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Dear Steve 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 14 March 2019. The visit was carried out by Her Majesty's Inspectors Lisa Summers and Neil Penswick.

Inspectors reviewed the local authority's arrangements for responding to contacts and referrals at their 'front door', the Families First Access Point (FFAP). Inspectors reviewed a range of evidence, including children's case records, as well as case performance management and quality assurance information. Inspectors also held case discussions with social workers and their managers.

### **Overview**

There are serious weaknesses in front door decision-making that fail to effectively protect children at risk of significant harm and fail to ensure that vulnerable children have their needs met. The screening of contacts to children's social care is not consistently effective. Children's histories are not routinely considered in order to understand their experiences, and decisions on contacts are made without the fullest of information. The recording of child protection enquiries is poor. Managers cannot reassure themselves that strategy meetings and subsequent child protection investigations are effective in exploring risk and understanding safeguarding needs. The quality of assessments is weak, and they lack depth in appreciating children's life experiences. Plans are often too vague and do not focus on children's needs. As a result, inspectors saw children who were unsafe whose needs were not being identified and addressed.

Senior managers were aware of many of the weaknesses identified during this focused visit through improved performance information and targeted auditing. However, they were unaware of the poor quality of screening and initial decision-making in the FFAP, and the detrimental impact on the protection of children.

## **Areas for priority action**

The local authority needs to take swift and decisive action to address the following areas of weakness in child protection:

- The identification and screening of risk and need when contact is made with children's social care.
- The quality of assessments and decision-making.
- The quality and effectiveness of managerial oversight and supervision.

## **What needs to improve in this area of social work practice**

- Decision-making and timing of premature case closures for children who remain at risk, or for whom the extent of the risk is unknown.
- The analysis and use of all relevant information about children's experiences when making assessments, including: previous history, cumulative risk and neglect.
- Proportionate decision-making for the most vulnerable children at risk.
- Ensuring that children are at the heart of practice.
- Multi-agency working, including partners' understanding of thresholds and their application, as well as attendance by partner agencies at strategy meetings.
- The recording and quality assurance of key documents are recorded and quality assured.
- The quality and effectiveness of case file audits.
- The sufficiency and experience of the social work workforce, including managers.

## **Findings**

- Prior to this focused visit, the local authority had identified concerns about the consistency and quality of practice at the front door. Senior managers have responded to the concerns and have developed a practice programme and have planned to increase social work capacity. However, at the time of this visit these were not yet in place.
- The director of children's services took up post in January 2018, followed shortly thereafter by the appointment of the assistant director. At that time, children's social care was experiencing a significant increase in the demand for statutory services. Immediate actions were taken to increase capacity in key areas of the

service to better meet demand. This included establishing a single point of contact and access for children needing help and protection, bringing together its multi-agency safeguarding hub and access point to social care and early help. Social work and manager capacity were increased in FFAP, and the number of child protection conference chairs were increased to meet the significantly increasing rate of children becoming subject to a child protection plan. Senior leaders have recognised and are responding to the need for further increases in capacity to meet the continued rising demand. The quality of current practice has not improved.

- Thresholds are not fully understood by partner agencies. Too many children are inappropriately referred to children's social care, instead of their needs being promptly addressed by the referring agency. Some partners inappropriately share information without consent being sought when there are no safeguarding concerns, and this results in parents not always being aware that concerns are being raised.
- The quality of contact information provided by partners is not always good enough to identify children's needs. Local guidance has recently been reviewed and strengthened to ensure that written referrals are produced to provide FFAP with a written evaluation of the child's circumstances at the point of referral. This is not routinely followed. Consequently, FFAP workers spend too much time seeking clarity from partners before cases can be progressed.
- The screening of contacts by the FFAP is not robust, and thresholds are not consistently applied to ensure that children are safeguarded and their needs are met. Initial management decisions lack clarity and rigour in providing direction to social workers on what additional information should be gathered and analysed. The local authority has clear expectations that contact decisions are made within 24 hours, but there are insufficient resources to enable this to be done safely. Inspectors identified that this resulted in some decisions being made without the fullest of information. History is not routinely considered in order to fully understand children's experiences and inform decision-making. The local authority immediately responded to concerns raised by inspectors, revising the decision-making timescales within the FFAP if there was not sufficient information available to make an informed decision.
- Inspectors identified a number of cases of children needing a social care response that had been inappropriately closed or stepped down to early help services, and others where children needed a protective response, and this had not occurred. This had left children in situations of ongoing risk of harm or situations where risk is unassessed.
- The initial response for some of these children was not robust enough to keep them safe. As a result, some children experience further incidents of harm and subsequent re-referrals being made for similar concerns. In a small number of

cases, partners are inappropriately asked to interview children to inform social care decision-making.

