Haringey

Inspection of children's social care services

Inspection dates: 29 October 2018 to 9 November 2018

Lead inspector: Anne Waterman
Her Majesty's Inspector

Judgement	Grade
The impact of leaders on social work practice with children and families	Requires improvement to be good
The experiences and progress of children who need help and protection	Requires improvement to be good
The experiences and progress of children in care and care leavers	Requires improvement to be good
Overall effectiveness	Requires improvement to be good

While children, young people and their carers do not consistently receive a good service, this is improving. Staff and managers are ambitious for children and young people and are tenacious in their efforts to help and support them.

Since the single inspection framework (SIF) inspection in 2014, a number of changes at senior management level have hindered progress to improve key areas of practice. Not all actions to address previous inspection recommendations have been sustained. The appointment of a permanent director of children services in April 2018 has led to a step change in the pace and focus in addressing practice deficits. This is beginning to have a positive impact. Leaders know their services well and are appropriately acting on the key areas for development found by inspectors.

Substantive improvements have been made in the provision of services for children who need help and protection, particularly in the multi-agency safeguarding hub (MASH) since the joint area targeted inspection (JTAI) on neglect in December 2017. However, there has been insufficient focus on the quality of practice in the disabled

children's team, where assessments are not up to date and plans are insufficiently child-focused.

The vast majority of children in long-term foster care live in stable homes and make good progress. However, not all children have their plans for permanence progressed in a timely manner. Assessments and plans for children in care are not updated when their needs change and a lack of rigour and challenge means that actions are too often reactive rather than planned. Services for care leavers have improved significantly since the last inspection, and they are well supported to achieve good outcomes and prepare for adulthood.

What needs to improve

- Assessment of children's needs when their circumstances change, in order to inform plans.
- Child-focused plans, particularly in the disabled children's team, where the understanding of thresholds when risks escalate also needs to improve.
- Timely and effective permanence planning for all children in care, including effective challenge brought by independent reviewing officers.
- Placement sufficiency for vulnerable adolescents.
- The quality and timeliness of case recording, including the recording of management decision-making.
- The quality of audits to inform practice and drive practice improvements.
- The strategic partnership response to criminally exploited children.
- The offer and take-up of return home interviews and the subsequent use of intelligence to inform individual children's plans and wider partnership activity.
- Pathways to private fostering.

The experiences and progress of children who need help and protection: Requires improvement to be good

1. The coordination of early help services is under developed. Plans to involve partner agencies in the lead professional role have lacked pace since the last inspection in 2014. Following the JTAI in December 2017, there have been improvements within the MASH. Early help workers effectively screen and signpost families, either onwards to early help locality teams, or to other appropriate services. The number of referrals to early help is rising, leading to more children receiving help in a timely way. However, too many early help assessments and plans lack focus and they are not always purposeful. For this reason, the impact of practice and interventions for children and their families is not always clearly demonstrated.

2. Actions taken following the JTAI, including well-focused corporate investment and commitment, have led to well-established systems in the MASH to ensure that children receive a timely and appropriate response to concerns. Thresholds for children at risk of significant harm are generally well understood and are consistently applied by a range of multi-agency professionals, who work well together to ensure that relevant information is available to inform decision-making. New developments since the JTAI have led to stronger health information-sharing from general practitioners and adult mental health services. Experienced and well-trained staff carefully oversee decisions so that children are effectively safeguarded.

3. The use of a red, amber, green (RAG) rating system ensures timely and appropriate progression, either to assessment for children when there are immediate concerns, or for further checks when more information is required. This ensures that children and their families receive the right help as quickly as possible. Consent is routinely and sensitively sought from parents when appropriate, and is systematically recorded on case files.

4. In the majority of cases, strategy discussions take place when risks escalate. Police attend initial strategy discussions in the MASH, and health agencies provide information, although health and other relevant agencies are not always in attendance. This limits the extent to which they can engage in and contribute to discussion and decisions. Plans are in place to improve the attendance of health professionals. Discussions held at hospitals have good health attendance.

