Inspection of North East Lincolnshire Council local authority children's services

Inspection dates: 4 October to 15 October 2021

Lead inspector: Matt Reed, Her Majesty's Inspector

Judgement	**Grade**
The impact of leaders on social work practice with children and families	Inadequate
The experiences and progress of children who need help and protection	Inadequate
The experiences and progress of children in care and care leavers	Inadequate
Overall effectiveness	Inadequate

Services to children and families in North East Lincolnshire are inadequate. Since the last inspection in 2017, when North East Lincolnshire Council was judged to be good, services to children and families have significantly deteriorated. Corporate leaders have overseen a decline in services to vulnerable children and their families. Two focused visits in March 2019 and October 2019 identified significant weaknesses in practice, resulting in areas for priority action which have not been fully addressed. A virtual focused assurance visit in May 2021 identified how the national lockdowns arising from COVID-19 placed significant demands and challenges on children's services, slowing the pace of change but identifying some improvements in discrete service areas. Some of these services have since declined.

This inspection has identified widespread weaknesses in assessment, planning and management decision-making, leaving many children at risk of harm. Inspectors referred children back to senior leaders to ensure that remedial action was taken where risk and need had not been identified or addressed. Remedial action was taken immediately where agreed. There is weak oversight of work, and risk assessment and management systems that should provide robust oversight of practice are ineffective.

Corporate leaders and senior managers do not have sufficient understanding about the quality of practice and the level of risk and need that children are experiencing.

Audits do not adequately focus on the experiences of children. Safeguarding concerns identified through auditing are not reflected in the local authority's self-evaluation and performance reporting is overly positive. Corporate decision-making is not prioritising the needs of children or providing the necessary resources to drive or sustain the systemic improvements that are required to make a difference to children's lives. The high turnover of social workers and managers has had a profound impact, resulting in multiple changes for children and families, inconsistency in planning, and drift and delay. Some children's cases are closed or stepped down without risk and need being fully understood or addressed, leaving children at risk.

What needs to improve?

- Child in need (CIN) and child protection planning and the effectiveness of multi-agency reviews to ensure that children are safeguarded, and their needs met.
- Timely escalation to Public Law Outline and robust monitoring of children subject to pre-proceedings.
- The quality and effectiveness of managerial oversight and supervision.
- The response to allegations against professionals.
- Timeliness of safeguarding checks for children in private fostering and connected carers' placements.
- Permanence planning.
- Senior leaders' self-evaluation of practice.
- Auditing and summary of findings to facilitate an accurate understanding of current practice.
- The sufficiency and stability of the social care workforce, so that children experience fewer changes of social worker.

The experiences and progress of children who need help and protection: inadequate

1. There are serious and widespread failures across the help and protection service. While improvements have been achieved in some discrete areas since the focused visits in 2019, too many children's needs are left unaddressed. The quality of professional practice and management oversight is weak, and the service is insufficiently resourced. This is resulting in failure to protect children from harm and poor planning in respect of their needs and future care.

2. Children and families in receipt of early help benefit from good-quality assessments. This is leading to focused plans that address their need for support, with positive outcomes. For these families, support is offered at the right level and is proportionate to need. However, the early help service is not yet fully staffed. Some families are on a waiting list for allocation and not all children are seen in a timely way. It was reported that as a result, some families have gone into crisis, leading to a referral to statutory services.

3. Arrangements in the integrated 'front door' have been strengthened. Thresholds are well understood, and contacts and referrals are responded to in a timely and effective manner. Management decision-making at the front door is clear, robust and well recorded so that children and families do not wait to progress to another part of the service. The response out of hours is not as strong. Risks are not always identified, leaving children vulnerable at evenings and weekends.

4. The immediate response to safeguarding concerns during the working day are effective and timely. The relevant agencies attend strategy meetings and appropriate information is shared to inform decisions. Subsequent enquiries focus too much on the presenting issue and not enough on the wider risks to which children are exposed. This means risk and need are not always fully understood, assessed or responded to.

5. When children progress from the integrated front door, management oversight of practice is less effective and practice quality is weaker, with the exception of the disabled children's team, where children receive a better service. However, some disabled children require allocation for updated assessments of their needs.

