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Mr Steve Reddy
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Dear Mr Reddy

Monitoring visit to Liverpool City Council children's services

This letter summarises the findings of the monitoring visit to Liverpool City Council children's services on 31 October and 1 November 2017. The visit was the fourth monitoring visit since the joint targeted area inspection (JTAI) of the multi-agency response to abuse and neglect in June 2016 that found evidence of serious and widespread deficits across the partnership. The inspectors were Nigel Parkes HMI and Sheena Doyle HMI.

Although the local authority has rectified many of the failings that were identified at the time of the JTAI, social work practice is still not good enough. Some aspects of practice and performance have slipped since the last monitoring visit. The new director of children's services (DCS) knows what improvements are needed. He is developing a clear and simple plan to drive improvement. This includes taking immediate action to address the shortfalls identified by the recent audits undertaken by the local authority.

During the course of this visit, inspectors reviewed the progress made in the areas of:

- The identification, assessment and reduction of risks, with particular reference to the quality of social work assessments and the impact and effectiveness of child protection plans.
- The level of critical challenge provided by child protection conference chairs and frontline managers.
- The impact and effectiveness of leadership and management, with a focus on how senior managers use performance management and quality assurance information to drive improvement.

During the visit, inspectors tracked and sampled a number of children's and young people's cases. Inspectors also spoke to social workers, family support workers, child protection conference chairs and managers. They considered a range of evidence, including electronic case records, minutes of meetings, management reports and case audits.

Overview

The results of the local authority's most recent case audits are disappointing. The local authority's own auditors found that overall only 11% of cases were good or better. This is partly a product of the pressure that assessment teams are currently under. In some assessment teams, caseloads are too high. This is having an impact on the quality of assessments and plans. Social workers are trying to give more weight to children's wishes and feelings, but the voice of the child is not yet consistently evident in case records. Some children and families have experienced repeated changes of social worker.

At the time of this inspection, the new DCS had been in post for four-and-a-half weeks. He is under no illusions about the size and scale of the task that he faces. The DCS understands the key priorities and is working on a simple nine-point plan to address the shortfalls. He has taken immediate action to ensure that referrals are not being stepped down inappropriately from the multi-agency safeguarding hub (MASH) to early help.

1. The identification, assessment and reduction of risks

Inspectors saw some examples of social work practice that is genuinely child centred. In these cases, social workers really listen to what children have to say. Their assessments include good observation, understanding and analysis of children's behaviour. But this is not routinely the case. Most of the single assessments provide little direct evidence of the voice of the child. Those that do so tend to provide a clearer picture of the voice of older children, at the expense of younger brothers and sisters.

Family support workers are doing some very positive work with children and families. They use plans that are simple and easy to understand. Risks are clearly articulated and assessed on a 10-point scale. This helps to ensure that their work is purposeful and effective.

Caseloads are too high in some of the assessment teams. This is because of difficulties in filling posts in the court, care and planning teams. The knock-on effect is adding to the pressure that assessment teams are under. High caseloads are having an impact on the quality of social work practice. Some children and families have had several different social workers. The impact of this for children is that, on occasion, the case-accountable social worker has been unable to attend the child protection conference. The impact on parents is that they are not always able to see social workers' reports 48 hours before the conference.

The quality of case summaries has dipped. They are not routinely updated. Some lack basic information. Others provide information in shorthand. Without further explanation, this limits their value.

The quality of chronologies has still not improved. They continue to be electronically generated without any editorial oversight. None of the chronologies seen provide a clear or concise summary of the key events in children's lives.

Most assessments are lengthy and detailed. They include plenty of relevant information and take account of the child's and family's history. However, they are heavily dependent on 'cutting and pasting' from other documents. This results in considerable repetition. Risk factors are identified, but are not always clearly articulated. The quality of analysis is still very variable.

Child protection plans are generally outcome focused, but most are not sufficiently specific or measurable. Risks are described at length and in detail, rather than being succinctly summarised. The way in which risks are described means that they are not always child centred. Additionally, while some tasks and actions are specific, most are not measurable. This dilutes the focus of protective action and means that it is not always clear who needs to do what and by when.

Core groups meet regularly, but they do not routinely review the level of risk. While some systematically review the progress of actions agreed in the child protection plan, others do not. Core groups are not consistently holding parents and partner agencies rigorously to account. This means that, for some children, improvement is too slow.

The results of a recent 'dip sample' carried out by the local authority on cases stepped down from the MASH are worrying. They suggest that one in five referrals had been wrongly redirected to early help. Inspectors who reviewed the evidence agreed that, in each of these cases, the children and families identified would have benefited from the involvement of children's social care. Immediate action has been taken to resolve this issue.

2. The level of critical challenge provided by child protection conference chairs and frontline managers

Child protection conference (CPC) chairs have taken on board the messages from previous monitoring visits. They are working hard to improve the quality and usefulness of child protection plans. The most recent child protection plans are more specific and measurable, but CPC chairs still need to make sure that risks are described clearly and simply in a way that parents, and others, find easy to understand.

More generally, CPC chairs know 'their' children well. They are able to articulate risks and protective factors clearly and succinctly. They use both formal and informal escalation procedures to address issues and concerns, but on occasion they tend to focus on process rather than substance.

Inspectors saw little in the way of management oversight on individual case records. Where it is recorded, management oversight does not consistently provide added value. On some occasions, it consists of a simple one-line summary of the current position. On other occasions, it involves a lengthy 'to do' list, without any indication of who needs to do what or by when.

3. The impact and effectiveness of leadership and management

The quality of performance management information has improved in the last 12 months. That said, the performance and management information summary report, which goes to senior leaders and managers, contains too much superfluous information. Some of the commentary is difficult to understand. The report itself contains very little in the way of targets.

Some case audits focus on compliance at the expense of impact and outcomes for children, but most are accurate. In the vast majority of cases, the local authority's auditors know what good looks like. With only one exception, inspectors agreed with the local authority's findings about strengths or areas for development. However, the way in which case audit overview reports are written is not always helpful. Some are repetitive. They include a considerable amount of padding. By endlessly rehearsing practice shortcomings, they are in danger of demoralising staff.

Four-and-a-half weeks into his new role, the new DCS has a clear sense of the size and scale of the challenge that he faces. He has identified the most pressing priorities and is developing a clear and coherent plan to address them. He recognises the need to focus on those issues and areas that will have the greatest impact. He is taking appropriate action to ensure that referrals are not being stepped down to early help inappropriately and that the MASH is operating safely.

The immediate priority is to appoint a competent, capable and experienced assistant director. Interviews are due to take place shortly.

I am copying this letter to the Department for Education. This letter will be published on the Ofsted website.

Yours sincerely

Nigel Parkes
Her Majesty's Inspector