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Inspection of Liverpool local authority children's services

Inspection dates: 13 to 24 March 2023

Lead inspector: Lisa Summers, His 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	Requires improvement to be good
The experiences and progress of care leavers	Inadequate
Overall effectiveness	Inadequate

Services in Liverpool for children who need help and protection and for care leavers are inadequate. The last inspection, in May 2018, judged all services as requiring improvement to be good. Since then, there has been a deterioration in the quality of practice. Senior leaders have not been aware of the extent of current practice deficits or the impact on children, due to a previous lack of senior officer scrutiny and challenge. There has not been a systematic approach to improvement, and this has been compounded by an ineffective response to long-standing issues of recruitment and retention. The capacity issues across the service seriously impact on the ability of social workers and personal advisers (PAs) to provide the quality of support they aspire to achieve. Two focused visits, in April 2019 and August 2021, identified repeated shortfalls in the quality of social work practice. Most areas for improvement from 2018, and subsequent visits, are either still a feature of current practice or have further declined.

This inspection identified serious weaknesses for children who need help and protection, which leave children being harmed or at risk of harm. Risk is not always recognised and when it is, the response is not always sufficiently robust, leaving these children without sufficient or timely protection. Too many children experience delay in having their needs met. This is a result of poor-quality

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assessments and planning or an absence of effective core social work practice, due to insufficient workforce capacity and a lack of management oversight and drive. Care leavers do not consistently get the help and support they need. Young people do not get to know their PAs before leaving care. This impacts on some young people's level of engagement. Efforts to engage those young people who are more resistant to support, particularly those who have additional vulnerabilities, are insufficient, leaving too many without necessary help in times of crisis. Care leavers aged over 21 do not consistently receive ongoing support when this may be in their best interests.

More recently, a new interim chief executive officer (CEO) has substantially accelerated the pace of improvement through additional financial investment and securing increased social work capacity, and work is under way to address placement sufficiency issues. This is now being supported through the recruitment of a new interim director for children's services (DCS). It is too soon to see the impact of these improvements on children and young people.

What needs to improve?

- Caseloads and regular reflective supervision, so that children and young people receive a timely, consistent service that is responsive to and meets their needs.
- The identification of and response to risk by social workers and partner agencies, so that children and young people are robustly protected, including when children go missing from home or care.
- The quality of decision-making when removing child protection plans, so this happens only when it is safe and when children continue to receive the right support.
- The quality of core social work practice, including assessments, plans and planning, and timely transition planning for young people leaving care.
- The quality of support, advice and guidance for care leavers, including those with additional vulnerabilities, to ensure that this is timely, consistent and responsive to levels of need up to the age of 25.
- The provision of information for care leavers about their entitlements and health histories.
- Purposeful visits to children and young people which are responsive to changes in need and risk and include life-story work.
- The robustness of senior management oversight, including for children subject to pre-proceedings.
- The timeliness of decision-making for children and young people, including when children come into care, and that children achieve permanence without delay.
- The sufficiency of suitable placements that can meet children and young people's assessed needs, including 'staying put' arrangements.
- The timely access to emotional and mental health support and dental care for young people.

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

1. The response to children who need help and protection is inadequate in Liverpool due to serious failures to safeguard children. Significant harm is not always identified and when it is, it is not always robustly responded to. Many children experience drift and delay in having their needs met, as a result of insufficient workforce capacity and a lack of regular management oversight and direction. Some children have had their child protection plan removed too soon and risks have not been mitigated. This is leaving some children at risk of, or suffering, ongoing significant harm.

2. Careline provides a single point of contact for concerns relating to children and adults. Thresholds for accepting contacts into children's social care are high, and these decisions are not always well informed. For some children, this leads to multiple contacts and children experiencing repeat incidents before they receive the help they need. When contacts are not accepted by Careline, children's information is stored in an email box for three months, even when consent is not secured. A lack of formal records of these concerns could potentially impact on understanding children's histories, should further concerns arise in the future. This has been quickly addressed by the new interim DCS during this inspection.

3. For some children, Careline takes too long to decide whether concerns meet the threshold and criteria for a contact, and, for some children, this is creating unnecessary delays. However, once concerns are accepted and progressed into the multi-agency safeguarding hub (MASH), screening is mostly timely and effective. Management oversight is clear, and thresholds are appropriately applied. The response to children who need help and protection outside normal office hours is mostly timely, appropriate and effective.

