Ofsted
Piccadilly Gate
Store Street
Manchester
M1 2WD

T 0300 123 1231
Textphone 0161 618 8524
enquiries@ofsted.gov.uk
www.ofsted.gov.uk

10 September 2018

Debbie Jones
Director of Children's Services
London Borough of Tower Hamlets
Town Hall
Mulberry Place
5 Clove Crescent
London E14 2BG

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 15 and 16 August 2018. This was the fourth monitoring visit since the local authority was judged inadequate for overall effectiveness in April 2017. The inspectors were Brenda McLaughlin, Her Majesty's Inspector, Louise Warren, Her Majesty's Inspector, and Tom Anthony, Ofsted Inspector.

Areas covered by the visit

Inspectors evaluated the quality of care planning for children in care, in particular the achievement of timely permanence arrangements for all children who are unable to live with their birth parents. They assessed progress since the last inspection and focused on areas of practice that had required significant improvement.

The visit considered a range of evidence, including discussions with social workers and their managers. Inspectors looked in detail at children's cases and met the manager of the independent reviewing officers (IROs), the headteacher of the virtual school and the local authority court manager. They reviewed the quality of practice provided by the permanency and adoption support team (PAST), the looked after children service and the revised pre-Public Law Outline (PLO) arrangements. They spoke to the service manager responsible for implementing the sufficiency strategy and with senior leaders about their analysis of progress. In addition, inspectors looked at local authority performance management information, improvement board and corporate parenting board minutes, evaluation reports provided by the Department for Education appointed improvement partner and reports on recent audit activity.

Ofsted

Overview

While there has been improvement in key areas since the last inspection, there are still considerable weaknesses in permanence planning and in assessments for children who cannot live with their parents. Overall, the quality of practice with these vulnerable children is improving, but it is still too variable. Senior leaders agree with inspectors' findings. They are determined to accelerate the pace of change and are taking appropriate action to address the significant deficits in the children in care services.

Findings and evaluation of progress

Management oversight of the permanence planning process is weak; some staff described it to inspectors as 'ad hoc and fragmented'. Options for permanence are not considered simultaneously, which prolongs uncertainty for children. Contingency planning is poor; this is building in delay for some children, including very young children. For example, inspectors looked in detail at a number of cases where adoption had not been considered alongside other options as part of legal proceedings for babies, when parents were not able to care for their children and the likelihood of family members being able to provide safe care was not assured. Senior leaders acknowledge that more work is required to change the culture, as adoption or long-term foster care outside of the family are only considered when other options have been exhausted.

Decisions about whether children should become looked after are now underpinned by effective and accessible legal advice, as clearly evidenced by the weekly focused and well-attended legal planning meetings. This is a vast improvement, as previously too many children, including those subject to the PLO, remained vulnerable to actual or potential harm for too long. Effective use of the revised PLO tracker is preventing drift and delay for those children who require statutory interventions via the courts, and supports the timeliness of court proceedings.

When children come into care, only 22% of initial health assessments are completed within timescales. This has not improved since the inspection in 2017. Many of these children have suffered abuse and neglect. This means that their immediate health needs are not understood quickly enough. The director of children's services has escalated this matter to the local clinical commissioning group.

Improved performance management arrangements mean that senior leaders and frontline line managers are very knowledgeable about service performance. Routine reporting, disseminated effectively to staff and elected members, is augmented by monthly practice clinics which hold managers to account. Case file audits are completed regularly but more work is needed to sustain the focus on the quality of practice and not just on the process. Caseloads are manageable and children in care are seen regularly by their social workers, who know them well. Purposeful direct work with children to

help them to understand why they are not living with their parents is improving, but it is not consistently good enough. In better cases, relationship-based direct work is tailored to children's needs and is age-appropriate. This is a significant improvement. More work is needed to ensure that all children who cannot live with their family have a life-story book.

