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Dear Vicky

Focused visit to Sefton children's services

Her Majesty's Chief Inspector of Education, Children's Services and Skills is leading Ofsted's work into how England's social care system has delivered child-centred practice and care within the context of the restrictions placed on society during the COVID-19 (coronavirus) pandemic.

This letter summarises the findings of a focused visit to Sefton children's services on 10 and 11 March 2021. Her Majesty's Inspectors were Mandy Nightingale, Lisa Summers, Brenda McLaughlin, Andrew Waugh and Nasim Butt.

The methodology for this visit was in line with the inspection of local authority children's services (ILACS) framework. However, the delivery model was adapted to reflect the COVID-19 context. This visit was carried out fully by remote means. Inspectors used video calls for discussions with local authority staff, carers, key stakeholders and young people. They also looked at local authority performance management and quality assurance information and children's case records. The lead inspector and the director of children's services agreed arrangements to deliver this visit effectively while working within national and local guidelines for responding to COVID-19.

Areas for priority action

- Timely application of the pre-proceedings stage of the Public Law Outline where risks for children are not reducing through child protection planning.
- The effectiveness of case supervision and the monitoring of children who are subject to child protection planning, including those children in the pre-proceedings process, to prevent drift and delay.

What needs to improve in this area of social work practice

- The quality assurance arrangements and senior management oversight of social work practice.
- The strategic and operational focus on achieving change and reducing risk for vulnerable children, including disabled children and care leavers.
- The capacity in social work teams and the number of children on social workers' caseloads.

Findings

- The impact of the COVID-19 pandemic has been significant for Sefton. For most of the last year, the local authority has been categorised as a high-risk area and subject to the tightest lockdown restrictions. Partner agencies in the multi-agency safeguarding hub (MASH) have worked well together to continue to provide an effective response to children in need or at risk of harm, in a town where deprivation is high. The local authority's relationship with education providers has significantly strengthened during the pandemic. Welfare visits have supported an effective focus on all vulnerable children attending school and on those children not attending school. Leaders have ensured that COVID-19 risk assessments have been completed for all children known to children's social care, to inform how often social workers visit them. This has been through a mix of face-to-face and virtual visits. However, visits to children in person do not always take children's individual circumstances into consideration. Regulatory flexibilities to support ongoing work with children and families during the pandemic have been kept to a minimum and their use has been monitored appropriately. Senior leaders have implemented additional services to support staff well-being during the pandemic. Some social workers reported that they do not feel listened to and valued by senior leaders.
- Too many children are left in unassessed or high-risk situations for too long. The slow pace of change in some areas means that change for children is not happening quickly enough and some planned service improvements are underdeveloped. Poor-quality supervision and ineffective management challenge contribute to drift and delay for children. Senior leaders know broadly the areas that need to change to improve social work practice and children's experiences. However, they were not aware of the degree of drift and delay experienced by most children.
- Senior and political leaders have maintained a focus on improving services for vulnerable children and have allocated additional funding to support the improvement planning. However, the action taken by leaders and managers is not always having sufficient impact on improving children's circumstances. Recruitment of experienced social workers to vacancies and additional posts remains a challenge. Social workers are not able to complete all the statutory tasks required of them and this hinders the building of relationships between

children and social workers. Some social workers told inspectors that the only way to keep up with their workloads is to work weekends and evenings.

