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Inspection of Sefton local authority children's services

Inspection dates: 21 February to 4 March 2022

Lead inspector: Lisa Summers, Her Majesty's Inspector

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

Services to children and families in Sefton Metropolitan Borough Council are inadequate. Over a long period, the political and executive leadership has not secured the structures, systems and processes to keep an effective single line of oversight of children's services. Services for children and young people had been dispersed across the council. Since the last inspection in 2016, there has been a significant deterioration in services. A joint targeted area inspection in September 2019 and a focused visit in March 2021 both identified serious weaknesses in child protection practice and management oversight resulting in areas for priority action. The council and senior leaders have not sufficiently understood these failures or taken the necessary actions to improve services for children. The appointment of an external interim director of children's services in June 2021 has exposed the extensive inadequacies, which the council and senior managers have sought to address through a systematic approach to much-needed improvement including the restructuring of services. The shortfalls identified at previous visits are still present in current practice.

This inspection has identified both serious and widespread failures in core areas of social work practice including assessment, planning, and management oversight. There is insufficient capacity across the workforce to secure a timely and appropriate response for children. As a result, some children are left with inadequate protection, and experience delays in having their needs met, including the need for timely permanence. A heavy reliance on agency staff across all areas of the service makes the service unstable. Children experience many changes in social worker, and there

is a lack of management oversight to support timely decision-making and planning in the best interests of children. At this time, the service is precarious. There is a lack of stable, senior management. Many improvements are very new, or plans are not implemented, and it is too soon to be assured of their effectiveness.

What needs to improve?

- Systems and resources to provide a safe, coherent and integrated service which makes children safer and improves children's outcomes.
- The embedding of corporate responsibility across the council and partners to safeguard children and meet the needs of children in care and care leavers.
- Caseloads and management oversight so that children receive a timely, consistent service to meet their needs, including outside of normal office hours.
- The performance and quality assurance arrangements to support practice improvements, including managers, conference chairs and independent reviewing officers' (IROs) oversight and challenge.
- The practice relating to securing parental consent prior to information-sharing in the multi-agency safeguarding hub (MASH).
- The urgency and robustness of the child protection response, including strategy meetings and child protection conferences.
- The quality of assessments, plans and planning, including transition planning and timely escalation into the public law outline (PLO), which is reviewed and enhanced on a regular basis when circumstances change.
- Visits to children that are responsive to need and risk, and that are purposeful, including life story work.
- The response to vulnerable children including for children at risk of exploitation, those who go missing from home and care, disabled children, children living in private fostering arrangements, and homeless 16 to 17-year-olds.
- The response to allegations against professionals.
- The provision of suitable, fully assessed and sufficient placements to meet the assessed needs of children in care and care leavers.
- The educational attainment and attendance of children in care, and the education, employment and training of care leavers.
- The timely access to emotional and mental health support and dentistry for children and young people.
- The access to care leaving support for those young people who are entitled to receive it.

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The experiences and progress of children who need help and protection: inadequate

1. Local authority responses to children in need of help and protection in Sefton are inadequate due to serious and widespread failures in safeguarding children. Throughout help and protection services, there is drift and delay in children having their needs met in part due to insufficient workforce capacity and lack of management oversight and challenge. This results in highly vulnerable children remaining at risk of significant harm.

2. There are serious gaps in early help services. The role of the lead professional is largely absent and, despite more recent improvement activity to create a targeted offer, the new service is not fully established. As a result, too many children are repeatedly moving back and forth between the MASH and early help teams without their needs being assessed and responded to before being closed.

3. Children who do not have immediate safeguarding needs experience lengthy delays before being transferred from the MASH for a social work assessment of their needs. Many contacts lack sufficient detail about the concerns, resulting in delays as workers seek further clarification before taking action. Unqualified workers inappropriately undertake work to check concerns and to prioritise the social work response. Parental consent is not always sought when needed. Social workers do not consistently consider children's previous history, and management oversight is insufficient. Arrangements outside of normal office hours are insufficient to respond quickly to children, including those who are at high risk. As a result, too many children are not receiving the help they need at the earliest opportunity, and, for a small number of children, safeguarding needs are not recognised and responded to promptly.

4. When risk of immediate harm is clear, the response in the MASH is much stronger. Strategy meetings are held promptly, with good multi-agency attendance, and risks are identified and appropriate action taken.

