Ofsted
Piccadilly Gate
Store Street
Manchester
M1 2WD

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

30 June 2021

Tim Aldridge
Corporate Director of Children and Young People's Services
London Borough of Newham
Newham Dockside
E16 2QU

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 25 and 26 May 2021. This was the fourth visit since the local authority was judged inadequate in March 2019. The inspectors were Andy Whippey and Tara Geere, Her Majesty's Inspectors.

The COVID-19 pandemic has continued to have a severe impact in Newham. It has presented many challenges in a very diverse, densely populated borough that includes a high number of low-income and multi-generational households. Newham has experienced additional pressure through an increase in referrals to children's social care since the easing of lockdown in April 2021. Despite significant challenges, leaders and managers have been able to sustain improvements to social work practice and have initiated some further improvements since the focused visit of October 2020.

Areas covered by the visit

During this visit, inspectors evaluated the quality of assessments and care planning for children who are the subject of child protection and child in need plans. Inspectors focused on:

- children on plans and at risk of exploitation
- children living in households where domestic abuse takes place
- children who are the subject of pre-proceedings, and the quality of pre-proceedings interventions
- step-up/step-down decisions at the child in need/child protection threshold
- children in need who live in families at risk of breakdown
- the protection of disabled children.

Inspectors considered a range of evidence, 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 evidence of sustained progress in the assessment and planning for children who are the subject of plans, although progress is slower than expected due to the impact of the pandemic. However, the overall quality of practice is still too variable; this is particularly apparent for child in need plans and for children overseen by the disability service. Improving the quality, effectiveness and oversight of children's plans is a current priority for the local authority.

Senior managers have acted on the recommendations of the October 2020 focused visit. Improvements were noted, particularly for those children affected by issues of domestic abuse, children on plans who are also subject to exploitation, and children who are the subject of the pre-proceedings phase of the public law outline.

The quality of supervision is improving. However, while social workers receive regular supervision, records would benefit from clearer action planning. Managers do not routinely analyse practice to ensure that the work is making a sustained difference to the lives of vulnerable children.

Quality assurance processes are improving, but they are not consistently effective. The use of audit is well established, but some audits do not accurately evaluate the quality of practice or support staff in their learning. Senior managers are taking steps to ensure that audits are more reflective of the quality of practice.

Findings and evaluation of progress

The use of chronologies is variable; some are not up to date and others do not contain all the relevant decision-making points and other significant information. This limits the use of previous history in informing current decision-making.

Many plans for children are too global in their description of intended outcomes, particularly child in need plans. The plans are not specific about what needs to change and how this is going to be achieved, by whom and when. This inhibits a clear understanding by parents and carers of the changes that they need to make to help to improve their children's welfare. Some cases make reference to safety plans, although the status and effectiveness of these plans are unclear, particularly when other plans are also in place.

The quality of the recording of visits to children is variable. In better cases, the purpose of the visit is clear, conversations with children are purposeful and the information gathered is linked to planning. However, this is not consistent, and for many children there is a lack of evidence of direct work on their records. For some children who live with their brothers and sisters who are also the subject of planning, recording does not sufficiently identify individual conversations with children or their unique personalities.

Core groups and child in need meetings do not consistently review the progress that children on plans are making. In these cases, changes to plans are not being made in accordance with the current levels of need and risk. There is some variation in the frequency of these meetings; this is particularly evident in some child in need cases, where considerable gaps between meetings inhibit the evaluation, effectiveness and progress of multi-agency planning. When meetings do take place, partner agencies attend and contribute effectively. Senior leaders have recently introduced new child in need processes, with the aim of improving the consistency of these meetings.

Case conferences are held in a timely manner. In most cases, children's circumstances are well considered, with a clear analysis of current needs and any apparent risks. Case conference chairs have now started to carry out a mid-point review between conferences. While this is not yet sufficiently embedded, it is providing better oversight of child protection planning. Such oversight is currently limited to ensuring compliance with designated processes such as visits and core groups and would be enhanced by more oversight of the impact of plans on reducing risk.

Step-ups to and step-downs from child protection plans are appropriate and are consistent with presenting levels of need and risk. However, inconsistencies remain in the completion of assessments to inform conference decisions and in the analysis of the impact of child protection planning, the remaining risks, and how they can be managed.

When the decision is made for escalation into the pre-proceedings phase of the public law outline, cases show some evidence of stronger practice and decisive action. However, in some cases there are delays between the legal planning meeting, at which the decision to initiate pre-proceedings is made, and the pre-proceedings meetings taking place. Letters issued to parents or carers following these meetings do not consistently set out the concerns clearly or explain what is expected of parents or carers. While inspectors saw positive examples of pre-proceedings work, senior managers recognise the need to improve the consistency and timeliness of pre-proceedings activity.

The introduction of panels in relation to children who are the subject of long-term child protection planning is not yet sufficiently embedded or showing impact. While clearly providing a forum for more effective oversight of these cases, the status of any recommendations or decisions and how they will be implemented are not clearly defined. Given the significant weaknesses identified in child in need planning, a similar process of more effective senior management oversight of long-term child in need plans should be considered.

The response to children affected by issues of domestic abuse is improving. Inspectors saw cases where there had been an increasing focus on working with fathers to change their behaviour, and more time was spent with children to better understand the impact of living in such an environment. Senior managers recognise

that there is more to do to develop the range of interventions offered and to incorporate the outcomes of interventions into assessments and planning.

The response to children at risk of exploitation has been improved with some strong joint management oversight between the youth offending service (YOS) and children's social care. The impact of join-up with the YOS and other partner agencies to provide a single integrated response is now visible in this area of work. This is resulting in more comprehensive information-sharing in multi-agency risk panels and planning forums for children at risk of exploitation. The newly introduced exploitation screening tool to identify children who may be at risk of any form of exploitation, taking into account known vulnerabilities and the level of risk, is now evident on some files. However, this is not consistent, and there is more to do to ensure that all children affected by issues of exploitation have an up-to-date, comprehensive risk assessment and an effective plan to reduce the identified risks.

In recent months, the children with disability team has been affected by staff turnover that has led to some disruption. As a result, some children have experienced a number of changes in social worker and delays in planning to support and meet their needs. The very recent transfer of the service into children's social care is a positive move, and senior managers are very aware of the improvements that need to be made.

Children's case records now contain more evidence of management oversight. However, its frequency and impact on improving social work practice is variable. Actions identified sometimes lack specificity and timescales, and they are not always followed through by managers. In most cases, supervision records demonstrate greater reflection and consideration of children's circumstances.

The proportion of agency workers in children's social care is high, most notably in the front door and safeguarding and intervention services, although over 55% of agency staff in these areas have been with Newham for nine months or longer. Senior managers are working hard to recruit permanent staff. Although caseloads are high in some teams, social workers who spoke with inspectors feel that their caseloads are manageable. Strong corporate support has enabled further investment in the service with the creation of additional posts. These are due to be advertised shortly and are intended to strengthen management oversight and enable a reduction in caseloads.

Staff spoke positively about the support that they have received during the pandemic. However, some social workers noted information technology (IT) issues that have an impact on their ability to undertake their work effectively, including an IT system that is 'clunky'.

In summary, the quality of social work practice is improving, but the pace of change has been affected by the pandemic. Senior leaders are fully aware that there are still areas of challenge to overcome before practice is of a consistently good standard and the needs of children are well served. Plans are in place to deliver further

improvements, and additional resources have been secured to implement these plans.

I am copying this letter to the Department for Education.

Yours sincerely

Andy Whippey
Her Majesty's Inspector