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Dear Janice

Monitoring visit to North East Lincolnshire Council children's services

This letter summarises the findings of the monitoring visit to North East Lincolnshire Council children's services on 8 and 9 November 2022. This was the second monitoring visit since the local authority was judged inadequate in November 2021. His Majesty's inspectors for this visit were Matt Reed and Kathryn Grindrod.

Areas covered by the visit

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

- Planning and achieving permanence.

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

Headline findings

Permanence planning for children has not improved since the standard inspection in November 2021. Too many children experience delay in their need for permanence being assessed, planned and achieved. The constant high turnover of social workers and managers is resulting in children's assessments being delayed and restarted without timely conclusion.

A lack of early consideration and assessment of family members and potential connected care arrangements means that all routes to permanence are not considered soon enough. Where children are placed in connected care arrangements, or placed with parents, many are unassessed, unmonitored and unregulated. This is leaving children in situations of unassessed and continued risk.

Very recent changes to the senior leadership team, including the Director of Children's Social Care, starting in post five weeks before the monitoring visit. This is leading to a greater understanding of the scale of the issues and improved strategic

planning. Despite this improved insight, there has been limited impact on improving the experiences of children who require permanence, or creating an environment where social workers can practise safely and effectively.

Findings and evaluation of progress

Since the inadequate judgement in the ILACS inspection in November 2021, there have been several changes of senior leadership in children's social care. This has contributed significantly to the stalling of improvement, not only in the practice area being monitored, but across the service. Most recently, a new interim Director of Children's Social Care has been appointed and the senior leadership team has been strengthened. Together, they are realistic about the scale of the issues and the need for the pace of improvements to increase. The service improvement plan is being reviewed to better inform strategic planning. There continues to be investment in children's services to support the improvement work, and senior leaders are engaging with the increased support by service lead improvement partners.

The recently updated self-evaluation reflects accurately what inspectors found during this visit. Children who require permanence are being adversely impacted by the constant turnover of social workers and managers, and lack of consistent and strong senior leadership. Children's experiences and outcomes are not improving, and currently social workers are not able to practise safely and effectively.

Too many children experience drift and delay in their need for permanence being identified, planned and achieved. Ineffective management oversight at all levels means that children who require permanence are not adequately overseen, delays are unnoticed, and the suitability of some children's placements is unknown. The high turnover of social workers is resulting in assessments being restarted by social workers who do not know the child, the child's history or fully understand the presenting risks. Children are having to retell their story on multiple occasions. Frequent changes of managers mean that they also do not know the children. This is leading to poor planning and reactive, rather than proactive, decision-making.

The absence of regular and effective supervision for social workers is limiting thorough consideration of children's needs, both current and future. When supervision does take place, there is limited reflection and exploration of children's experiences to enable detailed consideration of their plans. Due to the frequent changes of social worker and manager, actions agreed in supervision are often lost or incomplete, which is having a negative impact on children's chances of timely stability and permanence. Planning is disjointed, and the lack of cohesive decision-making is resulting in some children experiencing unplanned moves to placements that are not appropriate to meet their needs.

Family members are not assessed early enough to enable timely consideration of all permanence options for children. Some children live with relatives as connected carers, who are not fully assessed or approved as suitable. These placements are unregulated and not all are sufficiently monitored to ensure they are meeting

children's needs or mitigating against risk. This leads to children living in situations of unassessed and continuing risk, and delays in considering alternative permanence options for children.

Some children return home to live with parents without a clear assessment of need and risk. Local authority processes to assess, authorise and plan children's safe return to parental care are not being consistently followed. Management oversight and agreement is not always evident, and some children return to the care of their parents without an assessment of the suitability and safety of the arrangements. Consequently, a small number of children continue to suffer harm.

Too many children experience delays in securing legal permanence. There are delays in legal proceedings being initiated, leading to some children remaining in voluntary placements for too long. For others, incomplete assessments and missed court deadlines result in prolonged legal proceedings and delays in permanence plans being agreed.

There are some children who achieve permanence in a timescale that is right for them. This is due to individual social workers who are trying to do the best for children, despite the challenges. Inspectors saw some examples of good-quality direct work by social workers who are working hard to get to know children, and to help children to understand their history and plans for the future.

Independent Reviewing Officer (IRO) oversight and challenge is not robust, or effective, in addressing delays and ensuring planning is appropriate for children. Review meetings take place for most children, but the recordings are not evident in all children's files. Records that were seen during this visit lacked evidence of challenge to plans and lacked consideration of alternative options for children. IROs do raise disputes regarding delays in planning for some children. However, disputes are not routinely tracked or followed up and therefore have limited impact on improving the child's circumstances.

Case file audits are not assisting leaders and managers to understand children's experiences or the impact of services. Most audits seen by inspectors are overly optimistic about the quality of practice, and this is not consistently addressed by audit moderators. Audits are overly focused on compliance rather than a consideration of the impact of services on children and families. Social workers and managers are not routinely involved to promote their learning. The views of parents and children are not obtained, and they are unable to provide feedback on the quality of services.

Social workers who met with inspectors report competing demands due to workload pressures. This is affecting their ability to meet deadlines and achieve timely permanence for children. Some social workers report working several additional hours to meet demands, leaving them feeling overwhelmed and demoralised. Some social workers have been allocated several children at once where work is

outstanding and with deadlines which they are unable to meet. This is contributing further to delays in achieving permanence for children.

I am copying this letter to the Department for Education.

Yours sincerely

Matt Reed
His Majesty's Inspector