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Dear Hilary/Mark

Monitoring visit to Knowsley children's services

This letter summarises the findings of the monitoring visit to Knowsley children's services on 24 and 25 February 2026. This was the second monitoring visit since the local authority was judged 'inadequate' in January 2025. His Majesty's Inspectors for this visit were Rebekah Tucker and Leanne Cooper.

Areas covered by the visit

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

- Strategy meetings and Section 47 investigations.
- Quality and impact of assessments.
- Arrangements for children in need and those subject to a child protection plan.
- Children who are subject to pre-proceedings.
- Senior leaders' oversight of performance.
- The quality of management oversight and supervision.

This visit was carried out in line with the inspection of local authority children's services (ILACS) framework.

Headline findings

Since the last monitoring visit, increasing workforce stability at a senior leadership and management level is supporting purposeful and appropriately focused improvement planning for children and families. The director of children's services

(DCS) has secured significant financial investment to address practice shortfalls and to support sustainability in service improvements going forward. Robust governance arrangements are now in place to support the oversight of progress against the improvement plan, and political and corporate support for children's services is strong. There is a robust quality assurance framework, which is leading to a greater understanding of front-line practice.

This monitoring visit has found that reasonable progress is being made in specific areas of practice such as Section 47 investigations, child protection planning, and the auditing of casework. However, the quality of practice for children in need remains inconsistent. The quality of assessments and the response to domestic abuse have not improved since the inspection, with a deterioration seen in the quality and timeliness of some of the decision-making in the multi-agency safeguarding hub (MASH).

Findings and evaluation of progress

Leaders are demonstrating a clear commitment to making the improvements needed. There are some firm foundations established to support the transformation of social work practice. Significant financial investment from the council is supporting service development, and serving to embed the workforce model required to deliver the improvement plan. Stability in the workforce has largely been achieved, with no social work vacancies, low agency numbers, a recently recruited permanent DCS, a permanent assistant director and four permanent heads of service. Robust transition arrangements are in place for the incoming DCS to minimise disruption to staff, children and families. Through the prioritisation of recruitment and retention, the creation of 20 new social work posts has reduced caseloads to enable improved quality of practice and children's experiences.

Quality assurance processes are now more structured, with clearer accountability, and they are underpinned by a new quality assurance framework, which is providing leaders with more effective oversight of practice. Regular use of performance data, timely quality assurance reviews, collaborative audits, the use of a moderation panel, and the support of the social work academy, are contributing to a more accurate understanding of service quality. Nonetheless, there remains variability in the quality of social work practice with more work to do to achieve consistent outcomes for children and families.

For most children, when strategy meetings are convened, partners demonstrate a good understanding of risk and appropriately share information, which leads to timely decision-making and actions. Most strategy meeting minutes capture the information shared, recommendations for next steps and the child's voice. Management oversight demonstrates how decisions have been reached. For most children, the outcomes of strategy meetings are appropriate. However, for some children, with clearly identified risks from domestic abuse, strategy meetings are not always taking place in a timely way in the MASH. Social workers are not always

identifying the significance of risks faced by children from domestic violence. Practice in this part of the service has deteriorated since the last inspection and monitoring visit.

The quality and impact of safety planning is variable, with some children not having safety plans recorded on their files. For children who do have a recorded safety plan, these are not routinely shared with families in a purposeful way, to meet parental learning needs or first language requirements. For children who are living in homes where domestic abuse is the prevailing risk factor, the onus continues to be placed on the victim to protect themselves and their children, and this was also seen in child and family assessments.

For most children, Section 47 investigations are appropriately detailed and focus on the current risks, while considering the child's history and partner information. Social workers seek to obtain and reflect the voice of children as part of these assessments. The views of parents are sought, and appropriate professionals are contacted to share relevant information. Management oversight is clear and reasons for next steps are well considered.

The quality of child and family assessments remains poor. Assessments are brief in their content, do not consistently consider family history, nor do they identify cultural needs. Multi-agency contributions to assessments are not always evident. Social work analysis of children's needs is limited, compromising the quality of the recommendations made. The quality of management oversight of assessments is variable and does not adequately address the deficits in practice. For children living in environments of neglect and domestic abuse, there is an absence of specialist assessment tools to support social workers' analysis and recommendations.

There has been insufficient pace in improving the social work response to domestic abuse since the previous inspection. Senior leaders know that there is more to do to support practitioners' understanding of risk, so that timely action is taken to support children and families. Firm plans are underway to strengthen multi-agency practice in respect of neglect through the imminent launch of a neglect strategy, with an accompanying multi-agency assessment tool to support its implementation.