4. Children and families in Liverpool benefit from an effective early help offer. There are a wide range of services that are improving children's lives. Most assessments are detailed and consider a breadth of multi-agency information to inform planning. Work is child-centred, preventing the need for statutory support for many children. If children's situations deteriorate, there are timely systems to transfer into children's social care as necessary. Early help support is maintained until families are allocated to children's social care, to minimise potential drift and support a smooth transition.

5. When children are at risk of immediate harm, the response at the 'front door' is mostly swift, using partners in the MASH to take action in progressing strategy meetings. While most strategy meetings are timely, those held outside of the MASH are not always well attended by partners, with key agencies, especially health services, absent. This means that decisions are often being made without full information. The quality of strategy discussions is inconsistent. Some are too adult-focused; analysis is weak and there is a lack of focus on what risks mean for children's experiences. When there is a potential crime and

there are child protection concerns, joint enquiries with the police are not always started. In particular, the response from agencies, including the police, to children who experience sexual harm is sometimes poor. As a result, these children are not getting the help and support they need and these serious crimes are not always investigated.

6. The quality of assessments is inconsistent, with insufficient analysis of history to fully appreciate children's experiences or cumulative harm. In some assessments, there is an over-reliance on parental self-reporting. Poorer-quality assessments for some children mean that they experience repeated harm, as they do not have their needs met at the earliest opportunity.

7. Too many children experience delay in having their needs met, for a number of reasons. The quality of plans is inconsistent. While some appropriately focus on mitigating harm, others are too adult-focused, or lack specificity in how children's needs will be met. Planning is not always reducing risks effectively. Meetings to review children's progress, including core groups and child in need meetings, do not always take place, and when they do, there is insufficient attention on the impact of the plan for children. Meetings are not always well attended by partners, particularly health services, and this contributes to ineffective multi-agency planning and delays in meeting children's needs. This is further intensified when some children experience too many changes in social worker.

8. Some children do not receive sufficient protection, even when they are subject to child protection planning. Risks are not always identified and when they are, the response is not always robust, leaving these children at risk of ongoing significant harm. This includes some disabled children and some children who go missing from home or care, where the response is mostly weak. Return home interviews do not sufficiently explore or analyse why children go missing, and critical safeguarding concerns are not always appropriately responded to.

9. Child protection plans are ended too soon for some children, as critical work is not completed or risks are not reduced, with insufficient challenge from child protection chairs. The complexity of domestic abuse and its impact on children is not always fully understood by partners and conference chairs when making critical decisions. The actions of perpetrators and their willingness to address concerns are not consistently considered when decisions about future risks to children are made. Subsequent child in need planning is not always robust, and some services are closed to children too soon. This has resulted in some children experiencing further incidents of harm and repeated children's social care interventions.

10. Although most children are seen regularly, direct work is largely absent, and most visits lack purpose beyond meeting compliance requirements. Social workers are not always responsive to significant changes in risk to ensure that children are protected.

11. When the risks of criminal and sexual exploitation are clear and obvious, they are recognised, and the response is mostly effective. Social workers identify and understand children's individual risks and direct work is tailored to develop children's self-esteem and knowledge of risks.

12. The needs of disabled children are not consistently well met. High workloads are impacting on social workers' ability to complete fundamental work, such as regular visits, child in need plans and planning. As a result, these highly vulnerable children are not seen with the regularity they need or reviewed to ensure that they are safe and making progress.

13. The quality of pre-proceedings work has declined since the focused visit in August 2021. Too many children experience drift and delay due to immature systems and tracking and review mechanisms that lack sufficient management grip and challenge. Some children do not enter care soon enough and experience ongoing harm for too long.

14. There are a number of areas of stronger practice in Liverpool. The response to homeless 16- and 17-year-olds is mostly effective, through established and clear pathways with housing. Children who go missing from education are robustly tracked and monitored, and there are rigorous mechanisms to monitor vulnerable children who are home educated. Allegations against professionals who work with children are well managed, and timely, robust and appropriate actions are taken, keeping children safer.

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

15. Children in care are usually visited at a frequency that matches their level of need, and social workers take time to fully understand children's experiences. Despite this, direct work is rarely carried out. Life-story work is largely absent in creating a secure base for children to safely explore their journey into care and help them move into the future.

16. A small number of children return home from short periods in care in an unassessed and unplanned way, exposing them to further incidents of potential harm. When children return home after longer periods in care, these decisions are informed by comprehensive assessments and assisted by detailed support plans.

