which is promising. The EHAT is scheduled to 'go live' in schools at the beginning of the Autumn term 2014, and school staff are positive about the early help tool and the preparation they have received.
71. Careline, the single point of entry for children's social care services, responds promptly to requests for information and services. All decisions are made by suitably qualified social workers and signed off by social work managers. However, the quality of information provided by partner agencies is variable and is sometimes poor. This leads to unnecessary work in the already very busy team. The volume of contacts and referrals remains high. Understanding and application of the 'Responding to Needs' threshold document is not yet fully embedded.
72. Domestic abuse notifications to Careline vary in quality and timeliness. Reports are sent in batches, and in one case seen, a situation of significant violence, there was a delay of several days before the notification was received. Such delays have the potential to leave children at risk of harm.
73. The local authority's standard of transferring referred children to the social work safeguarding teams within two days is not met in all cases, resulting in some children not receiving the services they need promptly. However, in those cases

seen by inspectors where there was delay, no critical safeguarding concerns were identified.

74. Where children are at risk of significant harm they are responded to swiftly, although the sequence of events is sometimes unclear. Strategy discussions are not always held at the outset, and often only include children's social care and the police, which means that key information held by other agencies is not considered at this point. Child protection enquiries (section 47 enquiries) are completed, but in some cases are not recorded, and the record of action taken is not always sufficiently detailed. In contrast, the co-located joint investigation team (JIT) hold prompt strategy discussions with the police, which include relevant health information, and these are recorded well.
75. Social work safeguarding teams receive a high number of referrals each week. Caseloads are variable and in some teams they are too high. Caseloads vary from 29 to 45, with one social worker noted as holding a caseload of 54 children. A pilot duty system is being trialled in part of the service to address this. Early signs are promising but it has yet to be rolled out across the whole of children's social care and its sustainability is unknown.
76. Family support workers work closely with social workers, providing practical help and support to children, young people and their families. Inspectors saw individual examples of the positive impact of their work, for example in helping parents to better meet their children's needs or to improve home conditions.
77. The quality of assessment and intervention of children, young people and their families is variable, ranging from inadequate to good. The quality of some child in need cases (section 17, Children Act 1989) shows limited understanding of the impact on children of domestic abuse, parental mental ill-health and substance misuse. Records also lack consistent analysis of risk, protective factors and children's needs. In contrast, some good examples of holistic assessments, consideration of children and young people's needs and risk factors were seen.
78. In some cases, good liaison with the adult emergency mental health service occurred, resulting in children being appropriately safeguarded whilst parents' needs were also met. Liaison with substance misuse agencies also occurred in some cases seen. In other instances, there was too much emphasis on the needs of adults in the household, insufficient triangulation of positive parental self-reporting of circumstances, and weak identification of risk and analysis.
79. Assessments in the JIT and court teams, which have lower caseloads, are consistently better than in the safeguarding teams, where caseloads are high. Whilst no children were identified by inspectors as currently unsafe, significant drift and delay was evident for some children and was identified in the local authority's own audits.
80. Children and young people are mostly seen, and seen alone, by their allocated workers. In some cases there is evidence of good direct work with children, using a range of resources, such as games and drawings, to gather their wishes and views and help understand their experiences. However this was not

consistent, and in other cases children's views were not given sufficient consideration. Translators are used and documents are translated into other languages when needed. Consideration of children and young people's individual characteristics such as their ethnicity, religion, culture, gender and sexual orientation is variable. In some instances, careful consideration of these issues, together with the risk of forced marriage and complex health needs, is evident, but in other cases, insufficient attention was paid to these issues.

81. A multi-agency strategy on neglect has recently been launched in response to the findings of a recent Ofsted survey, and training is currently being rolled out to practitioners. Some children and young people have been exposed to neglect that has been insufficiently addressed in the past, leading to children being made subject to repeated child protection plans. There is evidence that risks to these children are now being better addressed, but the local authority and its partners will need to monitor the impact of this strategy and training to ensure future effectiveness.
82. In one social work safeguarding team, an electronic duty inbox was found to contain both new referrals and cases previously allocated to social workers in the team but deemed to require closure, pending managerial agreement. There was no easy way of distinguishing between these two groups. This system meant that children requiring further assessment or services were effectively unallocated until reviewed by a manager. The local authority took immediate action once inspectors brought this to their attention, reviewing all the children, which resulted in appropriate actions. Inspectors also found very high caseloads in this team, affecting social workers' ability to undertake good practice and record it in a timely way. These arrangements are not replicated in other teams and senior managers have now taken steps to appropriately reduce caseloads and enable case recording to be completed.
83. Recent initiatives have reduced unacceptable delays in children being considered by initial child protection conferences. Of the 35 initial child protection case conferences held since 28 April this year, only three have been late, by a short time and for valid reasons. The vast majority of core groups are held on time and attended by partner agencies. Review conferences take place regularly. One very good example was seen by inspectors of two children's schools proactively and creatively facilitating contact between two siblings living with their respective fathers.
84. Child protection conference chairs perform a quality assurance function in individual cases, for example by escalating concerns in relation to risk or poor practice. However, there are no arrangements in place to aggregate their findings and report these to senior managers as part of a continuous improvement process. This is a missed opportunity to identify trends and contribute to improving practice. The local authority is aware of this and intends to incorporate their contributions into the new quality assurance framework.
85. The number of children and young people known to be privately fostered is low, currently five. Good evidence-based awareness-raising activities have taken place. Although this has not yet resulted in more children and young people

being identified as being privately fostered, it has led to an increase in enquiries, including 12 notifications from a local language school regarding future placements.