5. Comprehensive and timely assessments with helpful analysis form the basis of subsequent work and planning. Children and parents are engaged in assessments and their voice and lived experience are prominent in the work carried out. The engagement of fathers is too variable, and evidence of their involvement was not seen in a minority of cases by inspectors. Consideration of the diversity of children's needs is well evidenced in assessments, for example in the regular and routine use of interpreters.

6. Children receive a service from the emergency duty team that keeps them safe and, in most cases, this is timely. There is an effective system for information-sharing with daytime services, although recording is not consistently child focused. The local authority and partner agencies have plans to revise the service and move to a 'children-only' service that is more closely linked with both the MASH and police in the near future.

7. Young people who present as homeless are responded to appropriately. This response includes immediate and extended family mediation to identify alternatives while their needs are being assessed. Most assessments are undertaken jointly with housing, particularly for those young people who are near their 18th birthday, and they are well supported practically to complete housing and benefit applications. Young people who need accommodation are provided with it.

8. Child in need (CIN) and child protection (CP) plans appropriately consider the main issues for children and their families. However, they are not always detailed or specific enough about the actions required to improve outcomes for children. This means that, in some cases, while core groups and child in need meetings are held regularly, it is difficult to know whether risks have reduced. When cases are stepped down from child protection, plans lack detail. However, in some cases, where social workers update plans once actions are completed, it is then clear what still needs to be undertaken to protect children. Contingency planning is not well embedded in practice.

9. For children on second and subsequent child protection plans at risk of neglect, there is clear evidence that sufficient progress is made in reducing risks. However, this was not sustained in all cases. In most cases considered by inspectors, repeat plans were appropriate and were because of new presenting risks. Plans demonstrate consistent engagement from professionals in core groups, and, in the main, actions are clear enough for families to know what needs to change. A range of support services are accessible to families to support them. Actions in plans are not always smart, measurable, achievable, realistic and target-specific (SMART). Open-ended timescales mean that it is difficult to show that sufficient progress has been made to reduce risk.

10. The Public Law Outline (PLO) process is not used consistently well to progress work with children who may require legal steps to ensure that they are safe. The PLO tracker document is not used proactively to monitor progress. PLO meetings are not always held when concerns first arise and letters before action are often lengthy, overly complicated, and not clearly aligned with child protection procedures. This means that parents do not always understand fully what needs to change. Decision-making, including applications to the court, is not always taken as quickly or as decisively as it should be.

11. Managers are aware of deficiencies in the effective application of the PLO process. They have recently instigated a new case management panel process

which reviews longstanding CIN or CP plans that are not demonstrating timely or sufficient change, as well as providing oversight of the progression of children's cases before the court. This is a well-considered update of performance management and case oversight processes, although it is at too early a stage to have yet had a measurable impact.

12. The local authority has put in place a clear, comprehensive and confidential system to manage allegations of abuse, mistreatment or poor practice by professionals and carers. There are effective professional networks that give confidence to professionals concerned about allegations against workers in contact with children. The designated officer has established effective and credible strategic relationships with key agencies, including faith communities. Records build a clear and accurate chronology of events and actions and provide evidence of a clear rationale for decisions about threshold and action. Regular and well-attended training has raised awareness and promoted the designated officer role that ensures a reliable response to safeguard children.

13. There are a low number of children who are privately fostered. In cases considered by inspectors, there was insufficient involvement of fathers in the assessment process, and support to improve the children's living arrangements was not effective. Practice in this area needs to be improved so that workers understand pathways into private fostering and are aware of the regulations.

14. Management oversight and supervision of casework is variable in frequency, quality and effectiveness. This has been significantly impacted on by the high turnover of social workers and managers. Despite these workforce challenges, a clear focus on embedding the local authority's model of practice is evident. All staff have received training and this is being consistently used. In the majority of cases, this is helping families to be clear about concerns and ensures that professionals focus their work on these key areas.

15. Most children are seen and seen alone by social workers, who visit them regularly to undertake direct work and build trusted relationships. This is not yet the case for all children, as some are not visited as frequently as they should be. In some cases, visits have taken place but there is no evidence of the work undertaken because recording was not up to date on children's files.