17. Children are helped to maintain contact with those who are important to them, including brothers and sisters and wider family. Family time is routinely reviewed and changed, according to children's best interests and their wishes and feelings.

18. Care plans provide sufficient detail regarding children's needs, although some children would benefit from actions being more individualised to their experiences and needs. Plans are routinely reviewed and amended through

child-friendly meetings, which are well attended. Children are encouraged to attend and contribute to their review meetings so they can shape decisions about their lives. Review meetings thoroughly consider children's needs and minutes are sensitively written to children. Independent reviewing officers (IROs) sometimes, but not always, escalate concerns about planning for children. The impact of these challenges is limited because of capacity pressures on social workers and managers.

19. Permanence for children is routinely reviewed and extended family options are considered, so children can live with those family members who know them best. There are still delays in securing permanence for children in some specific circumstances. This was a feature at the last inspection in 2018. There are delays in completing some regulation 24 assessments for connected carers and care proceedings can be delayed as a result. Some kinship carers are reluctant to pursue special guardianship orders (SGOs) due to financial implications for them, and this has not always been challenged robustly enough. Some children have remained at home on care orders for too long. All this means that these children remain subject to statutory interventions for longer than needed.

20. Most children in care are safe and settled where they live. Many children enjoy the full benefits of family life, living in foster homes, and decisions to secure these as children's permanent homes are based on children's needs. Some children wait too long for this formal matching, mostly due to changes in social worker or a lack of effective management oversight.

21. Due to sufficiency challenges, some children do not live in homes that meet their assessed needs, and some cannot live with their brothers and sisters. While many children have their needs appropriately met living in residential children's homes, some very young children live in residential provision due to a lack of foster placements. A small number of children experience unnecessary placement moves while a suitable placement is secured for them.

22. A small number of children live in unregistered children's homes. Oversight of these children is not consistently robust to ensure their ongoing safety and well-being. There are persistent efforts to move these children to suitable placements and, as a result, children do not usually remain in these arrangements for long periods. The new interim DCS has very recently strengthened the senior management oversight of these children.

23. Despite these delays, the quality of care children receive is strong and they are making sustained progress. When SGOs are granted, these are made in children's best interests to secure permanence, based on comprehensive assessments. Carers are supported to enhance their parenting capacity, which enables them to better care and protect their children. This is helping children to live with wider family and have a firm sense of belonging.

24. Most children in care have their health needs met, including their mental and emotional health. Despite the significant challenges in securing appointments

following the COVID-19 pandemic, getting children to dental appointments is improving. Most children in care make educational progress from their starting points and senior managers have plans to improve support for children's educational achievement, recognising that the quality of personal education plans is inconsistent. The virtual school provides effective support to promote children's education, when schools engage. Children are encouraged and supported to engage in community-based activities.

25. Assessments of prospective foster carers are thorough and panel processes are strong. Annual reviews of foster carers are comprehensive and the agency decision-maker systems are robust. Foster carers receive regular child-centred support and supervision from their social workers, who have a good understanding of the needs of children and their carers. Specific packages of support have enabled a small number of children with more complex needs to remain in placements with carers who are committed to meeting their longer-term needs. The training offer for foster carers requires strengthening, as it is not currently comprehensive enough to ensure that all children's needs are met.

26. The regional adoption agency, Adoption in Merseyside, provides recruitment, assessment and support services to adopters. The local authority's dedicated in-house adoption service is a real strength, adding to the positive experiences and outcomes for children. Matching processes are thorough and there is timely linking of most children with adopters. Introductions between adopters and children are thoughtfully planned. This means children are achieving early permanence.

The experiences and progress of care leavers: inadequate

27. At the last inspection, timely transition planning was identified as an area for improvement. In response, senior managers developed a dedicated transition panel, which ensures that young people are provided with the key documents they need as they move into adulthood. The panel identifies what accommodation is required and when transitions to adult social care should start. Despite this, transition planning still starts too late, and the panel only starts to consider young people's needs once they turn 17 and a half. Young people reported that they were not aware of their health histories. This means that transition planning has declined since the last inspection.