- A recently updated quality assurance framework is not effective in giving senior leaders sufficient assurance as to the quality of practice and the impact on children's lived experiences. Regular audits and themed dip-sampling activity are taking place, although too many audits are process-focused and fail to consider the impact of the social work practice on children's lived experiences. There is no shared understanding of what good looks like, to measure the progress of children's experiences and practice improvement. Audits are moderated by senior leaders to support consistency, but this is too new to have a significant impact on improving practice.
- The MASH has clear well-established systems and robust management oversight. The co-location and collaboration of partner agencies in the MASH is leading to effective decision-making for children. There is routine analysis of historical multi-agency information and consent is appropriately sought. Partners understand the thresholds for different levels of intervention and support and make appropriately timely referrals to early help services or the MASH. The initial response from the MASH is effective and most children receive the right service promptly.
- When children require immediate protection, multi-agency strategy meetings and subsequent child protection enquiries are timely and proportionate to the risks identified. Appropriate decisions are made and actions taken to reduce risk to children. When child protection concerns are raised for disabled children, these are allocated to social workers in the locality teams and co-worked with the allocated disabled children's social worker. This too often leads to insufficient management oversight, with safeguarding being considered in isolation to the impact of the child's disability.
- When children need a child and family assessment, these are mostly allocated promptly. The quality of assessments is variable and for some children this does not lead to consistently good decisions being made.
- The quality of social work practice in the locality teams is highly variable. Social workers in these teams have responsibility for working with children in need of help and protection and children in care to their first review. Too many social workers have high caseloads. This impacts on their ability to visit children regularly, complete direct work with them and update assessments when children's needs change.
- There is drift and delay in decisions being made for children subject to child protection plans. Some of this work is historical, although not all, and recent practice is not leading to sustained change for these vulnerable children. There is a lack of clear contingency planning for children, and challenge by child protection chairs and the core group is not effective.
- When circumstances do not improve for children, cases are not escalated to the pre-proceedings process or to care proceedings in a timely way. Children experience significant drift and delay because the arrangements for tracking and monitoring progress do not support effective management oversight and an

understanding of practice deficits. Challenge meetings, facilitated by senior managers, do not occur regularly or address the actions identified to progress children's cases.

- For children experiencing, or at risk of, exploitation and those that go missing, the local authority has worked effectively with its partners at a strategic level to support improvements in practice. For some children, the risks relating to exploitation and going missing are beginning to be more consistently identified and assessed. These changes are too recent to evaluate the impact on children.
- Effective partnership working between schools, parents and the local authority has reduced the number of children electively home educated where this was not the most appropriate choice. Leaders have purposeful systems in place to monitor and track children who are not in education. The First Day Response system supports staff to identify children not in school and to develop, and complete, welfare checks for all vulnerable children not in school.
- Decision-making for children to come into care is mostly appropriate, although too many children are subject to ongoing and long-term child protection planning where risks to them are not reducing and decisive actions are not being taken to improve their circumstances. For younger children, social workers have a good choice of placements to meet their needs. However, this is not consistently the case for older children and those with complex needs. Some children have too many placements before a suitable long-term match is found and a small number remain living in high-risk or unsuitable arrangements.
- Support for children's emotional well-being and mental health has not been consistently available throughout the pandemic, although a dedicated therapeutic service for children in care has been available for some children. Children's physical health needs are met. Children are well supported to maintain relationships with people who are important to them and family time is promoted and facilitated.
- The number of children in care attending school has slightly reduced during this term. The virtual school has effective strategies in place and is actively exploring the barriers from the child's perspective and finding better solutions to support individual children to attend school.
- The level of vulnerability of care leavers is not always reflected or considered when determining the nature and frequency for maintaining contact with them. Personal advisers (PAs) have maintained regular contact with care leavers during the pandemic, although young people told inspectors that there is a lack of bespoke support to meet their needs and contact with their PA is predominantly if the young person initiates it.
- Planning and work with children in care to help them prepare for leaving care starts too late for them to build a meaningful relationship with their PA. This reduces the effectiveness and impact of the work undertaken. Most care leavers live in suitable placements that are safe and meet their needs. This includes the opportunity to stay in their placements beyond the age of 18 years.

- Decision-making about care leavers' education, employment or training does not happen early enough. This reduces choice and opportunity for young people. Care leavers told inspectors that staff lack aspiration and ambition for them.

We have notified the Department for Education of the areas for priority action and we understand you will receive separate correspondence from them. In terms of our next steps, we will be considering whether our next activity in Sefton will be a focused visit or a standard inspection.

Yours sincerely

Mandy Nightingale
Her Majesty's Inspector