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Ms Colette O'Brien
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Dear Ms O'Brien

## **Monitoring visit to Liverpool City Council children's services**

This letter summarises the findings of the monitoring visit to Liverpool City Council children's services on 14 and 15 March 2017. This was the second monitoring visit since the joint targeted area inspection (JTAI) of the multi-agency response to abuse and neglect in June 2016 found evidence of serious and widespread deficits across the partnership. The inspectors were Nigel Parkes HMI and Stella Elliott HMI.

The local authority is making steady progress in improving services for children and young people in Liverpool.

#### Areas covered by the visit

During the course of this visit, inspectors reviewed the progress made in the areas of:

- Leadership and management, and in particular how effective senior managers are in using performance management information and quality assurance systems to understand how well children and young people are being helped and protected.
- Help and protection, with a particular focus on how effective frontline teams are in identifying, managing and reducing risks.
- The effectiveness of the local authority's response to missing children and/or those who are, or are at risk of, being sexually exploited.

During the monitoring visit, inspectors tracked and sampled a number of children's and young people's cases. As well as speaking to social workers and managers, inspectors considered a range of evidence, including electronic case records, minutes of meetings, management reports, tracking tools, case audits and improvement plans.





#### **Overview**

The local authority has responded positively to the findings of the joint targeted area inspection. Better performance management information means that senior managers, leaders and elected members have a clearer picture of what is happening at the frontline. Strategy meetings are being used more effectively to share information and ensure that children and young people are safeguarded and protected. The local authority's response to children who go missing and/or are at risk of child sexual exploitation is more robust than it was at the time of the JTAI. The quality of return home interviews has improved considerably.

However, the local authority's approach to quality assurance is not yet sufficiently well developed. Partner agencies are not confident in applying the thresholds for access to children's social care services. Social work assessments which are not sufficiently robust are having a negative impact on re-referral rates. In some cases seen, risks are identified but are not clearly articulated. As a result, child in need and child protection plans are not always as sharply focused as they need to be. The combination of a high volume of referrals and relatively high caseloads means that capacity is an issue for assessment teams. The help and protection that most children and young people receive are not consistently good enough.

## Findings and evaluation of progress

#### 1. Leadership and management

Nine months on from the JTAI inspection in June 2016, senior managers are starting to make better use of performance management information and audit activity to drive improvement. Since the last monitoring visit, the monthly performance management and information summary has been enhanced. The latest version now includes information about: the completion and timeliness of return home interviews; conversion rates from contacts to referrals to assessments, as well as drop-out rates at each point of the process; partners' engagement with the early help assessment process; and referral sources. This means that senior managers are able to recognise issues and be in a position to take appropriate action as issues emerge.

The value of the new electronic case recording system is really starting to be felt. Frontline managers are enthusiastic about, and are making good use of, the new performance dashboard to monitor workflows and workload pressures and to manage performance. Social workers welcome the prompts and reminders that the system provides which, they feel, help them to prioritise their work. As a result, timeliness in the completion of key social work tasks is improving.

The local authority's approach to quality assurance is not yet sufficiently well developed or embedded. A lack of consistency in the way in which case management audits are completed demonstrates that managers do not yet have a shared understanding of what 'good', or what the local authority describes as 'adequate',



looks like. Audit action plans do not routinely specify the timescales for completing remedial tasks. Less than 40% of the case management audits which were due to be completed as part of two themed audits of assessments and re-referrals were completed and returned. Audit findings have to be manually completed. Analysis of them is unsophisticated. Even so, there is an increased focus on quality, and team managers are now less likely to sign off assessments which do not meet the required standard.

## 2. The identification, management and reduction of risks

Partner agencies are still not consistently applying the thresholds for access to children's social care services. The number of multi-agency referral forms (MARF) completed is low and the local authority has identified that very few early help assessments are initiated by health visitors or midwives. This means that some children may not be getting the right level of support. The local authority and the Local Safeguarding Children Board are working together to address this. A series of '60-minute MARF' meetings have been well attended. Further work is planned, both to better understand partners' behaviour and to market early help services more effectively.

