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Dear Debbie

Monitoring visit to Tower Hamlets children's services

This letter summarises the findings of the monitoring visit to the London Borough of Tower Hamlets children's services on 12 and 13 December 2017. The visit was the second monitoring visit since the local authority was judged inadequate for overall effectiveness in April 2017. The inspectors were Brenda McLaughlin, HMI, Andy Whippey, HMI and Tom Anthony, Ofsted Inspector.

Improvements in the multi-agency safeguarding hub (MASH) have been sustained since the last monitoring visit in August. In the cases sampled by inspectors, thresholds for help and protection were appropriately applied, decision-making was timely and no children were identified as being at risk of immediate harm. However, practice to understand and respond to risks to missing or sexually exploited children remains underdeveloped.

Overall, most children benefit from the prompt allocation of cases to experienced social workers in the assessment and intervention (AI) teams. The quality of social work in the AI teams, while inconsistent, is improving, despite most social work caseloads being too heavy. Senior leaders have appointed five additional agency social workers to deal with the increased demand for the service. The recent restructuring of teams in the family support and protection (FSP) service and the introduction of more robust performance management processes are beginning to make a discernible difference for more vulnerable children and their families. This is a significant and positive change to the previously poor practice in these teams.

Areas covered by the visit

At this visit, inspectors revisited the progress made in the areas of help and protection, including:

- the quality of management decision-making in the MASH and the application of thresholds for statutory intervention
- the quality of assessments and plans, and whether they are improving outcomes for children and their families at the 'front door' and the FSP service.

The visit considered a range of evidence, including electronic case records, supervision files and other notes. Inspectors reviewed improvement plans and operational group minutes, and considered the quality and impact of audit activity and the effectiveness of management oversight. Inspectors also spoke to a range of staff, including managers, social workers and the chair of the improvement board.

Overview

A relentless focus by senior leaders on ensuring compliance with statutory requirements, such as visiting children at home, is starting to change the culture in children's services. More team managers are making use of data to track the timeliness of interventions for children. Improved performance management systems aligned to audit activity are increasingly holding social workers and other professional staff to account for the quality of their practice. Social workers and their managers are much more focused on ensuring that children's voices and their lived experiences are captured and acted on. However, this is less apparent in multi-agency case conferences and core groups. Managers are prioritising action to improve these weaker areas of practice.

Generally, most staff who spoke to inspectors welcome the changes made by senior leaders. Conversely, there is some concern about the breadth and scale of the new initiatives. For example, while they are aware that the preferred social work model has changed, staff struggle to articulate its replacement. This is leading to confusion and a lack of clarity regarding the assessment process. The majority of social workers raised concerns with inspectors about their capacity to consistently produce the expected good-quality work, due to heavy caseloads. A refreshed workforce strategy is intended to reduce the heavy reliance on agency workers, and there is evidence of some agency staff converting to permanent posts. Investment in 'back to basics' training – a three-day mandatory course for all social workers and managers – is designed to embed a shared understanding of expected social work standards of practice across all teams.

Findings and evaluation of progress

Inspectors tracked children's cases alongside social workers and sampled a range of work across the MASH, the AI team and the FSP service. Clear management

direction when allocating work in the AI teams ensures that social workers understand what they are expected to do. Most children are visited more than once during the undertaking of assessments to ensure that their views are gathered to inform assessments and plans effectively. However, the quality of analysis is variable and does not consistently address what it means for a particular child living in these circumstances at this particular time.

The quality of assessments is improving from a low base. Social workers' more confident use of direct work tools to assess and analyse risks to children is beginning to inform decisions about children's ongoing plans. This is helping to reduce delay in the provision of services. However, the system implemented to review progress for children after 10 days, as identified during the previous visit, is currently not occurring in some teams due to the volume of work, leading to drift for some children. The recent increase in resources is intended to address this.

Strategy meetings and section 47 enquiries are mainly effective and timely in the AI teams, and more cases are appropriately progressing to initial child protection case conferences (ICPC). Children previously receiving services under 'children in need' in the FSP service are now correctly progressing to ICPC. This is a practice improvement since the time of the last inspection, when too many children at risk of significant harm did not receive the right level of protection. However, of the cases sampled by inspectors, some are progressing to child protection conference without the required multi-agency checks. In addition, the actions identified in strategy meetings are insufficiently clear or are not recorded.

Children's independent reviewing officers do not have sufficient oversight of practice and do not provide effective enough challenge. This was an area for improvement from the last inspection. The quality of child protection plans seen is mostly poor. There is significant delay in producing child protection minutes, in some cases, and this impacts on the ability of the multi-agency core group to develop and drive forward the plan. Core groups and child in need meetings, although improving, do not consistently meet the statutory timescales or measure progress sufficiently against agreed multi-agency plans.

There is increased management grip at all levels of the organisation. The monthly strategic operational meeting, chaired by the director of children services, is now well established. However, it needs to systematically demonstrate effective management oversight by bringing forward and reviewing specific safeguarding actions. Team managers are accessing a daily dashboard, which identifies when actions are completed and the date for the completion of future actions. Regular performance clinics, chaired by service managers, are effective in addressing delays for children. Supervision is mostly taking place within the required timescales, although the actions identified are not being routinely reviewed in subsequent supervision meetings. This means that it is more difficult to measure progress against managerial direction. Audit activity is becoming increasingly embedded, but could be used more effectively as part of the improvement programme. In particular, the audit pro forma

could usefully contain agreed practice standards, allowing the audit process to focus on the impact and outcomes for individual children.

Following the appointment of dedicated staff and increased joint working with the youth offending team, services for children missing from home and care and those sexually exploited or involved in gangs are actively being reviewed across the partnership. These vulnerable groups of children will be the focus of the next monitoring visit.

In summary, it is encouraging that most improvements identified by the previous visit have been sustained and, in many cases, further improved. Senior leaders and elected members have an increasing in-depth knowledge of their strengths and areas of weakness. They are aware of the challenges that they face to embed the positive changes that have been made, while simultaneously addressing the areas of poorer practice. They fully recognise that there is considerably more work to be undertaken to ensure that vulnerable children in Tower Hamlets experience consistently good-quality help and protection from harm. Leaders and managers demonstrate considerable determination, commitment and tenacity to embed and sustain these changes.

I am copying this letter to the Department for Education. This letter will be published on the Ofsted website.

Yours sincerely

Brenda McLaughlin
Her Majesty's Inspector