86. Children at risk of child sexual exploitation (CSE) or who are missing from home or care receive a co-ordinated multi-agency response. The Director of Children's Services has been proactive in promoting the visibility and importance of CSE, resulting in most schools being actively engaged. This has led to an increase in disclosures from young people of CSE, and an increase in cases considered by the multi-agency child sexual exploitation panel (MACSE), particularly since the recent roll out of a theatre production to secondary schools.
87. Arrangements for monitoring and tracking children missing education are robust. Systems for reporting children missing off roll are well-established and used by schools, children centres, and alternative education projects. The database is updated on a daily basis and procedures implemented swiftly and effectively. The children missing education (CME) team is well represented on all multi-agency groups, including the multi-agency risk assessment conference (MARAC), multi-agency response to guns and gangs (MARGG), MACSE and the Fair Access Panels. This ensures that children at risk of missing education through permanent and fixed term exclusions are known, and action plans that include home visits are implemented swiftly to reduce the risk, or potential risk, of harm. The CME co-ordinator works well with colleagues in other local authorities, tracking families who move between them, ensuring that these children are kept safe and protected from harm.
88. MARAC arrangements are in place, co-ordinating responses to the most serious instances of domestic abuse, with appropriate attendance from children's social care representatives and partner agencies, including those providing alcohol and substance misuse services. An improvement plan is in place and includes actions to raise practitioners' understanding of MARAC. Services are available to support victims of domestic abuse, including the Freedom programme and independent domestic violence advocates (IDVAs). In one case seen, a comprehensive package of support was in place which was improving outcomes. However, there is insufficient IDVA capacity, which could lead to children, young people and their families not receiving an appropriate or timely service.
89. Attendance by children's social care representatives at multi-agency public protection arrangements (MAPPAs) meetings, which manage serious offenders in the community, is not yet good, with an attendance rate of 58 out of 80 at level 2 meetings and 5 out of 7 at level 3 meetings over the last three months. However, where young people are the subject of the MAPPA meeting, there is good attendance by children's social care representatives.
90. Movement of children from mainstream schools into alternative education provision, as a result of exclusion or an arranged move, are effectively and regularly managed through the two primary and secondary Fair Access Panels. This ensures that children who are experiencing difficulty in mainstream schools are moved swiftly and safely to tailored provision that can more appropriately address their behavioural and emotional needs.

91. The local authority has a good grasp on those children who are known to be receiving elective home education (EHE), and provides good support to those willing to receive it. 160 children were registered for home education in this academic year, 23 of whom are known to children's social care and 45 of whom have subsequently been placed in education provision.
92. A recent report to the LSCB regarding EHE highlights the potentially large number of children being home educated who are known to health services but unknown to education and other local authority services. At the present time, there is no information-sharing protocol between the local authority and health partners to enable these children's names to be shared routinely, and privacy legislation is regarded as preventing information sharing without parental consent. Health partners report that consent is often withheld. The local authority is rightly concerned about the potential safeguarding risks to these children, who are living in the area, potentially missing from education, but not being offered EHE services.
93. Effective arrangements are in place to investigate allegations against professionals working with children. Referrals are received from a wide range of statutory and voluntary agencies and progress against agreed actions are tracked by the local authority designated officer (LADO).
94. Social workers in Liverpool are passionate about their work and morale is generally good. Social workers said their managers are both visible and accessible, with much informal case discussion being held; however, this is not recorded on either the child's file or the supervision record. Formal supervision records are variable in terms of quality, detail and frequency and contain little evidence of reflective practice.
95. Children and young people are not supported to express their views to child protection case conferences by an advocacy scheme.

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

96. Good support is available to young people on the edge of care. Family support services provide an instant response to young people and families in crisis and where coming into care is an increased possibility. The service is flexible and workers will support families outside office hours. 72 out of 76 children referred between February 2013 and March 2014 were successfully supported without requiring accommodation by the local authority.
97. Good use is made of family group conferences (FGCs) and family meetings. In 2013–2014 the service received 100 referrals, leading to 51 FGCs and 19 family meetings. In all but two cases a plan was agreed. There are currently four trained FGC co-ordinators. Fifteen family support workers are also receiving training in order to embed the system in other areas, such as post-adoption support. The service is anecdotally reported to be successful in approximately 60% of cases, but data is not currently systematically collected on its impact, which is a shortfall.
98. Children are benefitting from the local authority's good performance in meeting the revised Public Law Outline (PLO) timescales. Effective, robust processes, which routinely include access to good legal advice, are in place to consider whether cases should enter pre-proceedings or an application for a care order should be made.
99. Legal proceedings are initiated appropriately when risks to children increase or are not seen to be reducing sufficiently. The quality of court reports is good and improving, and applications are lodged in a timely way. This is contributing positively to reducing the length of care proceedings and counteracting previous drift and delay in care planning. The vast majority are supported by Children's Guardians and accepted by the courts, and Liverpool's performance is regarded positively by both Cafcass and the Designated Family Judge.
100. There are robust processes in place to ensure that all decisions to accommodate a child are considered carefully, challenged appropriately and made at a suitable level of seniority. There are appropriate arrangements for urgent cases. Decisions are informed by good quality legal advice. Inspectors did not see any cases where children came into care when they should not have done.
101. A significant proportion of children who are looked after by the local authority are placed at home with their parents under Placement with Parents (PwP) Regulations (The Care Planning, Placement and Case Review (England) Regulations, 2010). There are currently 186 children in this category, of whom 44 were placed in 2013 and 35 in 2014. There is also a cohort who have been at home for over two years without a plan to discharge the care order, which suggests drift and delay in care planning. The local authority is making some progress in this area and has recently begun to utilise an agreed accelerated process for discharging legal orders where appropriate. Since 1 January 2014, five care orders have been discharged with a further 22 discharges agreed by local authority managers but not yet finalised in court.