6. Overall, high staff turnover across the service means that many children are experiencing frequent changes of social worker. This is inhibiting children's ability to form stable, trusting and meaningful relationships with professionals. Assessments and interventions stop and start as social workers and managers change. Many assessments lack depth, lack professional curiosity and are missing detailed analysis of history and risk to inform planning. Some children are closed to services prematurely before risk and need are reduced and managed. This leads to children remaining in situations of harm for too long and repeat referrals to statutory services for the same reason. Although some direct work is being undertaken, for many children, their views and experiences are poorly understood. Gaps in supervision and ineffective management oversight have led to a lack of impetus to improve children's situations. For some children, this has resulted in repeated episodes of harm and multiple interventions.

7. Child in need (CIN) and child protection planning is ineffective for many children. Children do not make timely progress and their needs remain unmet. Children's plans are not routinely updated. Gaps in the multi-agency review of plans mean that any progress or change is not monitored or fully understood. This includes whether risk is escalating. Weak and inconsistent practice by child protection conference chairs results in some children being taken off child protection plans before risk is reduced and managed effectively. Inspectors identified several children where there were significant concerns about their safety and planning. The local authority reviewed these children and, in some cases, took immediate remedial action to ensure the safety of the children.

8. There is a heavy reliance on written safety plans to manage risk to children who are suffering, or at risk of harm. These plans are reliant on parents, many with

complex needs of their own, being compliant, understanding the risk and being capable of change without any assessment of their capacity to do so. The impact of domestic abuse is not clearly understood. Too often, the safety plan puts unrealistic expectations on the victims of the abuse. There is over-optimism with regard to parents' ability to change and a failure to recognise non-compliance. This results in some children being closed to services prematurely and experiencing further harm.

9. For many children, drift and delay was identified at some stage in their journey through children's social care. This was particularly evident for those children exposed to neglect. Drift was caused by a number of issues, including inadequate assessments, failing to take sufficient account of family history, poor planning, poor management oversight and high social work turnover.

10. When children become subject to pre-proceedings, their circumstances do not improve within a timescale that is right for them. The legal gateway panel is contributing further to drift and delay. Senior managers fail to take timely action when children's circumstances do not change or intensify. Identified actions are not always followed up or challenged. Assessments and planned interventions are not completed or are restarted due to high social worker and manager turnover, which is delaying action to safeguard children.

11. Not all vulnerabilities are well understood. Safeguarding checks are not completed in a timely way in private fostering arrangements to ascertain the safety of the carers. Appropriate checks are made when children, including those in care, go missing from education, but there is insufficient management oversight for those who are not in full-time education or vulnerable pupils who are not in school.

12. Most children who go missing receive return home interviews, but these focus predominantly on the missing incident without making links to the young person's wider risk. There is an effective multi-agency response and monitoring of children, including children in care and care leavers, who are at risk of, or suffering exploitation, which is making them safer.

13. When children make allegations of abuse by professionals, the local authority response is not robust. The designated officer position is not held at the right level of independence, seniority, skill or experience. Decisions regarding allegations against professionals have been found to be flawed and as such leaders cannot be sure that the right decisions have been taken to safeguard children. All designated officer decisions for the last six months are being reviewed as a result of this inspection.

The experiences and progress of children in care and care leavers: inadequate

14. High staff turnover and weak management oversight have a negative impact on the experiences of children in care. Too many children experience numerous changes of social worker. Some children have had periods without an allocated worker, and some have not been visited in line with their plan. As a result, many children have experienced significant delay in their need for permanence being assessed, in achieving legal permanence and securing a stable home.

15. Not all children enter care at a time that is right for them. Some children enter care in a crisis. For others, ineffectual planning and lack of robust management oversight have resulted in them remaining in situations of harm for too long and creating further drift and delay in planning for their futures. There are some early signs of improvement in the edge-of-care service, which have had success in diverting a focused number of children appropriately from care. This is a relatively new service which is yet to have a wider impact.

16. When care proceedings are issued, children experience delay in assessments and plans progressing. The Children and Family Court Advisory and Support Service (CAFCASS) and the local judiciary report that the local authority is working hard to improve the quality of practice. They acknowledge that there remains a backlog in court work due to the COVID-19 pandemic. They also report that notable delays are due to numerous changes of social worker and manager and the discontinuity that this brings to care planning and delay in family assessments.

