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Dear Mr Kay

Focused visit to North East Lincolnshire children's services

This letter summarises the findings of a focused visit to North East Lincolnshire children's services on 22–23 October 2019. The inspectors were Rachel Holden, Her Majesty's Inspector, and Jan Edwards, Her Majesty's Inspector. This is the second visit following the focused visit to the front door in March 2019, where inspectors identified three areas for priority action in weaknesses for child in need and child protection practice.

During this visit, inspectors looked at the local authority's arrangements for children in need, children subject to a child protection plan and children subject to pre-proceedings.

Inspectors looked at a range of evidence, including case discussions with social workers, managers and senior leaders. They also looked at local authority performance management and quality assurance information and children's case records.

Overview

There continues to be significant weaknesses in the quality of services for children in need and those in need of help and protection. Some children are not being appropriately safeguarded or having their needs met in a timely way. Children were found to be at risk during this visit.

Two priority actions from the previous focused visit have not been sufficiently addressed. The local authority has failed to take swift and decisive action to improve the quality of assessments and decision-making, and the quality and effectiveness of managerial oversight and supervision.

Many children at risk of harm are not being seen by social workers appropriate to the level of risk and need. Risks to children are not being appropriately assessed, and, therefore, some children remain in unsafe situations for too long. Multi-agency meetings to share information, identify risk and review the progress of children's plans are irregular. When risks are identified or when they escalate, they are not progressed to pre-proceedings in a timely manner. Social workers' caseloads are excessively high, which prevents workers from undertaking effective work with children and their families.

Management oversight at senior and operational levels is weak. Performance data is unreliable. Scrutiny and challenge by senior leaders are ineffective. Senior leaders have been aware of the poor practice for some time through an improved audit process. However, this is not leading to improvements in practice or in the services that children receive.

Areas for priority action

In addition to addressing the two priority actions not resolved following the last focused visit, the local authority needs to take swift and decisive action to address the following areas of weakness in children in need and child protection:

- Visits to children proportionate to the level of risk and need.
- The quality of planning for children.
- The frequency and effectiveness of multi-agency reviews.
- Swift and effective remedial action following case file audit and child protection conference chair challenge.
- Timely escalation to pre-proceedings.

What needs to improve in this area of social work practice

- The size of caseloads for all social workers in the children and family assessment and safeguarding teams to enable effective social work practice to take place.
- The support and development of social workers in their assessed and supported year in employment (ASYE).
- Improved and accurate performance data and reporting.
- The challenge and scrutiny of performance data and the effectiveness of services by senior leaders.

Findings

Since the last focused visit, two priority actions requiring the local authority to act swiftly and decisively to address weakness in child in need and child protection practice have not been sufficiently addressed. The local authority's actions and responses have not been effective enough and have not had the desired impact on practice.

Assessment quality remains poor. In many cases, assessments were incomplete, or, in some children's cases, had not been started. Where assessments do take place, analysis of risk is limited. The child's and family's histories are not well considered, and there is a lack of professional curiosity when assessing a child's experiences and circumstances. This means that risk and need are not always recognised. During this visit, inspectors identified children at risk who required urgent interventions.

Children at risk of harm are not being seen often enough by social workers. Visits to children are not proportionate to the level of risk and need, and the quality of some of these visits, when they do take place, is poor. The records of visits are not always up to date, children are not seen alone where it would be appropriate, and the visits are mainly adult focused. Often, other children in the household are not considered or seen alone. This means that children's voices and their experiences are not heard or understood.

Senior leaders have acted too slowly to address the significantly high caseloads and deficits in practice in the children's assessment and safeguarding teams. Social workers, including those who are newly qualified, have exceedingly high caseloads. This impacts on their capacity to carry out visits to children, undertake qualitative work, and to practise safely and effectively. This is leading to drift and delay in identifying and responding to risks and need. Too many children remain in situations that are unsafe for too long. Numerous changes of social worker mean that children and families are experiencing stop and start assessments, which leads to delays in children's needs being identified and responded to. The significant gaps in visits and interventions hamper the development of trusting relationships between social workers, children and their families, and impact on case planning and progression.