102. The timeliness and quality of assessments required by the PwP regulations are currently too variable in quality. On some children's files, no relevant assessment or plans can be found. On others, the assessments and plans range in quality from poor to good. Overall, the local authority is not consistently supporting a safe return home for all children for whom this is the plan.
103. The local authority is very successful in placing the vast majority of looked after children either within the city or in neighbouring local authorities. Only 52 children and young people are placed at a distance of over 20 miles, and all such placements require senior manager consideration and authorisation. Suitable placements are identified promptly via the local authority's participation in a regional consortium for foster care placements and a parallel arrangement for residential placements. Children who are placed in neighbouring local authorities benefit from continuity of social worker and school placement. They also benefit from well-established and effective professional networks, notification processes and information sharing, for example, between looked after children nurses in each area. The local authority service to support the education of looked after children (LACES) also provides support for children attending schools in neighbouring local authorities.
104. Children are being seen in the majority of cases by their social worker at least in line with statutory visiting timescales and this is monitored by IROs and team managers. Children are seen alone by social workers. In most cases, children are able to develop a good relationship with their social worker. Children who have greater needs, or are experiencing a multiplicity of problems, are seen more frequently, demonstrating sensitive and responsive social work support.
105. Children are helped to have good contact with other family members and with their brothers and sisters, if they do not live together. Contact is often facilitated by foster carers and family support workers and sometimes by schools, with arrangements being made that are most suitable for each child's circumstances. Children's views are taken into account when planning and reviewing contact arrangements.
106. Some good examples of effective direct work with children and young people were seen during this inspection. Some social workers use a variety of creative techniques and strategies to help children express and explore their views, wishes and feelings. This helps children to understand why they are looked after and what their care plan means. However, not all children who would benefit from direct work or life story work were receiving this, including children who are going to be adopted.
107. Case recording is not consistently good enough. For example, the completion of statutory visiting forms are not always sufficiently detailed, so the picture of the child and their voice does not come through. In most records there was evidence of comments about how the child presented during the social worker's visit, comments from carers, and what the child said; however, such recording is variable in quality and consistency. In some cases it was clear that children's wishes had been listened to and taken into account in their plans. The local

authority's audits of tracked cases and the recent quality assurance audit of looked after children cases also identified variability and deficits in these areas.

108. Information about children's often complex and diverse backgrounds is not consistently identified and recorded. This means their heritage and identity needs are not sufficiently central to understanding, and as a result there are shortfalls in this aspect of care planning. For example, in one case seen by inspectors, a child's dual heritage status had not been sufficiently acknowledged and taken into account in her assessments and plans. However in other cases, the support for children in this regard was positive, for example, support for a young person with special educational needs to take part in activities from which they have greatly benefitted and, in another case, a foster carer has been pivotal in helping a young person to maintain contact with their birth family in Africa.
109. Up to date care plans are in place for the majority of children and young people, but they are not consistently informed by an up to date assessment of children's needs or their progress. The current care plan template on the electronic recording system does not encourage social workers to improve their practice in this area, and this is recognised by the local authority.
110. The timeliness of looked after children's statutory reviews is at nearly 99%. Nearly two thirds of children and young people attend their own reviews, and IROs make good efforts to see children just prior to their reviews. The service has proactively sought feedback from children, parents and carers with a view to increasing their participation rate. This has led to better written materials, helping children to understand what the service can do for them, what their rights and entitlements are, how to complain, and how independent visitors and advocates can help them. The service learns from feedback to improve practice, and some young people co-chair their reviews or take the minutes.
111. The IRO service is not yet fulfilling all its statutory duties. IRO caseloads are too high, typically 100 to 110 children, and the service lacks sufficient administrative support. IROs do not routinely meet children between their reviews, and are unable to ensure that recommendations from reviews are distributed and followed up promptly. They undertake basic monitoring after reviews and escalate concerns when necessary, but they do not have a quality assurance role and do not influence or hold to account members and senior officers as the 'corporate parents' for looked after children. This is a missed opportunity to capitalise on the overview and expertise that the service can offer.
112. Satisfactory arrangements are in place for ensuring that looked after children at risk of sexual exploitation or who are missing from care receive a co-ordinated multi-agency response. Return home interviews are carried out by social workers. However, there is no monitoring system in place ensure that interviews are always held and done to a sufficiently good standard, or to build up intelligence and capture themes from these interviews to inform future safeguarding practice.
113. The authority's recruitment, training and assessment of new foster carers are managed by a private contractor. The recruitment target has been missed and

this, coupled with attrition for other reasons, has resulted in a net decrease of in-house carers. However, the local authority's sufficiency duty is met by effective placement finding by the Placements North West (PNW) consortium. The consortium can identify suitable places in children's homes as well as independent foster carers, ensuring that children's future placements match their needs.

114. The fostering service improvement plan currently lacks timescales by which objectives are to be achieved. The plan should include clear timescales, ascribing responsibilities, and specifying reviewing arrangements to enable clear oversight of progress. The service does not have an effective performance management tool to monitor compliance with training and development requirements for foster carers and address any shortfalls in compliance robustly.
115. The fostering panel provides a good level of scrutiny, and minutes show robust discussion and challenge. For example, one set of carers had their approval varied recently pending their demonstrable commitment to training. Other carers have been re-assessed by an independent social worker following concerns about their quality of care. Approvals are signed off by the agency decision maker in a timely manner.
116. Foster carers are supervised regularly by allocated supervising social workers. Training is available for foster carers and covers a wide range of relevant issues. However, not the local authority's foster carers meet the minimum stipulated training and developmental standards. A 'friends and family' support group has been set up to build professionalism and encourage mutual support, as this group of carers have traditionally been the most resistant to attending training. Training is being further encouraged by the introduction of a new payment framework linked to skills. However, management oversight of carers' compliance with training and development requirements is hampered by the lack of a tracking tool which consolidates all the training attended by carers. A database is currently in development to address this shortfall.
117. Carers who met with inspectors described good basic training but insufficient specialist training for more experienced carers. Carers report feeling generally valued and part of the professional network, and all were aware of delegated authority issues.
118. There has been a recent increase in the number of minority ethnic carers being trained, which will help the local authority to ensure wider placement choice and matching for looked after children from minority ethnic communities.
119. Not all fostering placement breakdowns are currently the subject of a specialist review meeting, which is a missed opportunity to better understand the reasons for placement breakdown, and to learn lessons and inform continuous service improvement and matching arrangements.
120. The majority of children live in suitable, stable foster placements. In 2012–13 only 9% of children experienced three or more placements, which is better than statistical neighbours and the national average.

