Inspection of Knowsley local authority children's services

Inspection dates: 18 to 29 November 2024

Lead inspector: Rebekah Tucker, 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

The quality of services for children in Knowsley has not improved since the last inspection in 2021, when services were judged overall as requires improvement to be good. The impact of a substantial churn in leadership at director of children's services (DCS), senior and middle management level has seen a significant deterioration in the quality of services and practice for children in need of help and protection and for care-experienced young people.

Although current senior leaders describe Knowsley as being on an improvement journey, there has been little progress in the areas requiring improvement since the last inspection and two subsequent focused visits in October 2022 and January 2024. There has been a lack of sufficiently experienced senior and middle leaders to drive the necessary improvements. Strategic and operational oversight has not ensured appropriate standards of practice, or robustly recognised and managed risk for vulnerable children, leaving too many in unsafe situations. This inspection has identified serious and widespread weaknesses in services for disabled children, young carers and care-experienced young people.

Despite the financial pressures that the council faces, there has been further investment to increase staffing, but this has not had the necessary impact on improving the quality of social work practice.

What needs to improve?

- The leadership capacity of social work practice which meets professional and practice standards, to drive the quality of social work interventions with children.
- The identification of, and response to, risk by social workers in relation to children in need and children subject to child protection plans.
- The quality of social work practice and management oversight for disabled children.
- The quality of social work practice, specifically assessments, plans and planning.
- The social work response to domestic abuse and neglect.
- The quality of help and support for children with vulnerabilities, specifically young carers and children aged 16 and 17 years who present as homeless.
- The quality of visiting and direct work with children and young people, including life-story work.
- The quality of support, advice and guidance for care-experienced young people, 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 caseloads of personal advisers (PAs), to enable them to provide timely advice, support and guidance to care-experienced young people.
- The quality of supervision and management oversight of social workers and PAs, so that children and young people receive a timely and consistent service that is responsive to their needs.

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

1. The quality of services for children who need help and protection has declined and is now inadequate. There are serious failures across children's services that leave children either being harmed or at risk of harm. Significant harm is not recognised for too many children, and when it is, the response is not consistently robust. Frequent changes in social worker and poor assessments result in children not always having their needs met, and too many children experience drift and delay. Planning is weak and overly adult-focused. There is a lack of clear and detailed safety planning. This is compounded by a lack of robust management oversight and direction, which means that some children continue to experience ongoing harm. The needs and vulnerabilities of specific

groups of children are not well enough understood or met, including disabled children, young carers, homeless children and those exposed to domestic abuse and neglect. When safety concerns arise for these children, swift action is not consistently taken to understand risk. Disabled children have been left in unsafe and unassessed situations, at risk of harm.

2. Most children in Knowsley can access a wide range of early help support services and interventions, through a mature 'family first' offer. Early help assessments are child-centred and timely and inform clear and specific planning for children and families, preventing the need for statutory support for many. The interface between early help and statutory social work is understood, with step-up and step-down processes appropriately supported by regular management oversight and rationale.

3. The multi-agency safeguarding hub (MASH) is mostly effective, and children and families are supported to access the right support at the right time. Thresholds are mostly understood and appropriately applied in the MASH. When concerns escalate, children are referred into the MASH in a timely way, although a small number of children experience delay in receiving the services they need.

4. Although most families are offered the right level of support and intervention at the 'front door', if parents withdraw consent to progress assessments or additional support, this is not always challenged. Managers do not sufficiently consider what this means for children. This acts as a barrier to children getting the right help at the right time. As a result, children's cases are closed without the necessary support being provided, and some children experience repeated contacts for similar issues.

