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Dear Risthardh

Monitoring visit to Sefton children's services

This letter summarises the findings of the monitoring visit to Sefton children's services on 15 and 16 November 2023. This was the fourth monitoring visit since the local authority was judged inadequate in February 2022. The visit was carried out by His Majesty's Inspectors Lisa Summers and Louise Walker and HMI designate Gareth Dakin.

Areas covered by the visit

Inspectors reviewed the progress made in the following areas of concern identified at the last inspection:

- The quality of help and protection for disabled children.
- The quality of support for children who are exploited or who go missing from home or care.
- The response to children aged 16 or 17 who present as homeless.
- The quality of help and protection for children living in private fostering arrangements.
- The effectiveness of managing allegations against professionals by the designated officer.
- The impact of managers on frontline practice.

This visit was carried out in line with the inspection of local authority children's services (ILACS) framework. A range of evidence was considered during the visit, including electronic records, performance management information, case file audits and other information provided by senior managers. In addition, inspectors spoke to a range of staff, including social workers and managers.

Headline findings

Sefton is making some steady progress in improving services for children with specific vulnerabilities. This is underpinned by a refreshed and more focused improvement plan with clear priorities, the development of specialist services, a restructuring of existing teams and a better understanding of performance data. The quality of social work practice for disabled children, for those children who go missing from home and care, for children at risk of exploitation and the management of allegations against professionals is improving from a significantly low base. Children are now receiving more timely and responsive help, that for many is effective at reducing risks and is ensuring that children's needs are better met.

Senior leaders continue to address legacy issues of drift and delay for disabled children as a result of too many changes in social worker, and there is more to do to improve the protective multi-agency response when children are at risk of significant harm. The pace of improvement for children aged 16 or 17 who present as homeless has been too slow, and children living in private fostering arrangements continue to receive a weak service, with the same shortfalls identified at the last inspection still present today.

Findings and evaluation of progress

Since the last inspection, leaders have taken a systematic approach to improving services for disabled children. Significant work has been undertaken to visit and reassess disabled children and to take immediate protective action when needed. The service has been refreshed and restructured. The creation of a resource-only service to oversee direct payments, commissioned services and short breaks without the need for social work intervention is enabling social workers to target resources, providing a more proportionate service to meeting children's needs. These developments, and additional social work capacity, have helped to reduce caseloads, allowing social workers to deliver more of the fundamental elements of social work practice which were missing at the last inspection. The recruitment of managers experienced in both working with disabled children and safeguarding is supporting a better identification of children at risk. The service still remains fragile due to a high dependence on agency staff, and there is more to do to improve the quality of practice and the response to children who need protecting.

While there are improvements in recognising risk of significant harm, the protective response for disabled children is not sufficiently robust. Partnership arrangements with the police are not strong enough to reduce delays in the police referring some children to children's social care, even when there are immediate concerns. This is leaving children in situations of unassessed risk.

When children are at risk of significant harm, strategy meetings are mostly timely and well attended by partners, which facilitates robust information-sharing to identify risks. Managers record clearly the rationale behind decisions and next steps for social

workers to follow. While some immediate safety actions are identified, multi-agency safety planning to keep children protected during the period of subsequent enquiries is largely absent.

In some circumstances, child protection enquiries, including police investigations, take place before the strategy meetings are held. While this facilitates immediate protective action, it means enquiries are undertaken without full information and a broad understanding of risk, which could impact on future investigations.

The quality of child protection enquiries is inconsistent, and they are not always timely. Stronger assessments of risk detail children's histories well, to understand the cumulative impact of harm. Weaker enquiries do not add to the information shared at the strategy meeting and they fail to consider wider information. There is insufficient analysis of risk to inform decision-making. A small number of children wait too long for a multi-agency plan following the outcome of child protection enquiries. Although these children are seen regularly, safety plans are over-reliant on the non-abusing parent to protect children when domestic abuse is a feature.

The quality of recent assessments for disabled children is improving. These assessments are more detailed, child-focused and provide a clearer understanding of children's needs and how the child's disability impacts on the wider family. For children who are non-verbal, social workers use observations and interactions with parents and carers, which is supporting a better representation of children's views. During the assessment period, services and support to children and their parents are now provided at the earliest opportunity.

Care planning is not consistently informed by up-to-date assessments and too many children are waiting for their needs to be reassessed. Managers are now using supervision to prioritise and progress these assessments.

The quality of children's plans is inconsistent. Stronger plans are detailed and have clear outcomes to measure success, while weaker plans lack timescales to inject pace and prioritisation. Plans are mostly regularly reviewed through multi-agency meetings which consider the impact of the plan. Despite this, too many children experience drift and delay due to some legacy issues. These include changes in social worker, a lack of previous management oversight and, for some children, difficulties in recruiting specific carers to meet children's needs. As a result, children's needs are not always being met soon enough.

A significant number of children have experienced too many changes of social worker. As a result, some parents are reluctant to further engage with new workers. Social workers recognise this and are tenacious in trying to repair fractured relationships with parents and children. Despite thie challenges of engaging with some parents more children are now being visited regularly and in accordance with children's changing needs. Social workers access specialist training to enable them to communicate with their children using a variety of methods. Most visits are

purposeful and are used to review the plan or package of support to ensure children's needs are better met.