121. There is appropriate consideration of placing children with their extended family and friends. At March 2014, 30% of looked after children were living with family or friends. These carers spoke positively about the support they receive. The use of Special Guardianship Orders (SGOs) to achieve permanence for children is increasing; it was 3% in 2010–11 and 10% in 2012–2013, which is a positive trend and is higher than the England average. This is well supported by a policy which means that families can receive ongoing support, including financial support.
122. A high proportion of looked after children enter care with poor education histories and low levels of attainment but go on to make satisfactory or better educational progress for their age. In 2012–13 attainment at age 11 years and at 16 years was slightly above the national averages, although the achievement gaps between looked after children and all pupils in Liverpool remain too wide. The three year trend at Key Stage 2 and Key Stage 4 shows that these are narrowing, albeit too slowly for 16 year-olds. A key factor is the disproportionately high number of looked after children (62% of the total cohort) who have some form of special educational need. For example, in 2012–2013, of the 58 looked after children aged 16 years who were eligible to take GCSEs, nine (17%) achieved five GCSEs including English and mathematics and 41 of this group (71%) were predicted not to achieve higher grades due to their additional learning needs. Despite the gap in attainment between looked after children and their peers, there has been an overall improvement of 4% over the last four years, which is the same rate of improvement as for Liverpool pupils overall.
123. The completion of personal education plans (PEPs) at 82% continues to improve year on year. In most cases they are used well to support the educational and academic progress of young people. However, some plans contain insufficient information about levels of progress and the planned learning targets are too generic. LACES is aware of the discrepancies, and staff regularly audit PEPs and provide feedback to the designated looked after children (LAC) teachers in Liverpool schools and schools outside the city where looked after children are placed. The PEP is used very effectively to monitor pupil premium expenditure. Clear guidance is provided to schools and alternative education provision suggesting how the award should enhance the learning experience for children. Tracking and monitoring the progress of this group inside and outside the city is prioritised by LACES, and is well supported by school designated teachers and the local authority's team of school improvement officers.
124. Targeted initiatives which focus on raising attainment levels and achieving potential for looked after children are well established, and evaluations of these programmes show that the outcomes are steadily improving levels of progress. For example, evaluation of the reading project shows that those children who received support improved their reading levels significantly over the two year period. Innovative research and training by LACES in understanding trauma and attachment issues is beginning to shape strategies and approaches for teachers and teaching staff.
125. Nearly all looked after children attend good or better schools and no child is attending inadequate provision. No looked after child has been permanently

excluded for over three years and those receiving fixed term exclusions are also decreasing in number. In January 2014, 24 secondary pupils were placed in alternative education provision, which delivers tailored programmes that address specific emotional, behavioural and social needs. They attend school for 25 hours a week and these hours are often further enhanced by additional tutorial sessions or after school activities.

126. A new electronic data system for attendance monitoring, both within the city and out of area, ensures daily checks and swift action. Attendance of looked after children in primary schools is high and better than the Liverpool average. Secondary school attendance is also slightly better than the Liverpool average. Persistent absence figures for secondary pupils who are looked after is slightly higher than the national average, but the trend shows a steady reduction in these figures over the last four years.
127. Systems for reporting children missing off roll are well established and used by schools and alternative education projects across the city. The database is updated on a daily basis and procedures implemented swiftly and effectively. Of 897 referrals between September 2013 and March 2014, 861 children were found and 36 cases were followed up further by the CME team.
128. All looked after children and young people living in Liverpool aged 5-17 years receive a free leisure pass. The children in care council is involved in reviewing its use for looked after children and care leavers. Inspectors saw several examples where children are being encouraged and helped to take part in activities which they enjoy.
129. Children and their carers receive a good service from the looked after children's health team. They benefit from prompt initial health assessments and advice at regular clinics at Alder Hey hospital. Review health assessments happen in a timely way and are carried out by suitable health professionals. Health reviews take place in a variety of venues which take account of preferences expressed by children and carers. Timeliness of health reviews and treatment is very good, with 93% of assessments, 92% of dental appointments and 90% of immunisations completed on time. As a result, children's health needs are met promptly. Health professionals routinely provide reports for looked after children reviews and attend these reviews as appropriate.
130. CAMHS practitioners provide valued consultation 'clinics' and advice and training to social workers, carers and other professionals. These services help to meet children's lower level needs. The single point of access at Alder Hey hospital is designed to ensure that referrals of looked after children are assessed swiftly and offered services, including signposting to local voluntary groups and consultation with specialist practitioners. However, looked after children with more complex needs experience unacceptable delays in receiving specialist support from mental health practitioners. Inspectors saw cases and heard from staff about instances where the delay in meeting children's mental health needs was having a detrimental impact on the stability of their care placement. There is an urgent need for the local authority, health commissioners, and providers to improve access to these services for looked after children.

131. The local authority is currently unable to assure itself about the effectiveness of CAMHS as the provider does not currently provide information about Liverpool children; it only provides composite data relating to all the local authorities who access its services. This means that the local authority cannot track and monitor the timeliness of response and whether treatment and services have been effective in meeting children's needs.
132. There is an active and influential children in care council (CICC) but the membership consists primarily of older looked after children. The participation worker is aware of this and is working hard to engage younger children through a newsletter and group sessions during school holidays.
133. The NSPCC 'safeguarding through advocacy' scheme currently supports 72 older looked after young people and provides them with access to an allocated advocate. The service has a particular focus on safeguarding arrangements for looked after young women who are pregnant or have a child, offering support to the young women and their children in relation to domestic violence. Young people's evaluation forms reported that they found the service useful, but information about common themes and outcomes of advocacy engagements is not available and this is a shortfall.
134. The quality of management oversight in the looked after children's social work teams is satisfactory. Children's case files showed evidence of management oversight and decision making. However, these records are usually brief, task-focussed and do not show reflective consideration of the child. Social workers receive regular formal supervision which is of satisfactory quality, and have easy access to valuable informal but unrecorded advice, direction and consultation from their line managers. A further strength is that additional oversight of practice is provided by the pre-proceedings panel, legal decisions and gatekeeping panel, and the fostering and adoption panels.

The graded judgment for adoption performance is requires improvement

135. Adoption managers and staff demonstrate commitment in their desire to continue to improve adoption services in Liverpool. They have benefitted from independent reviews of the service and are implementing recommendations from these. Senior managers are also clear about the need to improve the service and several initiatives are in place seeking to achieve this. However, the adoption improvement plan is not resulting in improvements in performance.
136. At the present time, some children wait too long to be placed with an adoptive family following court approval. It currently takes 842 days from the point of a child coming into care and then moving to their adoptive placement; the current national threshold (2010–2013) is 608 days. This means that Liverpool children wait an additional 234 days to live in a permanent family. There has also been a reduction in the number of adoptions from 55 in 2012–2013 to 46 in 2013–2014.
137. Once the court has agreed that a child should be adopted it takes the authority too long to identify a suitable family, and performance is deteriorating. Indeed, there has been an increase in the number of days it takes from court orders

being made to children being placed, from 150 days to 190 days. There is emerging evidence that timeliness has begun to improve over the past six months. The local authority argues that its performance is skewed by virtue of its commitment to continuing to search for suitable adopters for children who are traditionally 'hard to place' because of their age and/or complex needs.