5. The services provided for disabled children in Knowsley are not effective, including those for disabled children in need of help and protection and those in care. Risk of harm is not always identified, and when it is, the response is not sufficiently robust. Section 47 investigations do not assess all the risks identified during strategy discussions and are ineffective in informing next steps. Assessments and plans are limited and are not sufficiently focused on meeting the needs of these children. Some children have remained in harmful or potentially harmful situations for too long, and many have experienced drift and delay, partly due to too many changes of social worker. Although leaders were aware of this at the time of the inspection and had taken initial steps to better understand the challenges faced in this area of the service, they were unaware of the extent of the safeguarding concerns for disabled children. Information received during the inspection identified further unassessed safeguarding concerns for disabled children. The immediate management responses received for these children demonstrated a lack of understanding in the identification and understanding of risk to children. Responses also highlighted ineffective management oversight and challenge. The pace of change for these children is too slow and lacks purposeful direction. At the time of the inspection, leaders had no clear plan for the disabled children's service.

6. Responses to neglect are weak and are not informed by an up-to-date multi-agency neglect strategy, despite the high level of deprivation in the borough. Too many children who experience neglect do not always receive a timely and effective multi-agency response. This means that some children experience neglectful situations for too long and appropriate action to safeguard children is not taken at the earliest opportunity.

7. The complexities of domestic abuse are not well understood by some social workers, managers and partners. The overreliance on victim/survivor-led safety planning is not effective. This means that too many children are exposed to harmful situations without effective safeguards. This was raised at the October 2021 inspection and improvements have not been seen in this area of practice, despite a rolling programme of training.

8. When significant harm is identified for children, most strategy meetings are attended by appropriate professionals and effective multi-agency information-sharing takes place to inform decision-making. Decisions made in strategy discussions are sufficiently detailed and appropriately focus on children's safety.

9. The quality of child and family assessments is mostly poor and does not adequately inform subsequent planning. While multi-agency information and children's histories are recorded, there is a lack of analysis to fully understand children's needs. Some assessments are overly adult-focused. Parental capacity and information from those people who are important to children is largely missing from others, even when children are living with extended family members or having regular contact with grandparents.

10. The quality of plans to support children in need of help and protection is variable, and risks to children are not always recognised and responded to appropriately. Safety planning is weak. It is not always clear what the plan is and how it has been shared, meaning that for some children social work interventions are ineffective. Social workers spend too long trying to engage with some parents and fail to prioritise children's needs. Plans are regularly reviewed through well-attended multi-agency meetings. However, they are mostly task-focused, and there is insufficient challenge when progress is slow. This leaves children in potentially ongoing harmful situations. A lack of contingency planning does not support families to understand what will happen should change not be secured.

11. Too many changes in social workers and managers, compounded by a lack of robust planning, have prevented timely and appropriate action being taken for some children and families.

12. Management oversight across help and protection is often briefly recorded and does not provide effective challenge or rigour. Senior leaders identified this in their self-assessment and, subsequently, acknowledged the extent of this shortfall in practice during the inspection.

13. Although children are seen regularly, this is not always by their allocated social worker. Duty social workers are used to ensure statutory requirements are met. This means that some children do not have long-standing relationships with their social workers, while others experience too many changes in social worker to form an effective relationship.

14. The quality of direct work with children is inconsistent. While some children have well-thought-out work done with them to help them to understand their situation, other children receive no direct work. When some children raise worries with their social workers, these do not consistently translate into action to reduce their anxieties.

15. For children who go missing or are at risk of exploitation, the well-established Shield Service provides an effective response in helping to protect children. For children on the edge of care, Knowsley has an array of additional support services that work with children and families to reduce risks and prevent children entering care, including family group conferencing and the multi-systemic team.

16. The response to some specific groups of vulnerable children is too variable. For some, their levels of need and risk are either unassessed or inadequately supported, meaning that too many children are left in situations of potential risk. Too many children who are referred to the young carers service do not have their circumstances assessed in a timely way. During the inspection, a significant number of young carers were identified by inspectors as having been on a waiting list for months. Senior leaders were unaware of this issue. Leaders took immediate action to ensure that these children were contacted and their young carer assessments were started. However, a lack of management oversight, grip and governance has resulted in too many vulnerable children and families not receiving timely support.

