

Inspection of Knowsley Council local authority children's services

Inspection dates: 11 to 22 October 2021

Lead inspector: Paula Thomson-Jones, Her Majesty's Inspector

Judgement	Grade
The impact of leaders on social work practice with children and families	Requires improvement to be good
The experiences and progress of children who need help and protection	Requires improvement to be good
The experiences and progress of children in care and care leavers	Requires improvement to be good
Overall effectiveness	Requires improvement to be good

For most children receiving social care in Knowsley, their experience of services has not improved since the last full inspection in 2017. Leaders have ensured that children are seen regularly, that they have assessments, plans and reviews completed in a timely way, and that they are provided with support from a range of relevant services. The impact of this work is not consistently effective because of continuing weaknesses in the quality of practice with children and their families. There are some examples of strong work from some individual social workers, but, overall, the quality of work undertaken with children in need of help and protection, and children in care, requires improvement to be good. The services provided to care leavers have deteriorated.

Following the last focused visit in January 2020, leaders recognised that the pace of previous improvement had not been sustained, and that the experience of some children had declined. During 2020, a more accurate self-assessment was developed, and changes were implemented to develop services for children.

Since the onset of the pandemic in March 2020, Knowsley has consistently had one of the highest rates of COVID-19 cases in the country and this has continued throughout much of 2021. This has exacerbated the pre-existing high levels of deprivation and inequality in the area. The additional demands of the pandemic affected the capacity of both frontline staff and strategic leadership, and have more

recently led to a rise in the demand for children's services, particularly for children at risk of exploitation and those experiencing domestic abuse.

What needs to improve?

- The quality and impact of the support provided to care leavers.
- The quality of assessments and plans for children in need of help and protection, particularly where children live in households where there is domestic abuse.
- The response to children who present as homeless.
- The quality of work with children who live in private fostering arrangements.
- The arrangements for the transition of children from children's to adult services.

The experiences and progress of children who need help and protection: requires improvement to be good

1. Children who need support are identified and provided with appropriate early help services. For many children, this provides sufficient support to meet their needs and help their families. When things do not get better for children, there are effective systems in place to review their progress and transfer cases to social work services for further assessment of their needs.
2. When children are at immediate risk, this is recognised and responded to effectively. Strategy meetings in the multi-agency safeguarding hub (MASH) are well organised and well attended by partner agencies, who share good-quality information to inform decision-making. The outcomes of these meetings are clearly recorded and include a rationale about alternatives that have been considered.
3. For most children, thresholds are consistently and appropriately applied to ensure that they get the right help at the right time. Decisions taken in the MASH about next steps are informed by thorough information-gathering and clearly evidenced analysis.
4. There are weaknesses in the response to children who are at risk as the result of domestic abuse. Delays in the police screening of some incidents of domestic abuse, and weaknesses in the quality of the initial risk analysis by workers in the MASH, lead to delays in referral to social care for some children. Decision-making for children who experience domestic abuse does not consistently demonstrate that workers have a good understanding of the nature of this risk. For some children, this means there is delay in action being taken to protect them from further harm.
5. The response to domestic abuse across children's services places too much responsibility on mothers to take action to protect their children. Safety plans often state that they, despite being the victims of abuse, are responsible for safeguarding and protecting their children, without considering the role of the

perpetrators. This leads to plans to support children and their families being less effective and children's experiences not improving. The local area partnership is currently developing a revised strategy to respond to domestic abuse, led by a new domestic abuse partnership board, which was established in May 2021. The rise in incidents, combined with the additional challenges of delivering services during the pandemic, has promoted an appropriate renewed focus to improve the outcomes for children and their families who are affected by domestic abuse.

6. Most children are seen regularly by social workers who listen to them and record what they say. However, social workers do not always carry out purposeful direct work to really understand children's lived experiences. This means that it is not always clear if social workers really understand if children's lives are improving because of the support that is provided.
7. Most assessments of children and families, including those for disabled children, do not include a thorough analysis of needs and risks. There is insufficient consideration of the impact on children of living with parents who have mental ill-health or problems with substance misuse, or when there is domestic abuse present in the home. Assessments do not always include enough attention to adult males, or evaluate children's needs in respect of their identity, particularly when they are from an ethnic minority background. For most children, assessments do lead to the provision of a coordinated range of services that offer some help and support. For some children, the gaps in assessments mean that not all issues that affect their lives are fully understood or addressed effectively, and as a result their situation does not improve.
8. Child in need and child protection plans are not focused on outcomes for children, and do not measure if their lives are improving. For some children, this leads to periods of intervention, with little progress being made. Most children have written plans, and they are reviewed regularly in child in need meetings, core groups and child protection reviews. Although these meetings are attended by relevant professionals who share information, the lack of focus on children's outcomes means that they are not effective at driving improvement. For some disabled children, plans are not well coordinated or regularly reviewed, and this leads to these children not getting sufficient support at the right time.
9. When the local authority remains concerned about children, and decides that legal action is necessary, the meetings and plans that take place in the pre-proceedings phase do not focus enough on what the child's life is like. This leads to drift and delay for some children. A few children are stepped out of pre-proceedings appropriately when plans are successful at reducing risk, but others are stepped out too soon, and this leads to further periods of intervention and delay before the right action is taken.
10. Management oversight does take place through regular supervision for most social workers, but it does not ensure that progress for children is achieved.