138. Currently there are 12 adopters awaiting a placement and 15 children for whom family finding is active. Adopters in training and approved adopters report that adoption social workers have early and appropriate discussions with them about potential matches. This demonstrates a determination to find potentially permanent adoptive matches as quickly as possible. The adoption service is recruiting carers from diverse sectors of the community. There is an over-representation of minority ethnic children in the looked after population but an under-representation of minority ethnic children who have a plan for adoption. The local authority does not know what factors are contributing to this discrepancy but has recently appointed a temporary adoption development worker to explore this issue and assist in determining the underlying causes. Findings are not expected until the end of the year.
139. Although trackers have been recently introduced, managers in the adoption service are not yet confident that they are aware of all children at their second review where adoption may be a potential option. Also, there is no readily available performance information on the completion of life story work. This means that the local authority cannot be sure that all children's life story books are started and completed at the right times or that the book accompanies the child to their new family.
140. There are a small number of children in 'fostering to adopt' families and there is evidence that some adopters have been asked if they are willing to consider being approved as concurrent or 'foster to adopt' carers. However, the local authority acknowledges that there is more to do to promote this arrangement as a viable option for more children.
141. Some adopters reported a delay between their enquiry and when they were invited to an open evening or able to join a training programme – one carer reported waiting for three months before participation in preparation work could begin. This delay risks potential adopters seeking other avenues for approval and, consequently, the local authority recruiting insufficient adopters to meet demand. Once engaged in the training process, adopters report positively on the quality of assessment and preparation training. However, the service does not systematically capture feedback from those participating in the adoption approval process, which is a missed opportunity, and therefore the service is not able to evaluate the quality and effectiveness of its recruitment, training and assessment activity.
142. The adoption service is embedding the two stage adoption approval process. In the small sample of cases considered by inspectors, the process from application as prospective adopters to approved adopters was completed within six months for all of them.

143. The post-order support team is well regarded by those who use its services. The team provides direct work with children and parents, support groups, and a telephone advice line. The team can also refer children to the looked after children CAMHS team for assessment and support. In 2013–2014, 133 packages of support were provided. Currently 38 children are receiving support. The post-order support team evaluates its services via feedback forms from parents and children. Aggregate findings indicate that parents and children value highly the support they receive and the help is appropriately targeted. The team's facilitation of a conference earlier in 2014 resulted in Liverpool's schools having more awareness of the support needs of adopted children.
144. The adoption panel benefits from an experienced and knowledgeable chairperson. Panel minutes are of a good quality and reflect the contents of the reports before panel. The panel provides appropriate scrutiny and challenge, although currently the adoption panel advisor role rotates between three adoption managers, which risks inconsistent or different advice being given.
145. The independent panel chair states that prospective adopter and child permanency reports prepared by social workers are improving. However, there is more to do to embed this awareness and the local authority is part-way through ensuring that all its social workers have had training in permanency planning. In most cases, planning is sensitive to issues of ethnicity and other aspects of diversity. The agency decision maker is thorough and prompt in considering panel recommendations and ensuring that the arrangements are robust.
146. Adoption panel business reports do not include any aggregated qualitative data such as feedback from prospective adopters or social workers who attend panel, adopters' evaluation of the service, or the status of life story work at point of placement. This lack of qualitative data impairs the ability of the adoption panel to contribute towards driving improvements in the local authority's adoption services.
147. The authority is making good use of the adoption reform grant and has appointed a dedicated family finder. The authority has also identified the need to improve and update its adoption service website to make it more adopter friendly.

The graded judgment for the experiences and progress of care leavers is requires improvement

148. Care leavers are supported by suitably qualified and experienced social workers and personal advisors, who carry manageable caseloads. They report that the service is accessible, welcoming and their workers give them good support and advice, including when they disengage or drift into chaotic behaviours.
149. Pathway plans show early indications of improvement, but the majority of plans are not yet meaningful documents that track measurable outcomes for care leavers. The plans capture young people's needs but do not translate these into future accountable actions that are understood by young people. The local authority recognises these deficiencies and is reviewing the format and content

of plans in consultation with young people. Staff have received recent training in effective pathway planning, however there is no oversight or evaluation from IROs of the quality of pathway plans.

150. There is good attention to safeguarding care leavers, particularly when they go missing. Careful collation of data means that risks to young people are known, assessed and responded to appropriately. This includes monitoring missing 'patterns', risks of sexual exploitation, risks from contact with family members and young people's offending and substance misuse. Social workers and personal advisors know their young people well and maintain regular contact with them. A significant minority of care leavers are parents and there is considered attention both to the parents' welfare needs and prompt and effective referral to safeguarding teams in respect of the children where this is appropriate.
151. There are no care leavers living in bed and breakfast accommodation and no care leavers report feeling unsafe in their accommodation. Semi-independent accommodation is of variable quality and is commissioned through a regional framework for care leavers aged 16 to 18 years of age. Most care leavers live independently in private rented accommodation at 18 years of age, and too few remain living with their foster carers. The local authority has recently instituted a number of measures to improve the level of support for care leavers living with private landlords, but it is as yet too early to see impact. The number of 19 to 21 year-olds reported as living in suitable accommodation has declined to 77%, indicating a need for more supported accommodation options for care leavers over 18 years of age, particularly those with greater vulnerabilities.
152. Some independence training is provided by semi-independent units for 16 to 18 year olds, but the service is unable to measure the quantity, quality and effectiveness of this work. Independence skills are often referenced in pathway plans but these generally do not state how they will be developed.
153. Services and entitlements information provided to care leavers is insufficient. No bespoke, young person-friendly written information is produced. Care leavers are signposted to national organisations which provide some information. The service provides financial support for care leavers who are not eligible to claim welfare benefits, but care leavers are not systematically advised of their financial entitlements, or information such as accommodation, education, employment and training pathways. The leaving care grant is currently low at £1,200 but inspectors were advised that there are plans for it to be raised to £2,000.
154. There is a range of trainee, apprenticeship and work preparation programmes for care leavers, and the local authority funds two information, advice and guidance workers who advise care leavers up to their 19th birthday. Some care leavers report that the local authority supports and advises them effectively. 31 care leavers attend university and they are well supported financially and practically. Approximately 50% of 16 to 18 year old care leavers attend further education courses supported by a bursary to encourage their attendance.
155. Too many care leavers in Liverpool are NEET. The overarching NEET number at 38% is above the national average. In addition, there are significantly higher