17. Most children aged 16 or 17 who present as homeless do not receive a swift and proportionate service. Most children do not have their Section 20 rights explained to them early enough, meaning that there are delays in children being safeguarded. During the inspection, senior leaders took immediate steps to address this at the point of receipt of the contact by the MASH.

18. Children who live in private fostering arrangements benefit from robust planning and review. Private fostering assessments are thorough and reach appropriate conclusions. Children are visited regularly to ensure they feel safe and that their wishes are heard. However, the quality of the support offered to private foster carers is variable.

19. For children in Knowsley who are electively home educated or missing education, there is strong oversight to quickly identify, track and support these children and their families.

20. Allegations against professionals who work with children are well managed.

21. The pre-proceedings stage of the Public Law Outline (PLO) is mostly understood in Knowsley. There is generally effective oversight of children who are subject to the PLO, which supports the completion of assessments to avoid delay. If children's circumstances improve, decisions to step out of pre-proceedings are mostly appropriate.

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

22. Children remain in the care of their family members, including through kinship arrangements, when it is safe for them to do so. When there are immediate safeguarding concerns, suitable action is taken and decisions for children to enter care are appropriate and within their timescales, supported by effective management oversight.

23. The quality and timeliness of permanence planning for children are inconsistent. Some children achieve permanence in a timely way, while others experience drift and delay. Children's plans for permanence are identified by the second review, including twin-track planning when appropriate. For those children, permanence is achieved in appropriate timescales. While some children achieve permanence through long-term matching with foster carers, others have remained in care for too long due to delays in securing special guardianship orders or discharging their care orders.

24. When children return to the care of their parents, decisions are mostly appropriate and in children's best interests. Assessments are detailed and consider the views of parents, independent reviewing officers (IROs) and children, and the necessary checks are completed.

25. There is variability in the quality and timeliness of assessments for children in care. Although they are regularly updated and family relationships are well considered, assessments are too descriptive and do not evaluate the quality of current and future planning for children. This results in reactive, rather than proactive, planning to meet children's changing needs. Children's identities are not routinely explored, with only very brief observations of a child's ethnicity and religion.

26. The quality of planning for children in care is inconsistent. Some care plans are detailed and focused on children's needs, while others contain actions that are not specific enough to impact on the quality of care for the child. Too many children have experienced drift and delay in their care planning, due to multiple changes in social worker. Although children's plans are regularly reviewed through well-attended multi-agency meetings, IROs do not always escalate their concerns about drift effectively. Review recommendations, although clear, are not always aspirational for children. Family time for children in care is carefully considered and planned. When appropriate, parents are encouraged to attend key meetings, and they contribute to planning children's care.

27. Most social workers take time to build good-quality relationships with children, visiting them in line with their needs. Some children in care, including disabled children, have experienced frequent changes of social worker. Children told inspectors how frustrating this is for them. This means that some children do not have the opportunity to build enduring and trusting relationships with their social workers. Most children do not have the opportunity to do life-story work. This means that children can struggle to understand their histories.

28. Children told inspectors that they know how to make a complaint. Children who live in residential care, and those over 16, are routinely offered an advocate should they wish. Children spoke highly of their IROs as 'stable people' in their lives that they can go to with problems. Some children said they do not feel the same way about their social workers, telling inspectors that 'they are unreliable'.

29. Children are not regularly consulted or supported to contribute to service development and review, although members of the care-experienced forum have recently helped to develop a revised pathway plan template for older children.

30. For most children in care, risks are recognised and responded to effectively. When risks to children escalate and deprivation of liberty is assessed to be needed, most children's circumstances are promptly put before the High Court. For these children, the orders are carefully considered and reviewed regularly through planning.

