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24 May 2019

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Dear Steve

Focused visit to Liverpool local authority children's services

This letter summarises the findings of a focused visit to Liverpool children's services on 30 April and 1 May 2019. The inspectors were Shabana Abasi, Her Majesty's Inspector, and Peter McEntee, Her Majesty's Inspector.

Inspectors looked at the local authority's arrangements for permanence planning and a number of options other than adoption that are available for achieving permanence for children in care.

Inspectors also evaluated the effectiveness of performance management, management oversight, supervision and quality assurance.

Inspectors looked at a range of evidence, including case discussions with social workers. They also looked at local authority performance management and quality assurance information and children's case records.

Overview

Liverpool children's services were inspected in May 2018, when all areas were judged to require improvement to be good. Although there has been some work done to improve services since this inspection, this has led to minimal impact on the experiences and outcomes for some children in care. Some of the inspectors' findings highlight that the concerns raised in the May 2018 inspection remain.

During the last 12 months, the local authority has strengthened its senior leadership team with permanent appointments. This has enabled the local authority to set the foundations for improving the quality of practice and for improving outcomes for children. Leaders acknowledge that there is more to do to ensure that permanence planning for all children in care is good. The local authority's self-evaluation demonstrates that senior leaders have an accurate knowledge of their services and have put in place a number of initiatives designed to strengthen and improve arrangements for permanence for children in care. This includes plans to safely reduce the overall number of children in care through a permanence plan that secures their longer-term placement. To support this aim, the local authority has arrangements in place to track and monitor the progress and the ratification of plans.

The findings from this focused visit mirror the areas of improvement that have been identified by the local authority through its own audit activity. A number of the areas needing improvement were also highlighted as requiring improvement in the Ofsted inspection in May 2018. The local authority's focus on improved compliance has not translated into improved practice and has not secured permanence for all children who need it. This means that the quality of some assessments and plans is still not strong enough. Management oversight, including that of independent reviewing officers (IROs), is poor and often ineffective and has not helped to ensure that planning for all children is progressed in a timely way.

Caseloads remain too high for some social workers and IROs. Senior leaders and elected members are working together to prioritise the recruitment and retention of additional staff as part of a service re-design that social workers feel optimistic will have a positive impact on practice, including a reduction in caseloads.

There continues to be strong political and corporate support for children's services. At a time of budget pressures, elected members have agreed to further substantial investment in children's services.

Progress has been made in the timeliness of statutory requirements such as reviews, completion of health assessments, dental checks and strengths and difficulties questionnaires. For the majority of children, their placements are meeting the children's needs and improving their outcomes.

What needs to improve in this area of social work practice

- The timeliness of permanency planning for all children in care.
- The quality and frequency of assessments to inform care planning.
- Care plans which set out clear and measurable outcomes.
- Recording of supervision sessions to include reflection, challenge and agreed next steps.
- The quality and consistency of oversight and challenge by IROs.

Findings

- Decision-making and application of the threshold for bringing children into care is appropriate. In a very small number of cases seen, there were missed opportunities to take more timely action to address escalating concerns for children.
- Permanence planning is not robust and does not consistently take place within the child's timescale. Drift in care planning has led to some children remaining in long-term foster placements by default rather than through effective and focused planning. Action is being taken to address previous delays, and senior managers are working through a backlog of cases to amend or formally ratify children's permanence plans. At the time of the visit, 70 children had been matched with their permanent long-term foster carers and 46 children had achieved permanence through their care orders having been discharged. Although there is some delay in securing permanence for many children, placements are safe, stable and are meeting children's needs and improving their outcomes. There is no systematic management oversight and regular review by the local authority of placements with parents (PwP) other than the initial sign off. There is no evidence of a regular review of the agreement by a senior manager apart from the initial sign-off. Social workers were unsure about whether this function is carried out in statutory reviews or by senior managers, which indicates poor understanding of the requirements for PwP approval and review.
- Family group conferences (FGC) are not always considered in cases where it would be appropriate to do this. Where FGCs do take place, they are used well to identify potential kinship carers at an early stage. This leads to timely completion of assessments in order to determine whether it is in children's best interest to remain living within their family. In most cases where a special guardianship order (SGOs) is considered as a permanence option, it is appropriate and in the child's best interest. However, for some children living with kinship carers, there is a delay in securing SGOs. This means that some children continue to receive a