5. Most assessments are poor. Assessments overly focus on the presenting issue without considering the history or information from partners to understand children's needs. As a result, children are not having all of their needs recognised and appropriate services identified. For some, this has resulted in cases being inappropriately closed without intervention. Assessments are rarely updated to understand if change is secured and to inform key decisions. If risk increases on open cases, strategy meetings and protective actions are delayed due to a lack of police availability. This has only very recently been escalated to the police by senior managers.

6. Many initial child protection conferences are significantly out of timescales and children are not benefiting from the necessary multi-agency plans which are essential to safeguard them.

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7. Most children are visited regularly, although this is not always by the same allocated social worker. Changes in social worker and high caseloads result in necessary work not always being completed. Visits often comprise the most basic checks on the children's welfare and are not purposeful.

8. Social workers in the disabled children's teams are not trained and supported sufficiently to respond to safeguarding concerns and meet the needs of these highly vulnerable children.

9. Child protection plans are more focused than those plans for children in need, but both lack specificity on what needs to happen and by when. Multi-agency child in need meetings and core groups are not always taking place and plans are not always updated. Consequently, too many children are receiving a poor service that fails to respond to concerns, address the children's needs and ensure that they are protected.

10. Children and families have access to a broad range of services including support for drug and alcohol misuse, mental health, and domestic abuse. Bespoke help is provided by family support workers at an early stage, such as parenting programmes. Support is not always provided quickly enough for children who need emotional and mental health services, including access to CAMHS. Domestic violence perpetrator programmes are not sufficiently accessible.

11. When children's circumstances are not improving, assertive and timely action is not always taken to step up into the PLO. This is despite repeated episodes of child in need and child protection planning. There is a lack of effective management oversight of children's progress to inform timely and critical decisions about initiating proceedings. As a result, some children experience ongoing delay in being safeguarded and having their needs met. This leaves children in risky situations for too long.

12. There are basic checks in place for children electively home educated. Support is provided and has successfully re-engaged children back into school-based learning. For children missing education, there is a diligent approach to ensuring that children are monitored and safe.

13. Risks to vulnerable children are not routinely well understood and responded to. Where there are private fostering arrangements, the required checks are not completed to ensure that the placement is safe. Children aged 16 and 17 years who present as homeless have a basic assessment of their needs, but they are not always informed of their rights to enter care even when this would be in their best interests.

14. The response to child sexual and criminal exploitation is not consistently effective and does not always reduce risks to children. Action is taken to manage immediate risks, but social work support is not sufficiently proactive in connecting, understanding and supporting children in the longer term to be

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safer. The response to children who go missing from home and care is weak. Return home interviews are not always offered, even when children are constantly going missing from care. When interviews take place, they lack depth to understand risks to inform planning to keep children safe.

15. When allegations are made against professionals working with children, the response is not timely. There are delays in following up referrals and organising strategy meetings to secure children's safety. The designated officer does not have sufficient capacity to progress the work and ensure a robust oversight. Records of the advice being offered, and actions being taken, are not consistently kept.

The experiences and progress of children in care and care leavers: inadequate

16. There are widespread and unnecessary delays in securing timely permanence for many children. Too many children live in placements that have not been fully assessed as safe or suitable to meet their needs. Ineffective management of the fostering service has resulted in a lack of regular supervision and review of foster carers. Managers are not assured that the welfare of children is sufficiently safeguarded.

17. Not all children enter care when they need to. This is as a result of a number of factors. A lack of up-to-date assessments results in an insufficient focus on children's experiences. This is compounded by poor management oversight and, for a very small number of children, there are no suitable placements for children to move into. This leaves children in harmful situations for too long.

18. There are too many children living in placements that have not been fully assessed or are not meeting children's needs. Some children with complex needs, including unaccompanied asylum-seeking children, live in unregulated accommodation, when their needs are such that they require a regulated setting. There are a significant number of family and friends who care for children who have not been fully assessed as being able to safely meet the needs of the children placed. Assessments of these carers are not timely, creating unnecessary delays for children in securing longer-term permanence.

19. Many children live in placements that meet their needs, including with their brothers and sisters when this is appropriate. Children are helped to maintain contact with people who are important to them, and arrangements are regularly reviewed. Decisions to change contact arrangements are made in children's best interests. If placements become fragile, there is swift access to dedicated support for children and carers, and this is preventing placements from disrupting.

20. There is drift and delay in achieving permanence for too many children. When children have experienced long periods of accommodation under Section 20,

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there are delays in securing their legal permanence when they are unable to return home. There are often delays in discharging orders for children placed with their parents for significant periods of time, or in securing long-term arrangements through progressing special guardianship orders. This leaves children subject to statutory interventions longer than is needed. Some children in long-term foster care have not had their placement confirmed as their long-term home. This does not give these children a sense of security, continuity and belonging.