31. The health and well-being of children in care are actively considered in care planning and reviews and, for most, their physical health needs are met. Children can access a range of universal and specialist services and carers actively promote their health and well-being. For some children who experience poor mental health, there is a delay in accessing child and adolescent mental health services (CAMHS) and other services. This means that some children are waiting too long to access vital services to support their ongoing emotional well-being.

32. Educational attendance and attainment for this cohort of children are below the national average. Education and career planning for children is often not strong, with care plans and pathway plans weak in setting out how children will be helped to achieve their educational aspirations. For some children in care, the support that they receive to attend school regularly is not as effective as it should be, particularly for secondary-age pupils. As a result, some children in care do not establish positive attendance habits. This means that too many children in care do not achieve their educational and career goals. Many children in care participate in sport and recreational activities, which helps them to build their self-esteem and to develop new friendships. When children do not participate in activities, they are not always appropriately supported to access such opportunities.

33. Most children in care live in placements that meet their needs. When children cannot remain in the care of their birth parents, they are placed with extended family members in kinship arrangements when appropriate. Viability assessments of family members are completed promptly, often during pre-proceedings, which prevents unnecessary delays for children. Regulation 24 assessments are timely and thorough and reach appropriate conclusions for children. Children in foster care live in homes where they are loved and have a sense of belonging. When children are matched long term with foster carers, this is celebrated with them. Most children who live in residential placements have their needs met. They are supported to access a wide range of social and educational activities to support their development.

34. A small number of children do not live in placements that meet their needs, including some very young children living in residential care. This is particularly the case for children with complex needs and those in sibling groups. In a context where sufficiency is a challenge, the needs of these children are not being met.

35. Too many children in care live in unregistered children's homes, due to a lack of suitable placements. IROs have regular oversight of these children, although they do not always challenge the appropriateness of these arrangements effectively. Senior leadership oversight and social work visiting for some of these children are not sufficiently robust. As a result, the well-being of some of these children is not properly understood.

36. Children who live at a distance from the local authority area receive equal support to those living in Knowsley. They are visited regularly by their social workers and supported to see their families, in line with their needs.

37. Planning and support for unaccompanied asylum-seeking children are variable, depending on individual social worker knowledge and experience. However, through the commissioned housing provision, most unaccompanied asylum-seeking children are supported to access health services and legal advice and to follow their religious beliefs and cultural practices

38. The assessment and approval of foster carers are effective and prospective foster carers value the training they are offered. However, many approved foster carers have not yet completed all their mandatory training.

39. The local authority is a member of the regional adoption agency, Adoption in Merseyside. Recruitment and assessment of adopters are strong, although there is a challenge to recruit sufficient adopters to meet the needs of children who are waiting. Opportunities to place some children in foster to adopt placements have been missed, meaning they may experience additional unnecessary moves before achieving permanence.

The experiences and progress of care leavers: inadequate

40. Since the inspection in 2021, the quality of support provided to care-experienced young people has deteriorated, and it is now inadequate. There are serious failures in keeping in touch with some young people when they turn 21. A significant number of young people have been inappropriately closed to the service when they are entitled to support and may need ongoing help. Young people are not reminded of their rights to access ongoing support through regular follow-ups. This shortfall was identified at the focused visit in January 2024. Despite this, there is still a lack of robust mechanisms to review these young people's needs, to determine what ongoing support they require as they reach the age of 21. Risks to young people are not always understood, and some do not receive timely and appropriate help to protect them. Although ongoing recruitment has taken place, there continues to be staff churn in this team, which has adversely impacted on workforce capacity. High workloads for PAs continue to impact on the quality of help and support given to young people. This has also not been addressed effectively, despite being raised in January 2024.

41. While PAs are allocated before children reach 18, contact is too infrequent to help children and workers get to know each other before the children leave care. PAs do not routinely attend key meetings relating to children's care, to understand their history and their needs. Pathway plans for children aged 16 or 17 are not consistently informed by up-to-date assessments. Most are too descriptive, incomplete and lack clear actions to support young people to transition to adulthood successfully.