17. Independent reviewing officers' practice is not strong enough to identify where drift and delay is occurring. There is insufficient independent scrutiny and challenge to drive the timeliness of work. Dispute resolution processes take place in a small number of children's cases with minimal impact.

18. When children enter care, family members are considered as potential carers. However, timely action is not taken to undertake safeguarding and other agency checks for managers to be assured that the arrangements are safe and appropriate to meet children's needs before approval. Staff vacancies and turnover mean that a high number of connected carer placements are unassessed and unapproved. A small number of connected carers spoken to as part of the inspection report feeling unsupported through having a frequent change of supervising social worker.

19. Not all children return home from care in a planned way or with adequate assessment of risk. For some children, this is leading to continued harm and further periods of care. When children leave care in a more planned way, this is assessed and well supported. The recent commissioning of a project team to focus on reunification is positive, but the role of the team is diluted as they are required to support other areas of the service which are under-resourced.

20. Children experience too many short-term moves before achieving permanence. This is leading to further emotional instability for children who have already experienced fractured relationships and separations. Decisions to separate brothers and sisters are not always based on clear assessments to inform the decision-making.

21. An improved foster care recruitment strategy has resulted in more carers being recruited and assessed, increasing the potential for more local authority carers for children. When children are matched to long-term local authority foster homes, foster carers report having good support and access to training to enable them to meet children's needs.

22. Permanent social workers know their children well and have been seeing children regularly. Most visits are purposeful, and children's voices are clear. However, children are not routinely helped to understand their history through life-story work to promote their identity. Family time is promoted but changes to supervision arrangements are not always sufficiently assessed to ensure that they remain safe.

23. Our Voice Listen Up is the name chosen for the children in care council. This is a small group of young people working hard to try and make a difference for children when they first come into care. They have produced welcome packs and postcards for children when they first come into care. They are in the early phases of starting to develop their voice and influence through attendance at the corporate parenting panel. These children and young people also reported to inspectors their frustration at the numbers of social workers they have had since coming into care and the changes in residential workers who move on without being able to say goodbye.

24. Children's emotional needs are mostly met through access to a range of services. However, for a small number of children, changes in social worker have resulted in delays in children being assessed for mental health and therapeutic support.

25. The local authority is part of a regional adoption agency. There are regular operational meetings to ensure that the agency is meeting the needs of local children. The local authority adoption manager provides good oversight of the recruitment, preparation and training of local prospective adopters. This includes a high number of adopters who will consider early permanence placements so that children can live with their potential permanent family at an early stage.

26. The members of the virtual school team know their children well. School leaders spoke positively about the support they receive from the virtual school, where needed, and the effective communication between schools and the virtual school team. Positively, personal education plans (PEPs) continued throughout the pandemic, although targets for children in care are weak and remain an area for improvement. The voice of the young person is incorporated into PEPs.

27. Children in care receive targeted careers advice early from local authority careers advisers and this continues when young people reach 16. Personal advisers and the not in education, employment or training worker combine to support young people aged 16 to 18 into either education, employment or training and numbers are increasing for this age group.

28. Support for young people aged 16 to 18 moving to independence is positive. Personal advisers work hard to ensure that young people leaving care are well supported. Pathway plans are timely and regularly reviewed. Young people are involved in the creation of their plans and their voices are clearly heard. Overall, plans identify the needs of young people but could be improved further by ensuring clear actions and timescales to meet needs and by ensuring that all receive a copy. Care leavers know how to access their records and are supported to do so and have access to their health histories.

29. Most care leavers aged 18 to 21 are well supported to live independently. They receive regular practical and emotional support from their personal advisers as they make the transition to greater independence. Most are in suitable accommodation which meets their needs. The service for care leavers aged 21 to 25 is not as developed to ensure that young people in this age group receive the same level of support and assistance.

The impact of leaders on social work practice with children and families: inadequate

30. Services to children and families have deteriorated since the last judgement inspection in 2017. Two focused visits in 2019 resulted in areas of priority action due to significant concerns regarding the responses to harm, children's safety and planning for vulnerable children. A further focused assurance visit in May 2021 showed that despite the pandemic, some improvement was evident in some discrete areas. However, overall services have deteriorated further. Corporate leaders and senior managers have failed to ensure that the areas for priority action have been sufficiently addressed to enable the safety and well-being of all children.