spikes of 55% of 20 year-olds and 49% of 18 year-olds who are NEET. This issue requires further analysis and targeted interventions, particularly in light of the further forthcoming raising the participation age (RPA) requirements. Staff working with older care leavers described challenges such as long term disaffection, histories of poor engagement in school and emotional and mental health issues as being the most significant barriers to care leavers engaging in and sustaining education, employment or training. The local authority and its partners have been slow to assist these harder to reach groups of care leavers to overcome their significant barriers to learning and engagement.

156. The physical and emotional health of younger care leavers are carefully considered by social workers and personal advisors. Needs are generally well documented in case notes and pathway plans, although specific actions often lack accountability, frequently relying solely on the young person to follow up. The looked after children nurse provides regular drop-in sessions and assists in signposting older care leavers to appropriate services. There are effective substance misuse reduction and sexual health pathways. A health passport for care leavers has been recently devised but has not yet been implemented.
157. The emotional and mental health needs of younger care leavers are addressed through CAMHS provision, which includes regular consultations for social workers, personal advisor and carers. Some short-term direct work with care leavers is also provided. The transition to adult services is supported by both CAMHS and dedicated transition workers in the adult service. However, there is little evidence of effective mental health and emotional wellbeing provision for care leavers aged over 18 years who do not meet the threshold for adult mental health services. This is particularly notable in the group of care leavers aged over 18 years who are persistently NEET.
158. The local authority has highly effective corporate parenting arrangements with care leavers. The regular Children in Care scrutiny meeting allows care leavers to influence service development through regular access to pan-council senior officers. Recent examples of influence include the development of a council rent guarantor scheme for care leavers in private rented accommodation and apprenticeships across the council. Care leavers welcome and value access to senior leaders and the follow up work they undertake. The achievements and progress of care leavers are celebrated appropriately by the local authority.
159. Performance management tools in respect of the work with, and progress of, care leavers is under-developed. Both quantitative and qualitative information to evaluate and improve service delivery are absent. There is no information on more vulnerable cohorts of care leavers, such as those with significant mental health difficulties, those with housing needs, or offending or substance misuse patterns. Therefore, managers are unable to evaluate the quality of service provision and identify shortfalls, either at individual case level or on a service-wide basis.

Leadership, management and governance requires improvement

160. The local authority is currently embarked on an ambitious programme of change. Significant factors such as the findings of the thematic inspection of early help, continuing high volumes of contacts and referrals to children's social care, and widespread differences across partner agencies in understanding the thresholds for statutory services, have informed the change programme appropriately. However, capacity is an issue at all levels, the pace of change is too slow, and high caseloads for some social workers is having a negative impact on the quality of social work provided.
161. Although the proportion of looked after children placed more than 20 miles away from home is commendably small, the number of children who are being looked after by the local authority remains high, placing a severe financial burden on already stretched budgets.
162. Leadership, governance and management arrangements comply with statutory guidance. The Director of Children's Services, who is responsible for children's social care and education services, manages a committed and energetic senior leadership team and provides strong leadership. External partners, including schools, provide support for issues of common concern, such as the need to strengthen early help.
163. The Director of Children's Services and her senior managers demonstrate a good understanding of the major challenges facing children's services in Liverpool. They are taking action to address identified shortfalls and service pressures. A neglect strategy has been developed, early help is being transformed, a new electronic information system has been commissioned and there are plans to reconfigure how children's social care is structured in order to improve the experience of, and outcomes for, children and young people. However, the absence of an overarching narrative in the form of a single 'master plan', which pulls together the different strands of activity, makes it difficult for partner agencies at all levels of seniority to make sense of the big picture, track progress and challenge appropriately.
164. Arrangements for good governance are in place, with clear reporting and lines of accountability between the Children's Trust Board (CTB), the Health and Well-being Board and the LSCB. However, the lack of good quality qualitative and quantitative performance management information, strategic and delivery plans that are sufficiently outcome focused, specific or measurable, inhibits scrutiny and blunts critical challenge. Without clear accountability and written timelines within plans, the ability of partners to hold each other to account is limited.
165. The joint strategic needs assessment (JSNA) is a well-developed and dynamic source of information about local needs as well as current and future priorities. While the priorities identified within it have helped to inform the development of the Children and Young People's Plan, the links are not fully established as evidenced by the sufficiency statement. This document is descriptive rather than analytical, and provides no meaningful information about future patterns of need or supply.