28. PAs are not allocated or introduced to young people soon enough, as this only happens when they turn 18. Young people do not get the chance to get to know their PAs before they leave care. While some young people do have positive relationships with their PA, a small number of young people between the ages of 18 and 21 have never met them or do not engage with them. As a result, these young people are not getting the help or support they need, leading to delays and a deterioration in mental health and living conditions for some young people. This included some young people under 21 years of age who are homeless or at risk of exploitation or criminality. Young people do not

routinely receive support beyond 21. The expectation is that young people will reach out if they need help. When they do, this is mostly given on a duty basis. Generally, these young people over 21 years of age are closed to the service, although they may require ongoing support.

29. When young people do not engage, there is insufficient persistence to re-engage them. As a result, PAs are not consistently supporting these young people's well-being and safety, particularly for those with additional vulnerabilities. Some of these young people receive poor support, and in the case of a small number, their whereabouts are unknown. For others, PAs work effectively with young people's broader networks to help them keep safe.

30. PAs are thwarted in their endeavours to meet the needs of their young people due to high caseloads, sometimes over 40. This means that PAs do not always maintain regular face-to-face contact with young people. When young people are engaged, some PAs use a variety of different platforms to keep in touch and are working alongside partners to meet young people's needs and maximise their life chances. However, high caseloads are limiting their ability to provide this level of help consistently. As a result, many young people receive support that is reactive to requests for help, rather than planned support that is helping them develop the skills and confidence they need to become successful adults.

31. Most pathway plans are not good enough and they are not always developed with young people. They do not routinely identify what support is needed, who will provide this, or by when. Young people's skills to support their independence are not reviewed or understood, to identify what specific help they need and how this will be met.

32. Young people are supported to access services to help improve their health and they are encouraged to access support through their GPs. PAs make appropriate referrals to support young people's mental and emotional health. Young people can wait too long to receive counselling support, and this is not sufficiently responsive in times of crisis. Senior managers and leaders have recently challenged health partners, as there is limited access to dental support. Although the transition panel identifies when young people require assessments to determine eligibility for adult services, there are delays in completing these, which impacts on wider planning. Pathways are currently being reviewed with adult services to resolve this.

33. Young people receive inconsistent help in accessing education, employment and training (EET). Although young people have separate EET plans, these are not strong enough to detail how young people are going to be supported back into education or into training or employment. Some young people go on to flourish in further education, training or employment, while others experience less positive or irregular support. Some young people are encouraged to access employment, education or training by their PAs and are supported by dedicated work coach mentors and Career Connect.

34. Most care leavers live in suitable and safe accommodation. Those living in semi-independent provision receive support to develop their independence skills, which young people value. There are difficulties in securing timely independent accommodation when young people are ready to move to independence. PAs reported that a lack of affordable quality accommodation was a challenge and a frustration for their young people.

35. The availability of 'staying put' arrangements is limited. When young people do stay with their former foster carers, this is positive and young people continue to benefit from continuity of family life.

36. Most young people were not aware of the local authority's offer to care leavers. Although the offer is published, information is not routinely available or widely understood. Senior managers are currently working to refresh the offer through consultation meetings with young people, who are helping to shape this.

37. Currently, participation opportunities for children in care and care leavers in Liverpool are limited. Young people do not have any active forum to ensure that their voices are heard, to routinely have their say or to shape and model services. This has deteriorated since the last inspection. Although children and young people's achievements are celebrated through dedicated events, young people who met with inspectors said that they did not have any experience of these.

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

38. Liverpool children's services was last inspected in May 2018, when it was found to require improvement across all areas. Two focused visits, in April 2019 and August 2021, identified repeated concerns in the quality of social work practice. Since then, there has been a deterioration in services, leaving some children with inadequate protection from harm or experiencing drift and delay, including in timely permanence. The quality of support for care leavers is inadequate and has deteriorated since the last inspection. Recommendations from the last inspection have not been addressed effectively and, where there were areas requiring improvement, these remain a feature of current practice.

39. There has been insufficient prioritisation and pace in tackling critical areas necessary to enable improvement. Social work capacity has not been adequately addressed since 2018. This is significantly impacting on the ability of social workers and PAs to respond appropriately to children and young people when they need to be supported. Fundamental areas of social work practice are not always implemented, and practice is too often reactive. As a result, risk to children is not always identified or robustly managed, to be assured of children's safety.

40. There has not been a systematic approach to improvement, despite significant council financial investment supporting a service redesign, increased capacity

across the service and significantly improved performance reporting. Insufficient corporate scrutiny of children's social care has meant that practice shortfalls identified in 2018 have not been addressed effectively, to make the necessary improvements to children's lives. The extent to which services have declined has not been understood by previous senior leaders.