- As part of the local authority's self-evaluation, senior managers identified that some children progress unnecessarily to strategy meetings where risks are not sufficient to need a child protection response.
- Current arrangements to ensure that children at risk of exploitation are protected are weak. The local authority has invested in gaining a deeper understanding of the prevalence and nature of exploitation in North East Lincolnshire, inviting the Home Office to undertake a locality review of criminal exploitation. However, this is not translated into improved practice. Regular multi-agency operational vulnerability meetings discuss children referred at risk of exploitation. The meeting is not effective in coordinating a comprehensive multi-agency response in understanding and managing risk or identifying how children's needs would be met. Risks and needs of brothers and sisters are not routinely considered.
- The local authority is over-reliant on the use of 'safety plans' to keep children safe. These plans are informal agreements with parents. Most of those seen by inspectors are unrealistic and rely heavily on parents and young people's compliance against a set of actions rather than providing a comprehensive multi-agency response to mitigate risk. When the presenting issues relate to substance misuse, domestic abuse, and parental behaviours, social workers are often too optimistic on the likelihood of change.
- When children are identified as being at immediate risk, the response is generally swift. Most strategy meetings are quickly convened, and, when recorded, appropriate information is provided by partners. However, not all key agencies attend meetings. This limits information-sharing and decision-making being used to inform child protection investigations. Many strategy meetings and child protection enquiries were not recorded or poorly recorded. In a very small number of meetings seen of better quality, concerns are identified appropriately but the meetings are not effective in planning subsequent child protection enquiries. Managers cannot assure themselves that strategy meetings and subsequent child protection enquiries are effective in exploring risk to children or that they consider and meet the child's need for protection.
- Assessments are weak and lack depth. The emphasis of too many assessments is on parental need rather than being focused on the child and understanding their lived experience. Information from family members is not always sought, even when they play a significant role in caring for children. Social workers overly focus on the presenting issues rather than understanding wider need. History is not routinely used to understand patterns of behaviour or the cumulative harm that children have suffered. Inspectors saw the regular use of an inappropriate phrase 'over chastisement' to describe physical assaults on children. This dilutes the seriousness of parents' actions, inappropriately placing the focus on children's behaviour. Assessments do not consider children's unique characteristics or

needs. As a result, plans are often too general and not sufficiently focused on children's needs, and they lack timescales to enable progress to be measured.

- Management oversight and challenge is not robust enough to keep children safe. Inspectors saw that when risk of significant harm has been identified by supervising social workers, more senior managers had inappropriately overturned decisions to proceed into child protection. Inspectors also saw some children placed in the care of family friends without the local authority having taken appropriate legal actions or without social workers recognising these as children in care.
- Social workers reported to inspectors that they are well supported, listened to and valued by managers. While social workers describe managers as accessible and say that they can access a good range of training, this is not improving frontline practice. The frequency of supervision is showing some improvements. However, supervision seen by inspectors was not always regular, and lacks reflection and critical challenge. This is a missed opportunity for social workers to learn from and improve their practice.
- Thematic audits identify that there is much work to do to improve core social work practice. Although the local authority has recently reviewed its auditing tools and processes, audits focus on current practice and fail to evaluate children's experiences. Poorer practice is misjudged as being good. The audits inspectors saw during this visit were uniformly poor and do not enable senior managers to improve the quality of social work practice.

Where a focused visit results in an area for priority action, Ofsted requires you to submit an action plan within 70 working days of receiving the final focused visit letter. We also ask you to share a draft of your action plan within 20 working days of receiving the focused visit letter. This is so we can be assured that the local authority is taking action with the urgency commensurate to the seriousness of the findings. You have already submitted an action plan. We anticipate that you will want to review that action plan in the light of this letter.

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

Yours sincerely

Lisa Summers  
**Her Majesty's Inspector**