42. Some social workers are not able to assess children's readiness for financial independence, which leaves care-experienced young people vulnerable financially. Social workers are not sufficiently aware of available toolkits to assess children's independent living skills, and these are mostly left for carers to complete. Social workers and PAs do not have sufficient oversight of this work to be assured that young people are helped to develop the confidence needed to become independent adults. Young people told inspectors that they did not feel well enough prepared for independence, particularly in understanding and paying bills.

43. Once young people turn 18, many benefit from long-standing and supportive relationships with their PAs. Some young people told inspectors that they valued these relationships and that PAs were there when they needed them. Most PAs know their young people well, maintaining contact through apps or online, as well as face to face.

44. PAs' high workloads are impacting on the quality of the help and support young people receive. Although most young people are seen regularly, visits are mostly task-focused or crisis-driven. If young people start to disengage from the service, there is sometimes insufficient persistence to reconnect with them.

45. For the significant number of young people over 21 who have been closed too early to the leaving care service, management oversight is limited and minimal contact has not been maintained. The expectation is that young people will reach out if they need help, rather than giving them an ongoing offer of support. Most of these young people have considerable funds available to them as part of the local offer, but it is unclear if they are aware of these entitlements. Although senior leaders took immediate steps to contact these care-experienced young people during the inspection, the current situation shows a lack of management grip and understanding of the needs of vulnerable young people. It also highlights a weakness in operational and strategic governance.

46. Most pathway plans are weak and too brief to provide a good enough understanding of young people's needs and how these will be met. Plans are not updated to reflect young people's current circumstances, so necessary actions are not up to date or agreed. Too often attempts to seek young people's views are limited, and plans are not consistently completed together with young people. This means that young people are not involved in shaping decisions about their lives.

47. Senior leaders do not have a sufficient grip or understanding of the care-experienced young people who may be at the greatest risk. Planning does not routinely explore young people's risks or vulnerabilities. Historical concerns, such as exploitation, are not considered or revisited to identify if risks are re-emerging. Young people at risk of domestic abuse do not receive timely support, nor are they helped to be safer.

48. Some young people with specific vulnerabilities do not consistently have their needs understood and met. The planning for young people who are parents does not sufficiently focus on developing their parenting skills. For those in custody, PAs do not see them often enough to be assured their welfare is safeguarded, and their pathway plans are not routinely updated once in custody. These young people do not receive funds for toiletries and phone calls. This leaves young people alone and without the ongoing help that they need.

49. There is a lack of aspiration and ambition for too many young people. Approximately half of young people aged 19 to 21 are not in education, employment or training (NEET), despite the availability of a range of services and opportunities. Young people's hopes and dreams are not sufficiently considered to inform planning to help them achieve their career ambitions and maximise their life chances as adults. Care-experienced young people's education goals are not specific or targeted enough to sufficiently identify the help they need to re-enter education, employment or training.

50. Although young people receive the key documents that they need as young adults, such as national insurance numbers, birth certificates and passports, they do not consistently receive their health histories. While physical health is considered, young people's overall health needs are not always explored,

particularly when they have experienced trauma, for example those who have entered care as unaccompanied asylum-seeking children. Despite the availability of the dedicated emotional well-being provision, young people reported delays in accessing this help at a time that is right for them.

51. Most care-experienced young people live in suitable accommodation that meets their needs. If young people's circumstances change, leading them to move into unsuitable accommodation, their needs are mostly considered and steps are taken to swiftly resolve the situation.

52. Care-experienced unaccompanied asylum-seeking young people are provided with solid support to live and settle in the UK. The dedicated housing and support provision continues to provide specialist services for these young people. This supports them to progress to independent living at a pace that is right for them.

53. Leaders continue to review and strengthen their local offer, informed by direct consultation with young people. This is now broad, highly detailed and accessible through an online version which is easy to navigate. The offer provides information on the role of the care-experienced young people's team and contact details for those services available to provide support. Most young people are aware of their entitlements through the local offer.