31. There are widespread and serious failings across all areas which have a profound impact on the experiences of children and for some, leave children at risk of being harmed. Corporate leaders and senior managers acknowledge the need for the service to improve. An improvement board has been set up. However, the board has not led to sufficient improvements in the quality of practice, nor to the quality of decisions or to the provision of help and care to children and young people. Not all senior leaders and council members understand the depth of the failings, either to hold each other to account, or to prioritise the needs of children in corporate decision-making. Education professionals, the local judiciary and CAFCASS express concern about the high turnover of staff and managers and report that this is affecting assessment and planning for children. The previously strong

communication and relationships with some schools achieved during the pandemic were reported by school leaders to have deteriorated.

32. There has been significant corporate interest and financial investment in staffing. Social work caseloads are reducing for some staff. However, social work levels are not sufficient to meet demand, leaving many service areas under-resourced and leaving children vulnerable.

33. Strengthened arrangements at the front door have been assisted by improved partnership working. Greater engagement of partner agencies and voluntary groups has also contributed to the development of an enhanced early help offer, although this is yet to be fully resourced, leaving many children with unassessed need.

34. Performance management arrangements are ineffective. They do not provide senior leaders with an accurate understanding of practice quality, or children's experiences, to drive service improvement or target resources where needed. Mechanisms to gather performance data have improved, but an over-reliance by corporate leaders and senior managers on quantitative data gives false assurances about performance and progress against the improvement plan.

35. Quality assurance processes are also ineffective. Auditing does not provide an accurate picture of the quality of work. High turnover of managers and a lack of experienced auditors have resulted in audits focusing on compliance rather than the quality of work and children's experiences. Despite audit moderation highlighting to leaders very recent safeguarding and practice concerns, this is not reflected in the self-evaluation of practice, which presents an overall more positive picture. The analysis and reporting of performance and quality assurance data are overly positive. They do not accurately reflect what the performance is like, what the issues are for staff and, most importantly, the experiences of the children, young people and families receiving the services.

36. Insufficient scrutiny of the quality of practice by senior leaders is not enabling the local authority to fulfil its corporate parenting responsibilities. Feedback from children and their families is not used to inform service planning or development. Children and families who spoke to inspectors about their experiences were negative in their feedback and echoed many of the inspection findings.

37. The legal gateway panel, chaired by senior managers, is not providing robust oversight of practice to improve decision-making. This has contributed further to the drift and delay in planning and children's circumstances have not improved in a timely way.

38. There is long-term instability in the children's services workforce. The turnover of social workers and managers has resulted in multiple changes for children and families, leading to inconsistency in practice and drift and delay in the response to risk, need and inconsistent planning. A number of children and families are

unable to consistently build meaningful relationships with their social workers. This was a consistent theme throughout this inspection, with multiple negative consequences for children.

39. To relieve some pressures following the focused visits, senior leaders increased social work capacity and employed project teams to reduce caseload pressures and address the weaknesses identified by Ofsted. However, the workforce remains significantly under-resourced. A lack of corporate clarity regarding the ongoing financing of the project teams is creating uncertainty among staff and managers. They are unclear about how corporate decision-making will assist the service to transition to a more permanent workforce to meet the needs of children, both now and in the future.

40. Managers at all levels do not ensure that children benefit from safe and effective social work. Gaps in supervision for frontline social workers mean that social workers are not helped to reflect on their practice or receive challenge in a structured or constructive way. Senior leaders do not employ effective methods to scrutinise and review the quality of practice and how children are helped and supported.

41. Social workers spoken to during the inspection stated that they felt supported, noting that there is more stability and structure in the work. They have access to training and development opportunities. Supervision is more regular, but it is not demonstrating that it is driving plans for children to improve their circumstances.

42. The designated officer service is under-resourced, resulting in children who have made allegations against professionals not having all risks assessed. As a result, the senior leaders cannot be assured that the right actions have been taken to safeguard children, potentially exposing them to further harm.

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