Managers do not routinely address weaknesses in quality that will drive improvement. There is evidence of child protection chairs raising concerns when work is not progressing, but this is often focused on processes rather than the quality of practice or the impact and progress of the plan for children.

11. When disabled children are going to need continued support from adult services, the planning for this transition starts too late. A lack of effective systems, and joint working at an early enough stage, lead to young people approaching their 18th birthday without having a clear and agreed plan for transition in place, causing uncertainty for them and their families.
12. The quality of work for children who are living in private fostering arrangements does not ensure that their well-being is promoted. Leaders and managers have not maintained sufficient oversight of this very small group of children. The quality of assessments of private fostering arrangements, and the systems in place to ensure that these placements are regularly reviewed, continues to be poor, despite recommendations at previous inspections.
13. When children who are 16 and 17 years old present as homeless, the assessments that are undertaken are too superficial, and do not lead to enough support to meet their needs. Although their immediate need for accommodation is addressed, for most of these children, there is insufficient help from children's social care despite their high level of vulnerability.
14. Children who go missing are offered effective return home interviews which consider the reasons for them going missing and any potential risks of exploitation. Information about the reasons for children going missing is appropriately shared with other agencies, such as schools, to allow them to support children.
15. Children at risk of exploitation benefit from thoughtful and persistent work by specialist workers. The relationships that they establish and the good-quality work they undertake lead to a reduction in risk for most children. Shield, the multi-agency specialist team, uses available intelligence to target offenders and potential perpetrators of exploitation to reduce risks to children. This includes working with local police to safeguard children caught up in police operations.
16. Children who are electively home educated and children missing from education are monitored to determine if their educational arrangements are meeting their needs. This has helped many vulnerable children to remain in education, and those children whose needs are not met by being educated at home are supported to return to attend school.

The experiences and progress of children in care and care leavers: requires improvement to be good

17. The experiences and progress of care leavers in Knowsley have deteriorated since the last inspection. Despite a workforce of caring personal advisers, who

manage to build some positive relationships with young people, a lack of effective corporate parenting has led to a decline in the service that they receive.

18. There is insufficient work with many young people prior to their 18th birthday, and, as a result, many care leavers do not receive the support they need to prepare them to move into adulthood at a pace that is right for them. Pathway plans for most care leavers are poor. They do not demonstrate ambition and aspiration to support care leavers to achieve the best for their future. Reviews of pathway plans do not happen as often as they should, including when circumstances change. As a result, professionals are not working successfully with most young people to ensure that they make progress.
19. Some care leavers are not supported effectively to achieve and progress with education, employment and training, and so many are not fulfilling their full potential. Some care leavers who are academically successful go on into higher education and do well. However, most care leavers are not helped to identify their long-term goals and aspirations, or supported to take the steps needed to achieve them.
20. Many care leavers experience difficulty in obtaining safe, secure accommodation that meets their needs. This leads to some care leavers spending periods of time staying inappropriately with friends or family in informal arrangements while they wait for their next home to be identified.
21. Care leavers talked to us about their experiences and much of what they shared reflected what inspectors had seen during this inspection. They feel that they do not have a choice about where they live; some were unhappy with their housing; and others did not feel that they had enough support with education or employment. Care leavers feel that they are often left to try and sort these things out directly with other agencies, as they perceive that their personal advisers are unable to help them.
22. When inspectors looked at how children are supported when they are still in care, they found that their experiences had remained similar to those seen at the previous inspection. Decisions for children to come into care are clear and appropriate to protect and support them. For most children, this occurred in a timely way. In a small number of cases, there was some delay, with children living in neglectful circumstances for too long.
23. Care plans for children do not always focus on the desired outcomes for children. They do not consistently pull together all actions that need to be undertaken or identify who will take them forward. This means that it is often hard to understand the work that is being done with children. There is a lack of contingency planning and this causes some reactive work and last-minute disruption, particularly for older children. Care plans are not written in a child-friendly format, so children do not have a document that they can use to understand the plan about their life.

