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Dear Tim

Focused visit to Newham children's services

This letter summarises the findings of a focused visit to Newham children's services between 20 October and 22 October 2020. The inspectors were Andy Whippey, Tara Geere, Emmy Tomsett, Tom Anthony and Nasim Butt, Her Majesty's Inspectors.

Her Majesty's Chief Inspector of Education, Children's Services and Skills is leading Ofsted's work into how England's social care system has delivered child-centred practice and care within the context of the restrictions placed on society during the COVID-19 (coronavirus) pandemic.

The methodology for this visit was in line with the inspection of local authority children's services (ILACS) framework. However, the delivery model was adapted to reflect the COVID-19 context. The visit was partly carried out by remote means. Two inspectors used video calls for discussions with local authority social workers, managers and leaders, and three inspectors were primarily on site, in the local authority office, speaking to social workers, managers and leaders who were office based. The lead inspector and the director of children's services agreed arrangements to deliver this visit effectively while working within national and local guidance for responding to COVID-19 and meeting the needs of the local authority's workforce.

This visit looked at the quality and impact of key decision-making across help and protection, children in care and services for care leavers, together with the impact of leadership on service development.

Overview

The COVID-19 pandemic had a sudden and significant impact in Newham in the early months of 2020 and subsequently. The pandemic presented a significant risk to public

health in a very diverse, densely populated borough in which a high number of households live on low incomes and in multi-generational households.

The local authority has planned and delivered a well-coordinated response to the pandemic. It has worked well with partners to mobilise and deliver a range of help and support. Staff have used creative approaches to minimise the impact of COVID-19 on the lives of children, families and care leavers. The use of regulatory flexibilities as a consequence of COVID -19 has been minimal. Where regulatory flexibilities have been used, they have been appropriate, and child focused, with records of associated risk assessments.

This was the first visit to Newham since the second monitoring visit in March 2020. Despite the immense challenges presented by COVID-19, inspectors saw some positive signs of improvement in social work practice since March 2020. There is much still to do to ensure that all children and young people in Newham receive a timely, consistent response to their social care needs, particularly those children who are the subject of child protection or child in need planning, or those children who are at risk of exploitation. Some weaknesses from the last inspection remain. However, recent initiatives, such as the development of the quality assurance framework, developing the model of practice and the strengthening of the senior management team, are starting to show signs of positive impact. Leaders show a very good understanding of the improvements required and, under the leadership of an insightful director of children's services, have developed relevant plans to address these.

What needs to improve in this area of social work practice

- Planning and intervention to protect children at risk of exploitation.
- The quality of child protection and child in need planning.
- Escalation arrangements where children's circumstances have not improved despite substantive interventions.
- The quality of analysis in assessments where domestic abuse is a feature.
- Return home interviews when children go missing.

Findings

- Children and families in need of early help mostly receive effective time-limited support that addresses their assessed needs. Team around the family meetings are used well to coordinate multi-agency support. For some children, the decision to support children and families in an early help framework is not reflective of their level of need. These children need to be stepped up to higher levels of intervention shortly after allocation, meaning that there is a delay in their needs being met.
- Children and families receive a prompt and proportionate response to initial contacts made to the multi-agency safeguarding hub. Managers make timely and appropriate decisions to safeguard children. Partner agencies' application and

understanding of thresholds are well embedded. Management oversight is clearly recorded and accompanied by a clear rationale for decisions made, as well as actions for social workers to follow.

- The quality and timeliness of assessments of children, particularly in the last six months, are improving. An area for further improvement is the quality of analysis within assessments, because these do not yet routinely reflect a robust analysis of risk and protective factors or what this means for children. Assessments do not yet routinely include the views of fathers. Senior leaders recognise the need to ensure that assessments are more consistently of good quality.
- Child protection enquiries are mostly effective and timely in identifying and reducing risk to children. Strategy meetings are well attended. The quality of planning to clearly define multi-agency actions plans is too variable.
- Information-sharing through multi-agency meetings during COVID-19 has been positive. Core groups and child protection conferences have continued virtually, with positive contributions from partners. These have ensured that the needs of those children requiring help and protection have been well monitored and reviewed. The local authority has effectively facilitated the participation of parents and young people in such meetings.
- Child in need and child protection planning, including in the disabled children's team, is insufficiently robust. While clearly improving, plans are not consistently specific, measurable or time limited, which hampers the measurement of progress. Actions are too general and not specific enough to clarify what needs to be done differently or when to do it in order to improve children's experiences and make them safer. The impact of child protection conference chairs in identifying and addressing drift in child protection planning for some children is limited. It does not routinely lead to sufficient challenge or escalation when this is required.
- Domestic abuse is a significant feature in Newham, and many children have experienced repeated periods of social care involvement, moving between different levels of interventions, without long-term change being sustained. While more recent work is improving, the local authority is now having to address a legacy of missed opportunities to intervene effectively for some children. In cases of domestic abuse, social workers demonstrate over-optimistic decision-making and unrealistic expectations of vulnerable mothers. Key decisions on reducing monitoring and support are made before sustained change has been made by parents. Fathers are not yet routinely involved in assessment or planning for their children, and this is a particular concern in cases of fathers or male partners who present risks to children through domestic abuse.
- There is an over-reliance on written agreements to protect children. This is compounded by the fact that the quality of most written agreements is not sufficiently clear as to the actions that parents need to take to keep their children safe or the consequences if these actions are not enacted. Most agreements do not provide an effective tool for families or professionals to help

protect vulnerable children, and the consequences of not adhering to agreements are not sufficiently explicit.