166. Commissioning arrangements, including joint commissioning, need to be much more robust. Commissioning activity is currently fragmented. Procurement has been outsourced and is being managed by Liverpool Direct and the draft commissioning strategy lacks substance and detail. The latest information about placements managed through the Placements North West (PNW) contract is not disaggregated and does not provide meaningful financial or other data on Liverpool's take-up of the contract. Discussions with health partners about the development of joint commissioning are well advanced.
167. Commissioning capacity has been increased by a specific post for looked after children placements. However the post will also monitor independent fostering and residential placements that are not part of the PNW contract, which will affect the capacity of the role to act as a change agent.
168. There is good understanding of, and commitment to, corporate parenting. The assistant cabinet member chairs the Corporate Parenting Board which the lead member also attends. The Board is informed by the work of the cross-departmental scrutiny panel led by the Children in Care Council, leading to improved outcomes for this group of children and young people.
169. There is good engagement with the LSCB. The Director of Children's Services meets regularly with the independent chair, who provides strong challenge. There is a similarly robust relationship between the Chief Executive and the independent chair of the LSCB. Performance management is seriously under-developed. Significant limitations with the existing electronic child's case recording system means that there are serious failings, with little or no 'real time' performance management information available. Frontline managers are reliant on paper-based systems to monitor caseloads and track progress. The children's electronic recording system causes delay and frustration and does not support performance management or the day-to-day work of social workers. Staff find it difficult to navigate the system and lose work when the system crashes. The local authority is aware of the problem and its many negative impacts; however, the planned replacement system is not scheduled to go live for another year, leaving the service with an inadequate electronic recording system until that time.
170. The Director of Children's Services and her senior leadership team do not have an effective 'window' on frontline practice; such as the quality of safeguarding social work practice and management oversight. They are dependent on the vigilance of service managers and on data that is generated manually, collected by over-stretched front-line managers or on data that is generated retrospectively by the strategic intelligence team. This impedes the scrutiny role of middle and senior managers, and affects senior leaders' ability to identify and respond quickly to issues and concerns as they emerge. This makes it difficult to provide proactive, as opposed to reactive, challenge.
171. Quality assurance is also under-developed. The authority's plan to establish a quality assurance unit bringing together IROs, independent conference chairs, the child sexual exploitation coordinator, complaints team, participation officer and the strategic intelligence team is intended to address that shortfall, but is not

yet in place and does not appear to bring any additional capacity to quality assurance overall. A comprehensive quality assurance framework has been developed and new, easy-to-use audit tools which are child-centred are in the process of being introduced. In the past 12 months, 269 individual case file audits have been completed across the safeguarding, looked after children and leaving care services. This has led to summary reports being produced and action plans developed. However, the process itself is not yet embedded. The contracts of the two independent auditors who have been carrying out that work are due to end in August and it is unclear whether existing managers in the service have the skill and capacity to fulfil this role. Learning from complaints also needs to be strengthened.

172. The senior management team in children's social care has a wide span of responsibilities, including significant operational duties. This hampers their ability to provide strategic leadership and oversight. There are limited devolved responsibilities to tiers of managers in the service, insufficient capacity building within the service and no attention currently given to succession planning. The Principal Social Worker role has been delegated to the lead for quality assurance, who reports directly to the Assistant Director rather than the DCS. This potentially limits the independence and the challenge to the service that this role can offer.
173. The quality of management challenge is variable, as is supervisory practice, which tends to be task-centred rather than reflective. Although inspectors saw some good examples of effective supervision and support leading to highly focused interventions and improved outcomes for children and young people, this was not always the case. Similarly, the quality of the challenge provided by independent conference chairs is not consistently good, as evidenced by the variable quality of child protection plans, most of which are neither outcome-focused nor measurable. IROs' workloads, which are above the national average, limit their ability to provide an appropriate level of critical challenge in some cases.
174. Newly qualified social workers in their assessed year of practice (ASYE) employed by the local authority have appropriately protected caseloads and more frequent supervision and management oversight of casework. However, the workforce includes inexperienced agency social workers with caseloads that are too high and who lack the benefits afforded to permanent employees who are newly qualified. This contributes to poor assessments and planning for some children.
175. While action is being taken to reduce the size of social workers' caseloads they remain unacceptably high and are having a direct impact on the quality of practice. The creation of a joint investigation team in the north of the city has helped to improve the quality of section 47 enquiries, but the creation of this team has been at the expense of the safeguarding and support teams in the north of the city. The early help agenda has yet to impact on the volume of contacts and referrals in the social work service.
176. While previously high sickness and absence rates are being brought under control, the turnover of staff is 7.6% in corporate parenting teams and 13.1% in

safeguarding teams; the North West average is 11%. At present all vacancies are being filled by agency workers; of the 271 social workers employed by the local authority, 45 are employed on agency contracts. This equates to 16.6% of the social worker workforce and is above the North West average of 9%. At the same time, the racial and ethnic profile of the workforce does not reflect the diversity of the local population. This has implications for the cultural competence of the workforce to respond to children and young people's diverse needs.

177. Workforce development is under-developed. There is an absence of a comprehensive workforce competency framework and no systematic use of performance appraisals and personal development plans. Led by the Chief Executive, work is underway to develop a multi-agency competency framework, but there is further work to be done. The absence of a central database capturing workforce learning and development is a key impediment. At the present time, basic processes are in place, for example, monthly checks ensure that social workers have continuous registration with their professional registering body. Social workers report that the size of their caseloads makes it difficult to find time to undertake training and therefore fill the requirements of registration renewal.

What the inspection judgements mean: the local authority

An outstanding local authority leads highly effective services that contribute to significantly improved outcomes for children and young people who need help and protection and care. Their progress exceeds expectations and is sustained over time.

A good local authority leads effective services that help, protect and care for children and young people and those who are looked after and care leavers have their welfare safeguarded and promoted.

In a local authority that requires improvement, there are no widespread or serious failures that create or leave children being harmed or at risk of harm. The welfare of looked after children is safeguarded and promoted. Minimum requirements are in place, however, the authority is not yet delivering good protection, help and care for children, young people and families.

A local authority that is inadequate is providing services where there are widespread or serious failures that create or leave children being harmed or at risk of harm or result in children looked after or care leavers not having their welfare safeguarded and promoted.

Section 2: The effectiveness of the Local Safeguarding Children Board

The effectiveness of the LSCB requires improvement

Areas for improvement

178. Ensure greater clarity in the levels of need framework between children in need of additional help and support and Children in Need whose needs have been assessed under Section 17 of the Children Act 1989.
179. Give greater prominence to the issue of consent in the levels of need framework.
180. Strengthen the LSCB's understanding of performance by reviewing, refining and streamlining the various datasets which the performance management sub-group is currently using.
181. Review the chairing arrangements for the performance management sub-group to ensure independent critical challenge.
182. Audit and evaluate the implementation of serious case review (SCR) action plans.
183. Develop a systematic approach to multi-agency quality audits to strengthen the quality assurance role of the LSCB.
184. Develop the voice of the child in the work of the LSCB in order to ensure that partners learn from the experiences of children and young people.
185. Monitor and evaluate both the take-up and impact of training.
186. Ensure that the Board has the right level of resources and capacity to be effective.