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

54. Since the last inspection in October 2021, when Knowsley was judged to be requires improvement to be good across all areas, the quality of social work practice has deteriorated for children in need of help and protection and for care-experienced young people. Poor practice identified in October 2021 and at the focused visits in October 2022 and January 2024 has not been addressed, and this remains a feature today. Alongside significant leadership churn, there is insufficient leadership experience across the service to drive improvements for children and care-experienced young people. There has been a failure to ensure the adoption of appropriate standards of practice through an effective practice model. Leaders have not robustly recognised and managed risk for vulnerable children, leaving too many in unsafe situations. Known deficits have not been addressed with effective improvement planning.

55. The local authority's self-evaluation was not an accurate reflection of the current challenges in children's services. Senior leaders did not know about the young carers waiting list, the premature closure of care-experienced young people over 21, and the lack of management grip, including in relation to disabled children. The DCS has rightly acknowledged that there is a need for further cultural change to bring about the best conditions for effective social work practice. The DCS secured significant financial support from the corporate centre during the inspection, to enhance senior leadership capacity. Cafcass

and the judiciary confirmed that relationships with the senior leadership team are strengthening.

56. There has been a lack of pace and appropriate prioritisation to improve services for children. Although there is ongoing council financial support, there have been a significant number of changes across the senior leadership team since 2020. This has been compounded by a lack of experience and knowledge across the workforce, which has led to insufficient grip of children's services. Leaders confirmed that the churn of social workers for children has further impeded the speed of progress.

57. The current DCS came into post in January 2024, bringing enthusiasm to the role, and is visible and engaging with the workforce. Despite this, there has been a lack of a systematic approach to identifying and addressing weaknesses. Improvement planning and recently revised leadership structures have not made sufficient impact on the quality of social work practice, with gaps in the operational and strategic experience of senior leaders. This is impacting on their ability to hold their services tight and recognise and respond to practice shortfalls in a timely way. Although the improvement board has a focus on compliance and 'getting back to basics', and sector-led improvement work has been completed, the impact of both on strategic decision-making and operational practice is limited.

58. Some areas of stronger practice have been seen in early help, the MASH, missing children and children at risk of exploitation services and in the emergency duty team (EDT) and at the PLO stage.

59. Although senior leaders have recently revitalised corporate parenting meetings, this has not been sufficiently effective in driving forward a strong corporate parenting approach for children and care leavers. Plans are not adequately developed to see any impact for children and young people.

60. The sufficiency challenges in Knowsley have been acknowledged by leaders, who recognise there is still an insufficient range of placement choices for children in care. This means that some children are not living in homes that meet their assessed needs.

61. Current performance management systems and processes are compliance-focused, but do not support leaders to have a sufficient breadth of sight across children's services in relation to the quality of practice. There is an absence of effective scrutiny to support improvement. Quality assurance and auditing processes have recently been developed, with a well-structured audit tool now in place. However, auditing is not consistently providing a clear enough line of sight for senior leaders to understand all service weaknesses.

62. Leaders understand that staffing instability and inexperience across the workforce have been significant barriers to improving the quality of social work

practice, with high dependency on agency workers. This means that some children experience drift and delay as a result of too many changes in worker.

63. The caseloads of PAs in the care-experienced service are too high. This does not support them to meet the needs of the young people they work with and has not been addressed since the 2024 focused visit. Leaders have not provided a detailed plan for how they are going to address this.

64. While staff say there is a breadth of training available helping them to understand the basics, this is not consistently influencing and improving practice. Knowsley's model of practice is not sufficiently understood or embedded. Social workers and PAs are not receiving regular and consistent supervision, and the quality is variable. This area of practice has not improved since the last two focused visits. Despite the challenges, social workers say senior leaders are now more visible.

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Piccadilly Gate
Store Street
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