Social worker turnover is high. Staff are not being supervised in a way that enables them to effectively carry out their roles. Some staff go many months without a formal opportunity to discuss their work and reflect on their practice. Management direction and oversight is weak. Social workers in their first assessed year of practice are overwhelmed by excessive caseloads and are denied the opportunity to reflect on and safely develop their practice. Management oversight is weak. When supervision does take place, this is not effective at driving children's plans or developing social work practice. However, during this visit, social workers spoken to reported feeling supported and content with their work.

The quality of care planning is weak. Children's plans are not informed by robust risk assessments. Some families have additional safety plans that are ineffective. Multi-

agency meetings to review children's plans are not always held in a timely way. When meetings do take place, there are often delays in minutes being written, or they do not exist in some cases. This does not give families and professionals the opportunity to review any progress and share information. This lack of focused planning means that children are left in situations of risk for too long before more decisive action to safeguard them is taken.

Where decisions are taken to enter pre-proceedings, this work is subject to drift and delay. Current systems used by senior managers to track this work are not robust or effective. However, there are plans in place to develop this area of work.

Where children have recently entered care, there are delays in decision-making in their assessments. Assessments, as well as some parenting assessments, are of variable quality and timeliness. They are overly descriptive, lack analysis and do not identify children's experiences well enough. Decisions to enter into pre-proceedings where children are either at risk of, or suffering, significant harm are not made soon enough. This results in children experiencing further harm. Deficits in this process mean that parents are not being given the earliest opportunity to improve their parenting and their children's circumstances.

Some families are receiving support from the early help (edge of care) service, which undertakes direct work and visits to families alongside social workers. The staff are skilled in delivering specific interventions, although drift and delay were evident in some cases seen, and it is difficult to see the impact on improving children's overall experience.

Senior leaders are aware of the concerns identified during this visit. However, there are weaknesses in the managerial response. The self-assessment accurately identifies where improvement is needed. Plans have been implemented to address some practice deficits. and the social work establishment has been increased. However, this is insufficient, and has not happened quickly enough. The recently introduced auditing team has vastly increased the number and quality of audits taking place. Practice in this area has improved. The audits seen by inspectors, including child protection conference chair scrutiny and challenge, are thorough and accurately outline where drift and delay are occurring in a child's case, as well as identifying practice strengths. However, this does not lead to remedial action to address practice shortfalls, progress children's plans, or safeguard children from known risks.

Due to some implementation problems with a new case recording system, the local authority is experiencing issues with the accuracy of the available performance management information. Currently, senior managers are relying on some manual counting. This makes the performance management information unreliable. The performance data available to managers, leaders, elected members and multi-agency partners has been unreliable for several months. This does not enable senior leaders to have an accurate understanding of performance, or, most importantly, the level of risk, needs, and experiences of children currently.

The performance data identifies that some children are unnecessarily subject to strategy meetings where risks do not require a child protection response. This has remained an issue since the last focused visit. Current strategies put in place to address this have not been effective, although work is currently being undertaken to address the issues. Recent practice to close open child in need assessments which have drifted, and then to re-open them in order to undertake a review of children's circumstances, is a concern. While the rationale to re-evaluate the level of risk and need is well intended, this methodology masks the recorded time taken to assess the presenting risk and needs of the child.

There is strong political and corporate support for children's services, and there has been significant financial investment since the last focused visit. Since the last focused visit, an improvement board has been put in place, and challenge and support have been commissioned from external consultants to support improvement. However, progress has been slow. Scrutiny and challenge by senior leaders are ineffective and do not translate into robust actions to keep children safe or improve the services available.

Ofsted will take the findings from this focused visit into account when planning your next inspection or visit.

Yours sincerely

Rachel Holden
Her Majesty's Inspector