21. When children leave care and return home, decisions are not always informed by careful assessments. Planning is not robust or regular, and this does not ensure that these decisions are safe and in children's long-term interests.

22. Senior managers have recognised serious and substantial weaknesses within the local authority fostering service, particularly around the recruitment, assessment and support of foster carers. Senior managers have recently restructured the service, increased management oversight, and introduced specific teams with specialist functions to support the improvements needed. Assessments of mainstream foster carers are appropriate. The provision of support and monitoring of foster carers' suitability is not consistent. Foster carer reviews are routinely out of timescales and not all foster carers receive the appropriate development opportunities and training. The lack of regular oversight and challenge of foster carers lessens the local authority's ability to be sure that children continue to live in safe placements that meet their needs.

23. When children have the oversight of the courts through care proceedings, such as adoption, their permanence plans are timely and well planned. Adoption is considered promptly and appropriately for very young children who cannot live with family members. Historically, it has been the custom and practice for some young children under the age of five years, and those traditionally regarded as harder to place, to be automatically discounted from being adopted. Managers have recognised and challenged this practice in the regional adoption agency, resulting in strengthened tracking and a significant proportion of matches being secured through inter-agency placements. While this is resulting in more children being currently adopted, the local authority is not aware of how many children have been detrimentally affected by this practice and senior managers are currently trying to identify these children.

24. Most assessments are weak and not routinely updated to understand children's current circumstances, resulting in care plans that are too basic and often superficial to ensure that children's needs are adequately identified. When children are subject to care proceedings, their plans and planning are of better quality, are more responsive and cognisant of children's wishes.

25. Social work visits are not supporting the development of enduring relationships. Visits, although regular, often lack purpose and children

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experience too many changes in worker. Life story work is not always completed to help children safely explore their past, present and future.

26. Senior managers are working to strengthen the voice of children through the very recent recruitment of a participation officer. The young ambassador group is in its infancy and, although the 'making a difference' group is consulted in shaping the care leavers' offer and corporate parenting priorities, the membership is limited.

27. Transition planning for children approaching adulthood is not sufficiently robust. Senior managers are starting to improve this through a recent service restructure to support personal advisers being introduced earlier to children. The newly developed next steps panel is supporting earlier planning to secure accommodation, necessary documentation, and finances. Pathway planning completed by social workers for young people still in care is not detailed enough to define the practical and emotional support needed to maximise young people's chances into adulthood. The local authority is currently piloting a resettlement passport to improve this focus.

28. There is an inconsistent response to meeting children and young people's health needs. While COVID-19 has significantly reduced children's ability to see a dentist, this is more recently starting to improve. There is a prompt response to meeting children and young people's mental health support, particularly when their needs are urgent or critical. However, there is not a dedicated pathway for children in care and care leavers to receive less urgent support, and this means that children often wait for long periods of time to have their needs met.

29. Children in care and care leavers are not well supported to make good educational progress. There is a lack of focus on education throughout care planning. Personal education plans are poor and lack children's input. Targets are not well defined and represent low aspirations. Low expectations of children in secondary education have led to low attainment, poor attendance and too many fixed-term exclusions.

30. Too many care leavers are not accessing employment, education, or training. There are too few apprenticeships for care leavers. The low educational attainment for young people in care in secondary school hampers their ability to access higher education as too few have the necessary qualifications. This has long-standing consequences to enable children and young people to have greater life opportunities and to ensure that they meet their full potential.

31. Not all young people who have left the care of the local authority are currently receiving a leaving care service, especially those that had been previously placed with their parents on care orders.

32. Services for care leavers aged 18 years and over are improving, from a low base and since the last focused visit in 2021. This is as a result of a significant expansion of the service and targeted staff development. Pathway plans completed by personal advisers are more comprehensive and often lead to effective multi-agency working, through which young people are well supported. This is particularly evident for young people who are parents or in custody.

33. Most care leavers live in suitable accommodation, and personal advisers are providing better tailored support reflecting young people's vulnerabilities and needs. Young people understand their entitlements, and these are consistently applied. Personal advisers demonstrate persistence in their efforts to build and maintain relationships with young people.

The impact of leaders on social work practice with children and families: inadequate

34. Since the last inspection in 2016, there has been a significant deterioration in services for children. The fragmentation and dispersal of a wide range of children's services across the council has not enabled the council, leaders and senior managers to have an effective oversight of children's services. As a result, shortfalls identified in and since 2016 have not been systematically addressed to make a difference to children, and poor practice previously identified is still present.