When needs and risks are first identified, timely and effective onward referral to the relevant team or agency helps to ensure that children, young people and families have the help and support that they need. Inspectors saw evidence of cases being stepped up appropriately from early help to children's social care, but not always appropriately stepped down from children's social care to early help. This is having an impact on re-referral rates. Although there has been a drop in re-referral rates in the past year, partly as a result of data cleansing, inspectors found concerning evidence of original assessments that had not been sufficiently robust and/or of child in need episodes that should have been extended.

Capacity is an issue. Inspectors saw some evidence of good direct work with children and young people, although this is largely dependent on social workers having the time to do this. The sheer volume of referrals means that assessment teams are under considerable and constant pressure. Even allowing for the fact that some social workers are working with large families and/or carrying cases that need to be closed, caseloads are relatively high and, in some cases, too high.

The local authority is making better use of strategy meetings to safeguard and protect children. In most cases, strategy meetings are well attended by the relevant partner agencies, and are used effectively to share information and to plan and coordinate multi-agency responses. There is clear evidence of management oversight, although the quality of strategy meeting minutes is variable.

A priority of the local authority is to improve the quality of social work assessments. The assessment template has recently been amended to ensure that greater prominence is given to the child's voice. Assessments seen by inspectors were of a reasonable standard, contained an appropriate level of detail and, in most cases,



evidence of effective analysis. However, chronologies are poor. Most read like running records, rather than a list of significant events in children's lives. The way in which historical information about families' previous involvement with children's social care is repeatedly and uncritically cut and pasted from referrals to strategy meeting minutes, assessments and child protection conference minutes calls into question how effectively that information is understood or used.

While social workers are able to describe key risks and protective factors, these are not clearly articulated in child protection plans. This is partly a reflection on child protection conference chairs, who are responsible for drafting child protection plans as part of the child protection conference process. Too many plans seen by inspectors lacked specificity and, although there is no evidence of children being exposed to significant harm as a result, this lack of focus has the potential to undermine the ability of core groups to rigorously monitor progress against agreed priorities. It also makes it more difficult for parents to understand what it is that they need to do differently.

# 3. Missing and child sexual exploitation

The local authority has made significant progress in their operational response to missing children and child sexual exploitation since last June, when the JTAI found evidence of serious and widespread deficits across the partnership. The consultant social worker with lead responsibility for child sexual exploitation is active and visible. Robust referral pathways are well understood and are applied in a way that ensures that children and young people are safeguarded and protected more effectively. Increased awareness of child sexual exploitation means that social workers know how and when to use the CSE 1 screening and CSE 2 assessment tools, and are using them well to identify children and young people who are at risk.

Changes made previously in response to the outcome of the JTAI, including the introduction of daily multi-agency child exploitation group meetings and monthly multi-agency child sexual exploitation strategic intelligence group meetings, are now well embedded. Children and young people who have been, or are at risk of being, sexually exploited are identified, and information and intelligence about perpetrators and potential hotspots are being pooled effectively. Vulnerability management plans produced by workers in the Protect team are clear, detailed and outcome focused. Risks are regularly reviewed. This aims to ensure that children and young people are appropriately safeguarded and protected.

The quality of recording of return home interviews (RHIs) has improved significantly. The fact that the vast majority of RHIs are carried out by the same small group of workers provides continuity and ensures consistency. By building relationships with children and young people who are potentially vulnerable, these workers are in a unique position to offer advice, guidance and support. This also contributes to the richness of the intelligence gathered over time. Inspectors saw and heard good examples of real persistence that has made a difference in the lives of children and



young people, including where disclosure has led to the arrest of a significant number of adults.

At the time of this visit, the regular monthly performance management and information summary does not enable senior managers to differentiate between the completion and timeliness of RHIs involving children who go missing from home, including whether they are known or are not known to children's social care and, for those involving children who go missing from care, whether they are being looked after in Liverpool or elsewhere. This is an omission, but there are plans in place to address it.

I am copying this letter to the Department for Education. This letter will be published on the Ofsted website on 13 June 2017.

Yours sincerely

Nigel Parkes

**Her Majesty's Inspector**