24. Discussions about education as part of care planning are not sufficiently aspirational or focused on children's attainment and progress; instead, they often focus solely on attendance. Personal education plans (PEPs) are not integrated effectively into children's care plans, which leads to insufficient focus on educational progress during looked-after children's review meetings. The quality of these PEPs is not good enough. They do not consistently have clear, specific targets and many do not contain enough detail about children's educational progress.
25. Social workers build positive relationships with most children in care and have a good understanding of their histories, needs, wishes and feelings. Although social workers can describe how many children benefit from direct work with them, this is not always clearly recorded on the child's case files. This means that case records do not consistently provide a good understanding of who the child is or their experiences.
26. Most children have time with their families that takes place at the right frequency and in the right environment for them. Social workers regularly review the frequency and quality of the family time children have. They consider both children's and their parents' views and the impact for children when seeing or having other forms of communication with their family, and they adjust arrangements appropriately.
27. Children in care have their health needs carefully considered as part of care planning. They regularly have health assessments, and their physical and emotional health needs are well met. Their emotional health is monitored effectively, and they are provided with timely specialist support when this is required.
28. Independent reviewing officers are visible and know the children well. They spend time with children and ensure that they are able to participate in their reviews. Although they raise challenges with social workers when things are not progressing as planned, this has often been done informally and it is not clear from case records if their work has had an impact. A new system for raising concerns has recently been implemented, and when this has been used it has led to positive outcomes for children.
29. Most children in foster care are living in stable placements and can build strong relationships with their carers that help them to make progress. For some children in residential care, their experience has not been as stable, and they have not made as much progress. For these children, particularly those who have the most complex needs and who are at the most risk, their care planning is too often focused on the presenting needs, rather than on longer-term goals for the future.
30. The quality of social work completed for children who are the subject of care proceedings is stronger than for other children. Assessments are thorough and child-focused. All available permanence options are considered for children at

an early stage of proceedings and the timetable for actions is then carefully planned and followed. This leads to effective permanence being achieved for many children.

31. Adoption is considered as a permanence option for children when it is appropriate to do so, and their individual needs are addressed well in their plans. This includes assessments to inform decisions about whether they should live with their brothers and sisters. This strong assessment of needs and planning leads to child-focused matching with prospective adopters, and children live with families who meet their needs.

The impact of leaders on social work practice with children and families: requires improvement to be good

32. At the last full inspection in 2017, services were found to have substantially improved from a previous judgement of inadequate and were judged to require improvement. During 2018, a focused visit by Ofsted reported that there was some further progress in some parts of the service, primarily in the MASH. However, at the Ofsted focused visit that took place in January 2020, inspectors advised the local authority that the pace of progress had not been sustained.
33. Shortly after the findings of this visit were published, the country experienced the start of the COVID-19 pandemic. Knowsley has been particularly affected, with very high rates of COVID-19 throughout that intensified pre-existing high levels of deprivation. Staff within the local authority have worked effectively with partner agencies to mitigate the impact of the pandemic on children and young people. They have ensured that compliance has been maintained with basic social work functions to help keep children safe, in spite of the challenges presented during the pandemic. In particular, there are strong partnership arrangements in the MASH and well-considered interventions for children who are at risk of exploitation. Consideration has also been given to identifying areas for improvement and strategic plans have been revised for key areas of service.
34. During this period, the appointment of a new director of children's services (DCS), in July 2020, led to further evaluation to fully understand the quality of children's services. This work identified that significant structural and cultural changes were needed to address the lack of progress and support future improvement.
35. At the start of this inspection, the DCS, and senior and political leaders, presented a clear and shared understanding that, despite their ambition, the experiences and progress of children in Knowsley had not improved. The chief executive and political leaders have provided continued support and commitment to address this lack of improvement, with budgets being protected and further investment delivered.

36. The corporate parenting board's scrutiny is not sufficient to ensure that its work is having an impact on improving services for children in care and care leavers. There is evidence of young people being able to contribute to these meetings, but it is not clear how the work that they are involved in is used by the local authority to improve services.
37. Quality assurance and audit activity has been strengthened over the last 12 months, and now offers a more accurate evaluation of the experiences of children and areas for improvement. Although it has provided enough information for leaders to have a broad understanding about the quality of services, audit work does not consistently provide detailed evaluation of social work practice in all areas. For example, the quality of assessment of children's needs and of planning is not fully evaluated, and, as a result, the findings from audit are not driving improvement.
38. Management oversight of frontline practice does not provide consistent quality assurance or lead to improvement in children's experiences. Most social workers have regular supervision, but this is often focused on basic compliance, such as children being seen and meetings taking place, rather than ensuring progress for children. The lack of impact of managers on frontline practice was identified by leaders as a key area for improvement, and a restructure of children's services has taken place during 2021. This has introduced an additional layer of management with smaller spans of control, but it is too early to see any impact on their work.
39. Senior leaders recognise that the restructure has created a relatively inexperienced management team. They have identified that a training and development plan is needed to equip the new management team with the skills and expertise to ensure development of high-quality services for children. A revised corporate workforce strategy includes access to bespoke training for all managers from January 2022, in addition to the corporate and national opportunities that are already available.
40. Over the last 12 months, leaders have appropriately prioritised the need to create a culture of greater ambition and aspiration for children within the workforce. They have taken steps to address poor performance and have been clear that the additional challenges of the pandemic should not get in the way of improving services for children. Work has continued to further embed the chosen model of social work practice and this is now used consistently. There are plans in place to develop this further to support practice improvement. The local authority is using opportunities to further develop services for children through wider national programmes and pilot projects. This includes work with the University of Bedford on contextual safeguarding and the Department for Education on a pilot for family group conferences.
41. Staff are positive about working in the local authority, and most feel that their workload is manageable. After a period of workforce stability, there has been a recent increase in staff turnover and the use of some agency staff. Despite

these challenges, staff described feeling listened to and supported. They appreciate the renewed drive from senior leaders to improve children's experiences and appreciate the good-quality training and support that are available.



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