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Dear Tim

Monitoring visit to Newham local authority children's services

This letter summarises the findings of the monitoring visit to Newham local authority children's services on 4 and 5 March 2020. The visit was the second monitoring visit since the local authority was judged inadequate in March 2019. The inspectors were Andy Whippey, Her Majesty's Inspector, and Tara Geere, Her Majesty's Inspector.

Limited progress has been made since the inspection in 2019 and many of the weaknesses identified at that inspection are still apparent. The recently appointed director of children's services has a clear understanding of what needs to change and has the resources and the plans to achieve improvement. Managers recognise that the pace of progress now needs to be significantly increased to improve the experiences and progress of children in care.

Areas covered by the visit

During this visit, inspectors evaluated the quality of care planning for children in care, and the achievement of timely permanence arrangements for all children who are unable to live with their birth parents.

Inspectors focused on:

- The quality of assessment and care planning for children in care.
- The timeliness and effectiveness of plans for permanence.
- The timeliness and effectiveness of decisions to match children with placements that meet their needs.
- The quality of case recording.
- The quality of management oversight and supervision, including the oversight of independent reviewing officers (IROs).

- The use and effectiveness of performance management and quality assurance information.

A range of evidence was considered during the visit, including electronic case records, supervision notes, case management records, performance data, audits and progress reports. In addition, inspectors spoke to a range of staff, including managers and social workers.

Overview

Inspectors found early signs of progress in improving permanence planning for children. However, delays in achieving permanence are still evident, and the quality of practice is too variable. Management oversight, including that of IROs, is often ineffective in both identifying and tackling delay.

The pace of improvement since the inspection in March 2019 has been slow. The recent appointment of an experienced and skilled director of children's services has given the improvement journey much-needed direction and impetus. Appropriate plans are now in place, underpinned by strong corporate support. Some of these plans have either just been initiated or are yet to be delivered, so the impact is limited. Now that the foundations are in place, and additional management capacity has been secured, the pace of change needs to accelerate to achieve positive impact for children in care. Social workers report good morale within the service; they are committed to the changes and express confidence in the proposed plans.

Quality assurance processes are not yet consistently effective. The use of auditing is well established, but many audits do not accurately evaluate the quality of practice or support staff in their learning. Senior managers have recently taken action to ensure that auditing is more reflective of the quality of practice.

Findings and evaluation of progress

Early permanence planning is clearly improving, but it is not yet sufficiently embedded within social work practice. This leads to delays for some children, as options such as foster to adopt, family group conferences and connected persons assessments are not always explored concurrently. Foster to adopt is not sufficiently considered as an option.

Permanence planning is not sufficiently robust and does not consistently take place in a timely way for all children. Arrangements for tracking permanence for some children have been ineffective in helping to prevent delay. In some cases, permanence planning meetings are not happening regularly, and when they do, they are not effective in ensuring that plans for permanence are implemented. This includes children who are accommodated through voluntary agreements with parents. The recent appointment of an interim manager to focus on the progress of permanence planning is a positive step.

IROs are not routinely tracking the progress of permanence plans. They are not sufficiently challenging when permanence planning meetings are not taking place, or when actions are not being completed in a timely manner.

Some children and young people have lived with their foster carers for a long period of time without a formal matching arrangement. This means that managers cannot be assured that these arrangements are meeting children's needs in the longer term, and that children do not have the reassurance of knowing that their placement is secure.

Social workers visit children regularly and children are seen alone. Social workers know their children well and show a commitment to achieving good outcomes for them. The recording of visits is variable, but many are thorough and evidence the wishes and feelings of children. Some examples of highly creative direct work were seen, and these were being used well to inform planning. They also included some strong and thoughtful practice. However, for some children, there is an absence of purposeful life-history work, and when it does occur, it is not always recorded on children's records. Managers have plans in place to improve practice.

Assessments for children in care are completed routinely, but they vary in quality. They are contained within social work reports for child in care reviews, but they do not always provide the detail or an appropriate analysis to cover all areas of a child's needs, particularly those with complex family histories. Assessments are not routinely updated when a child's circumstances change, and this undermines the effectiveness of care planning and intervention.

The vast majority of statutory reviews are timely and are attended by the relevant professionals. Children are encouraged to attend and participate in their reviews. However, children's views are not always well recorded within the minutes and, therefore, it is not clear how they inform care planning. When reviews are effective, they focus on achieving and monitoring the progress of children in placements. In weaker reviews, there are no specific timescales set against each identified action. This means that some actions are needlessly delayed, and the children's plans for permanence are not progressed in a timely way.

Management oversight, although evident in all cases, is not consistently helping to improve the experiences and progress of children in care. The quality of supervision is variable. Records of supervision contain updated information about children but do not always include decisive actions with associated timescales to improve children's well-being. Progress against actions is not consistently reviewed in subsequent supervision meetings.

Decisions for children to return home are mostly appropriate, but they do not always evidence management oversight of such decisions, or the rationale. Plans for children in care who are placed with parents are in some cases too generic. They do not make sufficiently clear what is expected of parents in order for the children to thrive at home. This inhibits the evaluation of progress and, as a consequence, the likely success of such arrangements.

The matching of children to placements equipped to meet their level of need is weak. Referrals do not contain enough information about children's unique personalities or their family histories to help to inform potential matching decisions. There is no coherent system for establishing whether proposed carers can meet a child's needs.

Plans for children with an identified adoption plan are now being progressed in a more timely manner, although a small number of children subject to a placement order still experience delay in being matched with an adoptive family.

Life-history work is not consistently undertaken with all children in care. Inspectors saw many examples where children and young people had been in care for a considerable period of time without sufficient work being undertaken to help them to understand their journey into and through care. Children are not being helped to understand the transitions and changes that they have experienced and the decisions that have been made about their lives.

Some children have experienced too many changes of social worker, and this has impacted on the pace of permanence planning. Senior managers are continuing to be proactive in securing a permanent and stable workforce.

Senior managers are committed to undertaking audits to evaluate the quality of practice. However, some audits are overoptimistic. As a result, senior managers do not always have an accurate assessment of the quality of practice and therefore they cannot assist staff with their learning and development. Audits are insufficiently focused on the impact of practice on the experiences and progress of children, and they lack clarity about the actions that are necessary to enhance children's well-being.

A range of performance data is collated. However, there is insufficient collation of information to ensure effective oversight of permanence planning. This includes the frequency of permanence planning meetings and the number of children who have a permanence plan in place by their second review. The local authority has recently strengthened its arrangements for the tracking of permanence plans.

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

Yours sincerely

Andy Whippey
Her Majesty's Inspector