Children are visited regularly and in line with their needs. Social workers mostly understand the needs of their children and have developed positive relationships with them and their carers.

For children subject to child in need planning, there is variability in the quality and timeliness of multi-agency planning and interventions. Social workers know their children well, and some children and families receive support that meets their individual needs. For some children, however, risk is not consistently identified or responded to, which can delay appropriate actions and limit the impact of intervention. For some children with a disability, their child in need planning does not adequately address their special educational needs. This means that they have not been supported to access an appropriate education provision. Actions set within child

in need plans are not consistently time bound, meaning that, for some children, these plans drift.

Most children subject to child protection planning receive a responsive service from social workers who understand the child, their parents and the risk involved. They are seen by their worker in line with risk and need and the plan is monitored through regular multi-agency meetings. The plans involve the appropriate agencies and are well coordinated. For most children, child protection plans robustly address children's needs and risks well, with timebound actions. Most social workers are able to draw on targeted services that help children understand their circumstances and support parents in reducing risks. Core groups are held regularly and are well attended by partners.

The local authority is enhancing its understanding of children who have been on child protection plans for over 18 months, to ensure that these children are being supported at the right level. Child protection chairs are providing increasing scrutiny and oversight of children, although it is too soon to see the full impact of this. Drift and delay remain for some children in stepping up into the pre-proceedings phase of the Public Law Outline (PLO), because their lived experience and risk are not always considered in a timely way. For other children, decisive action is now being taken when they are at risk of immediate harm. Appropriate tracking systems have been developed to support senior management overview of all children subject to a child protection plan for six months or longer. This is starting to lead to timely permanence for some children.

There is variability in the quality of decision-making for children whose child protection plans end at three months. For some children, the decision to end their plan at three months is proportionate to the level of risk and need, where they can no longer be safely cared for within their home and alternative permanency is secured. For other children, decisions to end child protection plans at three months are premature because there is not a holistic appraisal of all known static and dynamic risk factors.

Pre-proceedings work, as part of the PLO, is developing well, with effective tracking and oversight by senior managers. Regular legal gateway review meetings provide consistent oversight, and a more child-focused challenge to practice. This enables social workers and managers to understand clearly what needs to happen, and by when, and is supporting greater consistency in decision-making around the PLO threshold. Children and families benefit from multi-agency support to help reduce risks. Specialist assessments and drug and alcohol testing are completed in a timely manner. While kinship carers are considered within the PLO, wider family networks and carers are not. Although letters before proceedings clearly outline the seriousness of the situation for families, the language used within them contains professional terms and is not always relational and kind. This means that parents are sometimes not clear about what they need to do.

In a good practice example, the exploitation and contextual safeguarding service (Shield) was seen to provide timely intervention and support, when risks of criminal and sexual exploitation had been identified. Through the allocation of separate Shield workers to children and parents, sensitively targeted and individually tailored direct work and engagement are undertaken. This helps to build meaningful relationships and connections, and to support change and improve outcomes. For these children, effective partnership working was seen. Records are written directly to children and show timely visiting. Workers demonstrate a professional curiosity that continues to appraise the rapidly shifting risk factors with honesty, ensuring that the true picture of the child's life is always reflected on their files.

There is variability in the frequency and quality of supervision. For some children, supervision between the social worker and their manager is detailed, reflective and ensures that children's needs are met. For other children, this supervision is not sufficiently analytical and does not routinely consider the quality and impact of social work practice on children and families. Actions are not focused on children's outcomes and are not always timebound.

Management oversight does not always provide sufficient challenge or reflection to improve the quality of social work practice. For some children, this has led to their needs not being recognised or acted on in a timely way. Improvements in the quality of supervision and management oversight have largely remained static since the last inspection, and practice in this area remains inconsistent. While the local authority continues to work with its sector-led improvement partner, there is more to do to ensure consistency in the timely identification of risk.

Practitioners are positive about working in Knowsley. They told inspectors that they feel listened to and are well-engaged in the improvement journey, welcoming regular leadership updates. They said they could feel a real change, for the better, in practice expectations and how they work with children and families. Social workers are appreciative of the open-door policy and report reduced caseloads in recent months, and they feel that caseloads are manageable.

I am copying this letter to the Department for Education.

Yours sincerely

Rebekah Tucker
His Majesty's Inspector