35. A joint targeted area inspection in September 2019 and a focused assurance visit in March 2021 both identified significant weaknesses, resulting in a number of far-reaching areas for priority action. Despite this, vulnerable children are noticeably absent from the council's 2030 vision, and services have continued to decline throughout this period. The council and senior leaders have not demonstrated sufficient understanding of the scale and depth of the inadequacies, or taken timely and effective action to secure the necessary improvements for children.

36. The appointment of an interim DCS in June 2021 has supported a shared understanding of the extent of service weaknesses. The DCS and an expanded, new interim management team have taken considerable time and effort to understand the underlying causes of practice inadequacies through a detailed service diagnostic. This has exposed serious and extensive weaknesses in practice, processes, systems and structures. The council now has a clearer understanding of the depth and breadth of these deficits, and senior managers and the refreshed improvement board are establishing the basis for a systematic approach to improvement.

37. Following the focused visit in 2021, the DfE appointed an improvement adviser and the new improvement board met in July 2021 to oversee service improvements. Children's social care is still in the very early days of its

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improvement. Senior managers are working to develop an infrastructure which better supports a collective oversight of and responsibility for children. Senior managers are restructuring services and creating systems that have previously been absent, while starting to address the legacy and impact of practice shortfalls for children. Most improvement plans are not implemented, or too new, and it is too soon to see the difference that these actions will make to children.

38. Plans to implement the improvements needed are well supported through substantial financial council investment. This has enabled a rapid expansion of the workforce at all levels, and this is helping to reduce work pressures. This has not translated into an improved response to children, in part as a result of an upsurge in demand for children's social care services post lockdown, and a review of cases at the front door identified more children in need of statutory services. These children had not previously received the appropriate support and intervention they needed.

39. There are some very basic and early signs of recovery from a low starting point. The recent creation of a single point of contact in the MASH means that more children who need help and protection are identified. A greater focus on compliance is ensuring that children are now being seen regularly, increased capacity across the leaving care team is providing better support for care leavers, and the tracking of children with plans for adoption has enabled more children to secure permanence.

40. Relationships with key partners are underdeveloped and there has not been a shared understanding of the priorities for children and families. There is an improving focus that is supporting better joint work with the courts through stronger management oversight. The very recent restructuring of the corporate parenting panel with dedicated multi-agency workstreams is appropriately focused on improving outcomes for children in care and care leavers, and is beginning to support more effective challenge. Sufficiency is a substantial challenge in Sefton. Senior managers have recently reviewed the foster carer recruitment strategy and are working to increase the supported accommodation offer through the very recent development of a child commissioning function.

41. Workforce capacity across the service is insufficient to support good-quality social work, despite ongoing financial investment. Despite additional staff working in the MASH, there remains insufficient capacity to provide timely and appropriate oversight of contacts, and there are delays in assessing children's needs and in progressing initial child protection conferences. The approach to recruitment and retention has only recently been refreshed, including the implementation of a new workforce strategy, and many newly created posts are not filled or are waiting for staff to start. This includes at a senior manager level, with the permanent DCS due to start imminently. The overreliance on

agency staff at all levels is contributing to delays, with children experiencing changes in worker and essential work not always being completed.

42. Quality assurance is underdeveloped. While a broad range of performance measures is supporting better monitoring through the development of a more focused performance score card, there is limited data and mechanisms to help managers understand and challenge their team's activity. Data is not used intelligently to identify and understand areas for further scrutiny or what this means for children. Audits of cases lack depth, do not focus on impact for children and do not routinely identify poor practice. The breadth of audit activity has reduced recently due to capacity issues. There is an overreliance on senior managers dip sampling areas of practice, rather than an established framework, to test the impact of changes to services or routinely support service improvements.

43. Basic social work practice is underdeveloped and there is not a coherent framework to support social work practice. Managers are not routinely ensuring that children are benefiting from safe and effective social work, or providing sufficient challenge to improve outcomes for children. The footprint of IROs and child protection chairs is not consistent or effective to address issues of quality and planning for children. The rationale for senior manager decision-making is poorly recorded, which reduces accountability and does not support children's understanding of why important decisions are made about their lives.

44. There are some social workers, managers, child protection chairs and IROs who show clear commitment and focus on the welfare of children. Social workers spoke positively about management support, now and throughout the pandemic, and there is a renewed sense of optimism from staff about the plans to support practice. Staff are committed to and involved in shaping the service improvements. Social workers reported good training opportunities, although the approach to training is fragmented as many are unable to attend due to workload pressures.

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