- The activity of managers in identifying and addressing delay in some children's needs being met is insufficient. Consequently, there are delays in escalating to either a legal planning meeting or initiating the pre-proceedings phase of the public law outline when significant risks continue or are escalating. The number of children subject to pre-proceeding is low and senior leaders recognise that this does not accurately reflect the number of children who should be subject to such arrangements. The pre-proceedings tracker does not capture all key information or effectively track actions, progress and case direction.
- Managers have effective oversight of children who are missing education and those who are educated at home, despite a significant rise in the number of parents choosing to home educate. There are clear processes for identifying children missing education, and appropriate checks are undertaken to establish if children have a school place or if there are any concerns about their welfare.
- Leaders recognise that further work is needed to strengthen the local authority's response to children at risk of exploitation and children who go missing. A recently developed multi-agency adolescent strategy aims to strengthen arrangements to identify and respond to vulnerable adolescents. This is a welcome and a necessary development, although it is too early to evidence impact. Well-coordinated multi-agency arrangements are not in place and effective, robust action plans to minimise risk and meet need are not being consistently developed. Children at risk of exploitation are therefore not getting the help and protection they require. The need for children's social care to have more effective oversight of practice in this area is recognised by senior leaders.
- Services are not sufficiently proactive in ensuring that return home interviews are completed when children have been missing. As a result, the number of interviews completed is low. Opportunities are therefore being missed to robustly identify behaviour patterns, complete mapping exercises and identify the risks that children have been exposed to.
- Decisions to accommodate children and young people are timely and in their best interests. Children in care reviews are routinely taking place in a timely manner, and most social work reports give good updating information about children's circumstances and needs. Reviews have a clear focus on children's health, education and contact needs.
- Improvements in permanence planning are evident, but there is still variation in planning and tracking, which means some children do not achieve permanence in a timely manner. Independent reviewing officers do not always assertively challenge any drift in care planning. And while work to ensure consistent, rigorous challenge by managers to promote permanence without any delay is improving, it is still a work in progress.
- The virtual school team has responded effectively to the challenges posed by COVID-19, working with schools and children's social care to ensure that children's education needs have been prioritised. Children with education, health

and care plans are risk assessed and provided with suitable support to address the challenges they face. The local authority is proactive in ensuring that personal education plans are completed. Targets in some of these plans are not always sharp enough to support next steps in progress.

- Children in care and care leavers spoken to were generally positive about the support and help they have received. They value the frequent contact that was made by their social worker or personal adviser by phone, text, post and face-to-face visits during the past few months.
- Contact with family and other people important to children has been well prioritised despite COVID-19 restrictions. Children in care and care leavers spoke positively of the efforts made by workers to sustain these arrangements.
- Most children and young people in care or leaving care continue to have their health needs, including emotional health, identified and met as much as possible during the pandemic. Risk assessments in relation to any health vulnerabilities have been completed, and the completion of virtual health assessments means that children's health needs are identified. Emotional health support is quickly mobilised when required. The health offer to care leavers is less clearly defined and communicated, which means that some care leavers are not aware of the services on offer to them. More needs to be done to ensure that all care leavers have copies of their health histories.
- Pathway planning is improving and shows more consistent involvement of care leavers in developing their plans. Some pathway plans are not sufficiently ambitious or comprehensive enough. They do not consistently have a clear action plan to help achieve positive change or to mitigate potential risks. Plans are mostly well focused on helping care leavers into education, employment or training opportunities. The local authority is in the process of appropriately strengthening the offer to care leavers who are not in such arrangements.
- Leaders are aware of the need to improve children's experiences and stability within placements. This includes developing a wider range of resources and placements available through a revised sufficiency strategy. Work has started on improving processes and tools to support matching and monitoring of placements. However, it is too early to see the impact of this on children. For a minority of children, a lack of clarity as to whether placements can meet children's needs has led to disruptions.
- When children are placed out of Newham, placement matching is not routinely informed by consultations with host authorities. Leaders are aware that there is further work to do to ensure that timely notification letters to host authorities are consistently sent.
- Young people who are placed in semi-supported accommodation are now subject to risk assessments. However, these risk assessments are not being routinely updated or re-evaluated to ensure that such provision continues to contain sufficient safeguards to ensure that young people's needs are being met.

- Supervision is consistently evident. However, there is variation in the quality of supervision records, which do not always do justice to the quality of supervision reported by workers. Records of social workers' supervision of children do not consistently show reflection, analysis or rigour in order to demonstrate that social workers have monitored children's progress against their plans.
- While case audits and quality assurance are improving, they are not fully effective in improving systems and the quality of practice. Although case audits are regular, they do not sufficiently evaluate the impact of social work practice on children's experiences. Actions and learning, as a result, are not effectively communicated to individual workers or across the wider safeguarding system.
- Social workers, practitioners and managers are being very well supported through the pandemic. Staff spoke positively of the practical and emotional support that they received while working remotely, through regular keeping in touch meetings with managers to discuss well-being and how to maintain a healthy work-life balance. This has supported frontline practitioners to sustain their commitment to protect and care for vulnerable children.
- Social workers in Newham are highly committed to improving outcomes for children. For a small minority of social workers, caseloads are too high. However, social workers generally reported their caseloads to be manageable. Leaders have a plan in place to ensure that caseloads will be at a level where workers will have the time to consistently undertake direct work and build trusting relationships with children, parents and carers.
- Strong operational partnerships have enabled consistent support to be given to children during the COVID-19 pandemic. Feedback to inspectors from partners was positive about the strength of partnership working during these challenging times.

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

Yours sincerely

Andy Whippey
Her Majesty's Inspector.