Long-term and short-term placement stability is beginning to improve. Since January 2018, the proportion of children who have had three or more placement moves has reduced from 14.2% to 11.5%. Better sufficiency planning is leading to increases in the availability and choice of placements. The revised sufficiency strategy has successfully focused on the development of existing foster carers to increase capacity. Additional support and training have enabled carers to look after older adolescents and children with disabilities. Improved out-of-hours support and the opportunity to consult with the dedicated child and adolescent mental health services (CAMHS) psychologist have resulted in more foster carer placements for children locally. The co-location of a dedicated CAMHS professional with social workers is enabling children in care to access specialist help and support more quickly. This is assisting children and their carers, particularly adolescents with complex needs, to remain in the same placement.

An independent placements overview panel (IPOP), chaired by a senior manager, scrutinises existing placements and considers requests for placement moves and for new placements, to ensure that they meet the needs of the children and young people. The IPOP has assisted in reducing the number of children in residential placements from 30 to 16.

The recently developed edge of care team (November 2017) has been instrumental in decreasing demand for placements, particularly for older adolescents, and in reducing overall numbers of children in care. This team provides intensive wraparound support to children at the point when the risk of entering care is judged to be significant, and the workers in the team work alongside the allocated social worker to help the young person to remain safely at home. The focus of intervention is on practical support and is relationship-based to ensure that families are able to see tangible changes in relationships. For example, staff have worked with 43 families and diverted 33 children from coming into care. A further six children have been supported to return home to live with their families.

Assessments for children in care are not updated routinely, and too often, when cases are in court, the assessments focus on concerns about the parents. Too many children have not had an assessment for a number of years. In June 2018 the local authority identified approximately 160 children who did not have an updated assessment; this is over half the care population. Recently appointed managers are working to improve this inadequate practice. More training is needed to ensure that social workers recognise the importance of

Ofsted

ongoing assessment and analysis. Managers told inspectors that there is confusion about specific roles and responsibilities. The looked after children service currently holds 53 children in need cases. In addition, some unborn baby cases are transferred directly from the multi-agency safeguarding hub. Social workers in the looked after children team have not been trained to carry out this complex work.

Management oversight, although evident in all cases, is not yet consistently leading to improved outcomes for all children in care. Managers do not track whether permanence planning meetings are held within the local authority's own prescribed timescales, or if they are routinely reviewed. A very recent change to extend the remit of the adoption summit meeting to track all children with a plan for permanence is an improvement. This is still in its early stages and needs to be communicated to all of the teams. In addition, the PAST and the children's placement team need to work together with the looked after children service sooner to ensure that family finding starts when the permanence decision is made at the second statutory review. Connected carers' assessments and the special guardianship assessment process require further streamlining and unifying across the service to improve the quality of all assessments and minimise delays. Senior managers acknowledge that the looked after children service is underdeveloped and they are focusing on accelerating changes in the next phase of their improvement journey.

IROs have manageable caseloads, which enables them to deliver timely reviews for children in care. They assess the latest care plan and track decisions from previous reviews. There is increasing evidence of effective IRO challenge on case notes. They now monitor children between reviews, ensuring that actions are being carried out, but they need to do more to ensure that parallel plans for children are fully considered. This is especially significant for young children and those at the outset of care proceedings, when contingency planning should occur.

The headteacher of the virtual school provides strong leadership and a clear strategic vision for improvement across all keys stages and for children leaving care. A cohesive virtual school team works closely with designated teachers. The team provides appropriate challenge, holding schools to account and ensuring the effectiveness of the recently implemented electronic personal education plan system. All children in care in Tower Hamlets attend schools that are judged good or outstanding by Ofsted. However, this is more of a challenge when children move out of the borough. Pupil premium funding is targeted well to address both the pastoral and educational needs of children in care so that they can engage well in learning, for example by funding a dedicated sixth-form officer to support children in further education. Communication with children's social care is good, as the teams are co-located. This leads to better joint planning, particularly when children move placements.

In summary, inspectors found progress in many areas of practice with children in care. Senior leaders accept inspectors' findings and they are taking action to address the significant deficits identified during this visit.

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