

Ofsted  
Piccadilly Gate  
Store Street  
Manchester  
M1 2WD

T 0300 123 1231  
**Textphone** 0161 618 8524  
[enquiries@ofsted.gov.uk](mailto:enquiries@ofsted.gov.uk)  
[www.gov.uk/ofsted](http://www.gov.uk/ofsted)



22 October 2018

Mr Dwayne Johnson  
Sefton Metropolitan Borough Council  
Bootle Town Hall  
Oriel Road  
Bootle  
L20 7AE

Dear Dwayne,

### **Focused visit to Sefton local authority children's services**

This letter summarises the findings of a focused visit to Sefton local authority children's services on 27 and 28 September 2018. The inspectors were Stella Elliott and Pauline Higham, Her Majesty's Inspectors.

Inspectors looked at the local authority's arrangements for children in need and children subject to a plan, with a specific focus on services and practice for children who may be on the edge of care.

Inspectors looked at a range of evidence, including case discussions with social workers, meetings with independent reviewing officers (IROs), service managers and managers of the missing from care service. They also looked at local authority performance management and quality assurance information, children's case records and staff supervision records.

### **Overview**

Sefton local authority children's services were last inspected by Ofsted in April/May 2016, when the local authority was judged as requiring improvement to be good in all areas. Since then, a service restructure in Autumn 2017, including changes at senior management level, has contributed to the implementation of the current action plan to improve services for children and their families.

Since the last inspection, children in need of help and protection now generally benefit from better assessments that identify risk and inform the provision of appropriate intervention to keep children safe. Decision-making is usually timely and proportionate. Recent improvements in partner agency collaboration and ownership

of concerns have resulted in better focused help that supports families when they are experiencing difficulties in caring for their children.

The risks posed by child sexual exploitation and criminal exploitation are well recognised by the local authority. The multi-agency work that is being completed pan-Merseyside ensures that current and potential risks to children are swiftly recognised, with appropriate intelligence-sharing contributing to the protection of vulnerable children.

When children are stepped down from a child protection plan, this has not always been informed by a re-assessment that takes full account of all risk and protective factors.

Fewer numbers of children who are on care orders are placed at home with parents than at the time of the most recent inspection. This has been achieved because of the improved quality of reassessments enabling the court to agree to the discharge of the care order.

High caseloads for some social workers, including newly qualified workers, mean that the quality of practice is inconsistent.

### **What needs to improve in this area of social work practice**

- Manageable caseloads in the locality teams, improvements in recording of line management oversight and the quality of supervision.
- Updating children's assessments when their circumstances change to improve planning for all children.
- The processes used to escalate cases to proceedings to minimise drift and delay, including the clarity of pre-proceedings letters.
- Audit activity that informs workers' and managers' development and promotes consistent and high-quality practice for all children.
- Sufficiency of support and proactive services for those children identified as being on the edge of care.

### **Findings**

- Purposeful, direct work is being carried out to ensure that the child's views and feelings are well understood. Social workers know the children in their care very well, and children are being seen regularly. Inspectors saw that, in the children's interest, workers challenge partners and managers strongly. The impact of high caseloads diminishes the social workers' abilities to maintain consistently high-quality practice.

- While some assessments fully evaluate a child's needs with careful analysis of risk, protective factors, the child's voice and the family history, others lack reflection and detail, and are not regularly updated. Accepting parents' views was too prevalent in some assessments and in a small number of records social workers and partners were over-optimistic about parental capacity to change. This means that assessments are not capturing an accurate picture of the child's situation. The lack of management oversight and the poor-quality supervision in some teams compound these inconsistencies in practice.
- Thresholds are applied appropriately and are understood by partners, which enables the right support and intervention to be provided for children in need of help or protection. The development of multi-agency collaboration is a significant factor in ensuring that decision-making is mostly swift and effective. The current, slightly increasing numbers of children on a child protection plan and children becoming looked after are a positive consequence of the local authority and partners increasing their focus on the impact of neglect, substance misuse and domestic violence on children in this local authority. Attendance by some partners at core groups and child protection conferences remains a concern for the local authority and the LSCB, which recognise that the poor attendance of some partners means that meetings are not quorate, which impacts at times on timely decision-making for children.
- When children's experiences indicate that they may be at the edge of care, seven-day targeted services support some families in crisis, as well as through the provision of parenting courses. This assists families' understanding of effective behaviour management and improves their capacity to parent their own children. While crisis intervention and some targeted interventions such as the Community Adolescent Service are available, when situations escalate, families do not have the benefit of a wide range of proactive models of practice. For example, family group conferencing may contribute to children being better supported to live in their families and communities.
- The majority of children's child protection and care plans are strongly evaluated and progressed by IROs. The consistency of oversight of children's plans, provided by a well-established IRO team, means that children's wishes and feelings do not get lost. The impact and effectiveness of the practice-alerts seen on children's records, however, are not always met with a robust and immediate response from social workers. This is a missed opportunity to make use of the IROs' experience and independence, and to improve outcomes for children.
- When home situations for children in need or children who are subject to a child protection plan do not improve, the processes to escalate to proceedings are not smooth. The introduction of a legal tracker, overseen by a newly

appointed court liaison officer, is just beginning to embed. Letters to families in pre-proceedings are unclear. The current schedule of expectations does not spell out what families need to do in order to improve the care of their children and in what timescale.

- The multi-agency response to the needs and experiences of children is now effectively overseen by the LCSB. Challenge to partner agencies has been focused and is underpinned by close scrutiny of performance. Learning from audit activity and serious case reviews is increasingly disseminated well in a variety of formats. The introduction of seven-minute briefings is valued by social workers and helps to inform their current practice, assisting them to promote positive change in children's lives.
- The risks to increasingly younger children posed by criminal and child sexual exploitation is well understood by the local authority. The introduction of a missing from home/care team has helped to ensure that liaison with partners captures relevant intelligence, as well as identifying potential and emerging risks. Decisive action is effectively coordinated to mitigate and lessen the impact on children.
- The number of children on care orders placed at home with their parents has been reduced effectively over the past year. Care orders have been discharged as a result of the court's growing confidence in the quality of support plans and reports. The impact of this reduction is that some teams in the local authority have increased capacity to concentrate on the quality and improvement of their practice, and improvements in children receiving health and dental reviews.
- Recent audit activity has been intermittent, and the use of audit tools has been inconsistent. Although most audits highlight relevant issues in relation to social work practice, it is not clear how or when case holders and managers are given feedback in order to ensure that the impact of audits is supporting improvements to practice.
- The local authority's accurate self-assessment demonstrates that it knows its areas of strength and areas for development. Specifically, they know that high caseloads in several locality teams, and limited management capacity and oversight, impact on the consistency and quality of social work practice. Although plans to address these shortfalls are assisted by the recent approval of funds for additional social work capacity, the challenge remains for the recruitment and retention of sufficient social workers to progress plans for further improvement.

Ofsted will take the findings from this focused visit into account when planning your next inspection or visit.

Yours sincerely

Stella Elliott  
**Her Majesty's Inspector**