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Risthardh Hare
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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 25 and 26 June 2024. This was the sixth monitoring visit since the local authority was judged inadequate in February 2022. His Majesty's Inspectors for this visit were Lisa Summers and Rachel Fairhurst.

Areas covered by the visit

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

- The local authority's arrangements for the 'front door'.
- Initial responses to children in need of help and protection.
- The management of allegations of abuse against professionals who work with children.
- The management of concerns for children outside of normal office hours.

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 and case file audits provided by senior managers. In addition, inspectors spoke to a range of staff, including social workers and managers.

Headline findings

Leaders have not taken sufficient action to tackle some of the weaknesses found at the last inspection. The pace of improvement in some areas is too slow where leaders are not monitoring the impact of these changes well enough. In particular, the response to children at risk of significant harm is not consistently timely or reducing risks to children sufficiently well. Police do not always refer children soon enough when they have concerns. There are delays in some strategy meetings and initial child protection conferences (ICPCs) that leave children in situations of

ongoing risk without well-informed and appropriately focused multi-agency action to reduce this.

Despite these weaknesses, there is some positive progress. Since the last inspection, the front door has been restructured to include an early help pathway through the family advice and support team (FAST), and a pathway directly into social care through the children's help and advice team (CHAT), which are supporting more timely decision-making. Children who need early help now receive a more timely and effective service. The response to children who need help and protection outside of normal office hours and when allegations are made against professionals working with children has improved. Increased management oversight, monitoring and regular sampling are leading to greater consistency in application of thresholds. Assessment timeliness has significantly improved, and more assessments now demonstrate elements of stronger practice. Enhanced quality assurance is providing a greater understanding of weaknesses in the front door response.

Findings and evaluation of progress

There are still delays for some children in accessing the right support at the right time because of a number of issues. Some children are left in situations of unassessed risk due to delays in police progressing concerns, including when children need immediate protection. There are some delays in securing partners' information to inform screening. The management of social work resources in CHAT is not always sufficiently coordinated and this is having a negative impact on the timeliness of decision-making for some children.

Children who need early help receive an effective and timely response from FAST. Screening is robust and informed by detailed conversations with referrers. There is comprehensive management guidance to identify what additional actions are needed to inform decisions about next steps. This is leading to appropriate threshold decisions being made and the rationale is clear. Detailed child-centred actions are swiftly signposted to the appropriate services to progress. Following screening, FAST secures timely access to support from community services for children and families. This is a significant improvement from the last inspection.

The recently implemented conversational model in CHAT is providing a more tailored and responsive approach to identifying children who need help and protection. Social workers discuss referrers' concerns in detail. This is providing an opportunity to support professionals' understanding of thresholds and it is informing a richer understanding of children's experiences. When harm is clearly identified, decision-making is mostly swift. This has appropriately addressed the issues identified at the last inspection in relation to poor-quality referral information which contributed to delays in children receiving a timely response. The new approach has been supported by extensive training of frontline staff, a revised threshold guidance, and ongoing engagement with partners through the implementation board.

Most threshold decisions made in CHAT are now appropriate but not consistently timely. History is now better used, and the gathering of additional information is proportionate to inform threshold decisions. Managers are aware of all delays through detailed performance information, and there is clear management oversight of, and guidance for, social workers to follow when delays are identified.

When children need to be protected, the response is not consistently timely. Some strategy discussions are held outside of the local authority expected standards of being held within 24 hours. Inspectors were told that this was as a result of insufficient capacity of partner agencies in the CHAT. Police and health professionals attend strategy discussions across the service, and this is hindering their ability to respond in a timely way. Leaders have escalated concerns to the police, but this is not making a difference to the delays that children are experiencing. Leaders were not aware that these delays persisted.

Most strategy meetings are effective forums to share information and to understand risks to inform next steps for children. Actions for social workers to follow are mostly child-focused and detailed, with clear timescales. The quality of safety planning for children remains inconsistent. Where safety planning is weaker, it does not sufficiently focus on reducing risk or plans do not adequately record how risk is to be reduced. For these children, it is not consistently clear whether they are being protected during subsequent child protection enquiries. In stronger safety planning, the safety of the child is considered, and appropriate safety measures are in place, especially when risks are managed by the out-of-hours team.

Overall, the quality of child protection enquiries is inconsistent. Stronger assessments use history and information from partners. In these enquiries, the voice of children is clear, and the analysis is detailed. Risks are understood, and assessments clearly define the next steps if concerns are substantiated and if children continue to be at risk of harm. Weaker enquiries do not fully consider children's history to support an understanding of cumulative harm. The analysis overly focuses on parents' agreement to engage in additional support, rather than whether children continue to be at risk. The rationale not to progress to ICPC is sometimes unclear.