41. There have been recent changes at both senior leadership and manager level. The long-standing director of children's services very recently left the service, and there were gaps in the senior leadership team during this inspection. Since the new interim CEO took up post in October 2022, there has been a greater understanding of practice weaknesses, which has led to a recent acceleration in improvement, supported by political leaders. Governance and scrutiny arrangements have been recently strengthened, additional financial support has been secured which has supported a new service restructure, and assertive actions have led to successes in social work recruitment. The current interim DCS had been in post only a matter of days at the start of this inspection. She and the management team recognise that there is a significant amount of work to do for these improvements to have a positive impact on children and young people. The findings from this inspection were used immediately in shaping improvement plans.

42. Over the last six months, senior managers have taken action to address immediate capacity issues. Four additional temporary teams have been secured, with three remaining in place, focusing on specific areas of social work practice, including the discharge of care orders. Senior managers have appointed 44 social workers, including through overseas recruitment, who are due to start imminently.

43. Although caseloads have reduced, they are still too high, and staff are unable to deliver the quality of practice they aspire to. Vacancies in the disabled children's team mean that too many children are not well enough supported. Some children experience too many changes in social worker, so they are unable to build and maintain trusted relationships. Late introductions to PAs impact on some young people's ability to invest in these new relationships, so they disengage and do not consistently receive the support they need. This includes some of the most vulnerable young people leaving care, who are not supported in a timely way. For some, this leads to delay in having their needs met and a deterioration in their well-being.

44. Strategic partnerships in Liverpool are well established but do not have full oversight of the issues identified during this inspection. There are shared ambitions through the revised early help strategy, the recent relaunch of the neglect strategy, and partners' commitment to resourcing the local authority's new practice model. Health attendance at core meetings for children had been resolved in the past, although senior managers recognised this has started to deteriorate. Consequently, a formal challenge has recently been raised through the safeguarding partnership. The interim DCS arranged meetings with senior

partners to address the findings from this inspection and raised concerns with the police regarding the response to sexual harm.

45. While the needs of children in care are now better understood through improved profiling, sufficiency is a challenge. There is insufficient range and breadth of provision to enable all children to live in placements in line with their assessed needs. The fostering service is beginning a period of transformation, including proposals to improve the recruitment and retention of foster carers. The local authority has successfully secured funding from the Department for Education and additional council investment to progress the development of six council-run residential homes.

46. Senior management oversight of specifically vulnerable children is not sufficiently robust. Children subject to pre-proceedings are not robustly monitored or reviewed to minimise the risk of drift and delay. The oversight of the small number of children living in unregistered children's homes is not consistently rigorous to ensure that these children are safeguarded effectively. At the last inspection, delay in achieving timely permanence for children was identified as an area for improvement; this remains an issue in current practice and tracking of permanence remains underdeveloped.

47. Performance reporting has significantly improved since the last inspection. A broad suite of performance reporting and live data provides a wide range of information and analysis that is helping to manage the service at all levels. Performance data is used intelligently and is targeting areas for improvement effectively. For example, the timeliness of initial child protection conferences and assessments has recovered. Despite this, data is not always well enough used by frontline managers to ensure that core social work practice standards are met.

48. Although senior managers were aware of many weaknesses in practice, the extent to which risks for children are not robustly responded to was not sufficiently understood. There is insufficient auditing activity to identify and address these shortfalls in practice. When audits are completed, reflective sessions with social workers help them to consider their current and future practice, although some judgements on the quality of work are overly positive. Most audits identify weaknesses accurately, but corrective actions are focused on compliance and do not translate into improving children's circumstances.

49. Social workers reported how well supported they feel by first-line and service managers, but they described feeling disconnected from senior managers, as contact with them has been limited. Supervision by team managers is not regular enough to act swiftly on changes in children's circumstances, including increased risks, so that these are recognised and mitigated. Supervision is mostly task-focused and lacks reflection to help social workers think through difficult issues and identify appropriate actions. This has not improved since the last inspection.

50. Social workers, PAs, IROs and managers are committed to Liverpool and remain focused on seeking to make children's lives better. Workers described the team culture as supportive, and they aspire to provide good-quality support and services. Despite workload pressures, some are working creatively with their children and young people. Senior managers recognised that the current social work model is not having the necessary impact for children, and work has started on implementing a new practice model. Social workers welcome this new approach, which is more aligned to their values and beliefs.

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