statutory social work intervention when they no longer require this. For children who need to be in care from birth, permanency planning is appropriately considered. Increased use of foster to adopt placements has secured early permanence for some children.

- Assessments informing children's permanence plans are of variable quality. Stronger assessments evidence an informed analysis of risks and placement needs of children. Weaker assessments are not consistently comprehensive or analytical, and do not reflect the day-to-day lived experiences of the child. Assessments are not routinely updated when a child's circumstances change, and this undermines the effectiveness, of care planning and interventions. The local authority has recognised this shortfall in practice and has a target to update all assessments of children in care annually. At the time of the focused visit, 63% of children in care had had an updated annual assessment. Assessments considering whether brothers and sisters should be placed together or apart are generally detailed and contain good analysis of the risks and strengths of placement options. Arrangements for children to have contact with their families and other people who are important to them are often well considered and promoted.

- Social workers visit children regularly and children are seen alone. Recordings of visits are mostly thorough, and evidence the wishes and feelings of children. However, direct work that is undertaken is not always reflected in children's case notes. The recording for most children's care plans is weak. The overall aim of the plan, longer-term care planning, contingency and parallel arrangements are not always evident, and this leads to avoidable delay for some children. Better plans are appropriately detailed, and include clear contingency, actions and timescales, evidencing the improvements made to children's outcomes.

- Care planning meetings are not used consistently or effectively prior to reviews to focus on and drive permanency planning. IROs do not effectively challenge any drift or delay for the majority of children's plans, and records do not indicate how the review process is used to ask critical questions about the decisions made about children, or to consider their future needs. Senior managers have identified this as a priority area for improvement.

- The majority of statutory reviews are timely and are attended by the relevant professionals. Children are encouraged to attend and participate in their reviews. However, the views of children are not always well recorded within the minutes, and therefore it is not clear how the voice of the child informs care planning. Where reviews are effective, they are focused on achieving and monitoring the progress of children in placements. In weaker reviews, there are no specific timescales set against each identified action other than the date of the next review. This means that some actions are needlessly delayed, and children's plans for permanence are not progressed in a timely way.

- Life-story work is not undertaken with all children in care. Children wait too long to understand the transitions and changes they have experienced and the decisions that have been made for them. Senior managers have identified this as a targeted area of improvement, and a commissioned provider is undertaking this work with some children.

- Management oversight is evident on the majority of children's case files. However, it is weak, the rationale for managers' decisions is not always clear and the impact of management oversight on children's plans is not consistently evident. Supervision of social workers is either not taking place regularly or not being recorded. Where it is recorded, it does not provide a sufficiently analytical overview of the children's cases or clear case direction, nor does it demonstrate reflective practice.

- Quality assurance of practice through auditing of work is not consistently focused on the impact of that work on children. Audits are not always completed well, and case audits are not subject to a moderation process. This a missed opportunity to further strengthen the local authority's overview of practice.

- Strengthened performance data means that leaders have a better understanding of key priorities. Senior managers have taken responsibility for introducing and managing a number of permanence trackers and panels, and have a clear strategic overview. This has not yet translated into improved quality of practice and means that permanence has not been secured for some children within their timescales. Senior managers are acutely aware of the challenges that they face to develop the service further while simultaneously addressing the areas of weaker practice. They recognise that there is more work to be undertaken to ensure that practice is consistently good and that the best outcomes are achieved for all children.

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

Yours sincerely

Shabana Abasi
Her Majesty's Inspector