There are a number of children who experience delays in progressing to ICPC. For some of these children, the delay is the result of social work reports not being completed or shared to enable parents to fully engage in meetings. Some of these delays are significant. While children continue to be visited and most are supported through child-in-need planning, actions are not sufficiently focused on reducing these risks to safeguard them at this time. Management oversight is not sufficiently robust to be assured that appropriate actions are in place to mitigate harm and to prevent further delay. Escalation by conference chairs is ineffective.

There is timely and appropriate action when children need a social work response out of office hours. The emergency duty team (EDT) acts to ensure that children are swiftly safeguarded through a strong multi-agency response. There are now

sufficient resources to deliver the task with 24-hour social work availability. Handover arrangements from the EDT to daytime services are effective through daily meetings.

Decisions made by practitioners to progress to assessments of children's needs are sometimes overturned by the receiving team, leaving children with unmet needs and repeated concerns. This has been recognised by leaders and weekly review clinics have been introduced to consider any disagreements about threshold decisions.

Consent is now mostly considered and secured when appropriate, although the rationale behind this being dispensed with is not always clear to be assured that the right decisions about this are being made. Partners sometimes seek consent when this is not needed, given the seriousness of the concerns about children. This practice leads to unnecessary delays in referring to social care, as well as alerting potential perpetrators of concerns prior to strategy discussions taking place. This places children at further risk of harm and could impact on subsequent child protection enquiries.

The approach to dealing with domestic abuse concerns is improving. There are now clear discussions with victims in considering children's safety before contacting perpetrators. Additional resources of a dedicated Sefton's women and children's aid worker are enabling swift access to support victims. Victims are quickly contacted, risk assessments are completed, and safety plans implemented. This is providing a more holistic approach to supporting victims to keep children safer.

Assessments are showing some elements of improved practice. Most are now timely and informed by a broad range of partner information, and parents' and children's views. The weaker assessments are overly optimistic. They focus on children's behaviour without exploring root causes and they do not fully analyse a child's history to understand cumulative harm. As a result, decisions to cease social work intervention for some children are made prematurely. This is leading to some repeated referrals as children's needs remain unmet. Leaders recognise that there is more work to do to improve the quality of analyses, and to assess parental ability to make and sustain change. Targeted assessment training continues to embed in practice. Training has been well received by social workers.

Some parents withdraw consent to undergo an assessment without this being challenged by managers. Consideration is not being given to what this means for children or what needs to happen should there be further concern. As a result, some children do not get the help that they need at the earliest opportunity.

Responses to allegations made against professionals working with children are now more robust and timelier. When concerns arise, the response is now swift, and the local authority designated officer (LADO) ensures that appropriate actions are taken to keep children safer through strategy meetings. Concerns are tracked and monitored through to conclusion. When professionals are subject to ongoing investigations, decisions that impact on children and those under investigation are

not always shared with the LADO. This potentially places some children at risk of harm.

Leaders' line of sight of frontline practice has significantly improved from a very low base. Tailored performance reports show month-on-month trends and comparator information is supporting the identification of areas for further scrutiny. Not all areas of practice are being sufficiently monitored to test the impact of changes and improve performance; this includes the quality and timeliness of strategy meetings and where there are delays in ICPC taking place. Audit activity has broadened, with additional discrete sampling taking place to understand specific areas of practice. This is providing a much-improved understanding of the detail behind the data to inform improvement plans.

The approach to auditing is more consistent. There are routine discussions with social workers, independent reviewing officers and child protection chairs. Feedback from families is sought to understand the impact of social work practice. Most strengths and weaknesses in core elements of practice are recognised. Corrective actions for individual children are appropriately identified and are more focused on improving children's circumstances, rather than overly focusing on process. Resultant actions are monitored for completion. Some audits are overly positive because the response to risk is not consistently or robustly evaluated in respect of children's experiences or to support wider service learning.

Management oversight is more frequent, providing guidance, and the rationale for decision-making. Supervision is now regular, and more managers are reflecting on children's experiences to support social workers' thinking. This is not consistent. Weaker supervision is not helping social workers to think through the complexities within the family, to explore the risks or to identify specific actions to improve children's lives.

Social workers at the front door are very positive about the implementation of the new approach in CHAT and FAST. They reflected that this has rejuvenated their practice, and that the new model is building positive relationships with partners and facilitating a more child-focused response at the front door. Leaders are cognisant that CHAT continues to be heavily reliant on agency workers who have stayed with the local authority for a number of years. Some social workers have joined, or are considering joining, the permanent workforce. Social workers stated that there is a positive working culture and more regular feedback about their practice. These improvements are making them feel valued and buoyant.

I am copying this letter to the Department for Education.

Yours sincerely

Lisa Summers
His Majesty's Inspector