Key strengths and weaknesses of the LSCB

187. The effectiveness of the LSCB in promoting focused and productive partnership working which benefits children and families has increased over the last six months but is not yet embedded.
188. Having emerged from a period during which, by its own admission, the LSCB 'lacked strategic direction', it is now compliant with statutory responsibilities. An able and experienced independent chair has been appointed and in a short time good progress has been made in progressing core business. However, the LSCB still needs to be more effective in holding itself and others to account and has yet to fully realise its potential to affect the planning, development and scrutiny of services.
189. Robust governance arrangements have been established with clear and well-defined links to the Children's Trust and Health and Wellbeing Boards, underpinned by a three-way memorandum of understanding. The LSCB chair

meets regularly with the Director of Children's Services and with the Chief Executive. A written record is kept of these meetings.

190. An executive board has been formed, enhancing the LSCB ability to do business. Sub-groups have been reconfigured and issued with revised terms of reference which reflect the priorities set out in the LSCB's business plan. The Board is well constituted. Tangible evidence of partners' commitment to the LSCB is provided by partners' charring of the sub-groups. The LSCB's business planning process has been thoroughly overhauled, with overarching priorities for the next three years being agreed. There are plans that in the future each priority will be supported by an annual delivery plan. The current business plan requires updating but provides a clear sense of purpose and direction, is outcome-focused and measurable, and reflects local needs and national priorities.
191. The LSCB is making a significant contribution to the improvement agenda and is increasingly providing effective leadership and promoting partnership working. The LSCB has identified the need for an overarching narrative in the form a single 'master plan', which pulls together the different strands of improvement activity, to make it easier for partners to understand the overall direction of travel.
192. The LSCB has overseen the development of a new threshold document, 'Responding to Need', but needs to make sure that there is greater clarity about whose needs will be met at level three and level four of the framework. The issue of consent also needs to be given greater prominence. The LSCB also has good oversight of the development and implementation of the early help and neglect strategies.
193. The Board is self-critical and self-aware. The 2012–13 annual report showed good critical self-awareness, emphasised the importance of monitoring the quality and effectiveness of safeguarding in individual agencies and provided good information about identified pressure points in the child's journey. There is a shared commitment to continuous improvement.
194. LSCB meeting minutes provide good evidence of peer challenge, for example on child sexual exploitation, the introduction of the single assessment and, more recently, decisions in respect of publishing a particularly sensitive SCR report. The minutes also show the attendance record of Board members in a way that is open and transparent and facilitates challenge.
195. Since his appointment, the new LSCB chair has demonstrated independence by his challenge to children's social care over the shortcomings of the neglect strategy delivery plan and the high number of cases that, at one stage, were reported as being unallocated.
196. With the exception of health partners, partner agencies have all now completed section 11 audits of their safeguarding compliance on a self-assessment basis. The validity of those self-assessments will be tested through a scrutiny and challenge session planned for July. Given the complexity of the local health landscape, the clinical commissioning group plans to submit a section 11 audit on

behalf of health partners. Looking ahead, health partners need to complete individual section 11 audits, and discussions are already underway about how best to achieve this.

197. The LSCB's performance management function is not yet sufficiently robust. While LSCB members recognise their responsibility to monitor the effectiveness of frontline practice, including early help, the Board's performance management arrangements are under developed. The data set is developing but is not yet reliable or multi-agency. This undermines the Board's ability to hold each partner equally to account. The LSCB should consider whether the current chair of the performance management sub-group is able to sufficiently facilitate independent critical challenge given that most performance management data currently being scrutinised is from their agency.
198. Liverpool is an active member of the Merseyside Child Death Overview Panel (CDOP), which is effective in identifying, reviewing and responding to learning from child deaths.
199. Serious Case Reviews (SCRs) and Critical Incident Reviews (CIRs) are undertaken in line with statutory guidance. Good use is made of CIRs, and the way in which the learning from reviews is distilled and disseminated has improved over time. Lessons from the most recent reviews are clear and explicit, and the LSCB has developed an effective action planning template and tracking tool. However, the LSCB does not currently audit or evaluate the implementation of SCR action plans, although there are plans to do so in future through the critical incident sub-group.
200. The broader quality assurance role of the LSCB is under-developed. While the LSCB has been involved in the development of an action plan in response to the areas for improvement identified by a recent audit of contact, referral and assessment arrangements in children's social care, its broader quality assurance role is under-developed. In the past the LSCB has carried out a significant amount of multi-agency audit activity, but not in a way that was targeted or focused. The new audit task and finish group has recently started to audit a limited number of individual case files in order to get a sense of the child's journey, but this work needs to be developed further.
201. The LSCB needs to strengthen the voice of the child to ensure that partners learn from the experiences of children and young people. While there is a link to the Children in Care Council on the LSCB website, the voice of the child is not strong. This is one of the Board's top priorities and there is work in progress intended to achieve this.
202. The LSCB continues to provide a range of training courses on safeguarding and neglect but there have been problems with the take-up of these courses by professionals and about the availability of trainers to deliver them. In the absence of an agreed multi-agency workforce competency framework, which is still at the development stage, the LSCB is not in a position to monitor and challenge the take-up of training by individual professionals or partner agencies.

While there are plans to evaluate the impact of training on professional practice and outcomes for children, this is also not yet in place.

203. Despite partners' commitment to safeguarding in general and to the LSCB in particular, capacity for the Board is an issue as well as funding. The long-term financial viability of the Board is dependent on increased contributions from partner agencies, and discussions are taking place about how best to achieve this.

What the inspection judgements mean: the LSCB

An outstanding LSCB is highly influential in improving the care and protection of children. Their evaluation of performance is exceptional and helps the local authority and its partners to understand the difference that services make and where they need to improve. The LSCB creates and fosters an effective learning culture.

An LSCB that is good coordinates the activity of statutory partners and monitors the effectiveness of local arrangements. Multi-agency training in the protection and care of children is effective and evaluated regularly for impact. The LSCB provides robust and rigorous evaluation and analysis of local performance that identifies areas for improvement and influences the planning and delivery of high-quality services.

An LSCB requires improvement if it does not yet demonstrate the characteristics of good.

An LSCB that is inadequate does not demonstrate that it has effective arrangements in place and the required skills to discharge its statutory functions. It does not understand the experiences of children and young people locally and fails to identify where improvements can be made.

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