When children are supported through the resource hub, there is sufficient social worker oversight through regular reviews to be responsive to children's changing needs. The interface between this team and the social work team is strong, enabling a swift response to escalating needs.

Planning for disabled children to transition to adult services is not timely. Appropriate assessments are not progressed soon enough, due to limited resources in adult services. While senior managers have greater oversight of these children through the next steps panel, there is insufficient collaboration across the council to address and resolve this in a timely way.

Children who go missing from home or care are receiving an improving service. The creation of a dedicated team focusing on missing children is facilitating a greater sharing of multi-agency intelligence to inform protective actions. Return home conversations are helping workers understand why children go missing, where they have been and who they have been with. This is supporting the identification of risks and informing any immediate actions to be taken to reduce risk. For some children, this is starting to reduce the number of missing incidents. While children's voices are clear, there is more to do to understand what actions children feel are needed to prevent them from going missing. There is insufficient analysis to build a cumulative understanding of factors impacting on children who regularly go missing to inform the management of these risks.

Leaders have recently introduced the use of trigger plans to identify known associates and places where children go when they are missing. These plans are not always up to date or sufficiently robust in detailing exactly what needs to happen should the child go missing in the future. Key information, for example parents' contact details and intelligence from return home conversations, is very often missing, significantly limiting the usefulness of these response plans.

Following a full service review, a dedicated in-house multi-agency team, MySpace (Sefton protection against child exploitation), was created and launched in April 2023 to support children at risk of exploitation. Daily multi-agency meetings are becoming effective forums to share intelligence and identify children with emerging concerns, enabling children to be quickly seen by a MySpace worker. There is a strong focus on diversionary work, encouraging children's involvement in positive activities. Children are seen regularly and helped to recognise and understand exploitation through purposeful direct work. As a result of these developments, some risks for children are reducing.

The MySpace service is still in its infancy and leaders and senior managers recognise there is still more to do. While workers clearly articulate risks associated with exploitation for their children, a lack of a specific exploitation assessment limits

subsequent plans and reviews of progress. The quality of plans is inconsistent and many are too broad, lack specificity and timescales default to the next review. It is therefore unclear as to what the priority actions are and this is limiting their usefulness in measuring progress. Due to limited police resources, disruption activity is hampered.

Children who live in private fostering arrangements still do not receive a good enough or consistent response. Although awareness-raising activities have resulted in more children being identified as living in these arrangements, social workers do not have sufficient knowledge of practice expectations. While children are visited regularly, critical checks and assessments are not consistently timely to ensure that placements are safe and secure. This was a feature at the last inspection. More recently, additional oversight from child protection chairs has been introduced, but this has not been actioned soon enough and it is too soon to see the impact for children.

The very recent development and implementation of a joint homeless protocol and new pathways between housing and children's social care are showing some early signs of positive impact for children aged 16 or 17 who present as homeless. The quality of assessments is improving and emergency accommodation is now identified to keep children safe throughout the assessment period. Despite this, it has taken the council too long to establish this protocol and for sufficient emergency accommodation to be secured. Senior management reviews of all of these children have ensured that the children now understand their rights to enter care and the benefits this would bring. As a result, some children have now accepted this level of enhanced support.

Allegations against professionals in Sefton are now more robustly managed. A comprehensive recording system enables the designated officer to monitor and track the status and progress of allegations. Initial allegation management meetings are timely and well attended and identify risk and appropriate actions effectively. The safeguarding of children is a core priority for the designated officer and strategic regional collaborations are strengthening the response in Sefton.

Staff continue to be highly positive about working in Sefton, describing a nurturing and supportive culture. As a result, some agency staff are applying for permanent positions. Managers feel listened to when they make recommendations to improve practice, which makes them feel valued and gives them a sense of shared ownership in the development of the service. Managers understand their services well and know what improvements are needed. Senior managers recognise there is still more to do to improve the quality and consistency of supervision.

Performance management has more recently improved at a greater pace following the recruitment of a dedicated and experienced performance manager and data analyst. Data is now more accurate and reports have been refined to provide a better oversight of key areas of performance. Benchmarking information is used and

clear targets are now set. Reports are regularly reviewed through a number of management meetings and this is now starting to inform targeted audit activity to better understand the story behind the data. There is more work to do in identifying specific actions needed to inform further improvement activity. The monitoring of children who are privately fostered and social work practices for disabled children are not sufficiently embedded.

The quality of audits remains inconsistent. Shortfalls in practice are now more accurately identified and more audits are now moderated, which is helping to bring a sharper focus on the quality of practice. However, practice expectations to carry out audits collaboratively with social workers and involving feedback from families are not being consistently implemented. When this is done, there is insufficient reflection on the impact of social work practice in order to inform how to further enhance the support to children. Recommendations for next steps are still too focused on process rather than on children's experiences.

I am copying this letter to the Department for Education.

Yours sincerely

Lisa Summers
His Majesty's Inspector