16. Children and young people who are subject to, or at risk of, criminal exploitation, child sexual exploitation and gang affiliation are appropriately protected and supported by their social workers and other key professionals, who show a high level of concern, tenacity and care to build trusting relationships with them. Inspectors found that the lives of some young people had become more stable and less risky because of the support they have received.

17. Arrangements to support and understand episodes where children go missing are under developed and poorly resourced. Inspectors saw timely liaison

between police and social workers to ensure that they are informed about children who are missing. However, take up of return home interviews is very low. This means that detailed information about the reasons and whereabouts of children who are missing is not always known due to lack of engagement and reluctance of young people to speak about their experiences.

18. Visits to electively home-educated children where a safeguarding concern has been identified are not always timely in order to ensure that their needs are being addressed.

19. Thresholds in the children with disabilities teams are not well understood nor well applied when risks escalate. Assessments are not updated when needs change, and plans are insufficiently child focused. In the majority of cases, plans focus on the needs of parents rather than the child.

20. The quality of management oversight is inconsistent and social workers are not supported to follow child protection processes. A lack of management grip on the progression of plans means that children's needs are not always being met in a timely way.

21. The local authority has a youth centre that offers excellent provision for young people in Haringey. The centre offers a wide range of effective universal and targeted support, facilitated by highly motivated and skilled workers. The centre has established links across the local community, with effective partnerships collaborating well to offer support that engages children in expanding their horizons and achieving education and employment opportunities. Young people are highly involved and influential in developing and delivering this service, including, for example, the production of a hard-hitting and realistic video on the impact of social media on grooming behaviour and risks involved in relation to child sexual exploitation. Young people regard the centre as a safe space, and it is well placed to support further preventative work with them around issues such as youth violence and gangs.

The experiences and progress of children in care and care leavers: Requires improvement to be good

22. Threshold decisions for children coming into care are appropriate and timely in the majority of cases. Social work statements to the court make clear, evidence-based recommendations that are well matched to children's current and likely future circumstances and needs. They do not, however, always provide a good depth of analysis or a sufficiently strong sense of children's wishes, feelings and lived experience, even when social workers have undertaken effective direct work with children. This means that the child's lived experience is not evidenced fully in a small number of cases. Once before the court, work is progressed swiftly. In most cases, appropriate parallel plans are in place, including consideration of placements with special guardians or

connected persons. Assessments are carried out alongside work to pursue alternative permanence options, including adoption. However, in a small number of cases parallel planning was not in place for young children.

23. Children with a plan to return home are supported appropriately by social workers and other professionals to ensure that children are safe and thriving. Services are appropriately put in place to support parents, for example the provision of cognitive behavioural therapy.

24. Assessments of children's needs are not updated in a timely fashion when their circumstances change. This means that interventions are often reactive and are driven by immediate need rather than consideration of the long-term needs of children because plans do not include actions to address these.

25. Children's care plans cover the relevant broad issues but are not detailed or specific enough. Plans do not get updated until immediately before the next review, and this means that current plans cannot be shared with relevant professionals or children and are not used effectively in supervision to drive progress against required actions.

26. The local authority is working to strengthen the independent reviewing officer (IRO) challenge. However, this is not yet consistently evident in their work with children. This was particularly evident through the lack of challenge seen in progressing children's permanence plans.

27. Children in care are visited regularly in response to their needs, and often beyond statutory expectations, by social workers who know them well. Inspectors were impressed by the efforts made by social workers to develop relationships with children who have had difficult experiences and have shown sensitivity and empathy towards young people in these circumstances. Although social workers were able to give examples of the direct work they had undertaken with children, this was not always evident on children's records.

28. The use of advocates and independent visitors to support children is not consistently considered. Although inspectors saw an example where a young person had exceptional support from his independent visitor over several years, overall there are very low numbers of young people who benefit from this.

29. Social workers sensitively explore children's histories in the child's timeframe, to ensure that they can understand their pasts. Life-story books and later life letters are well constructed. Foster carers feel well supported by their supervising social workers and through access to numerous support groups. They are also able to receive direct support to help them look after children who have complex emotional and behavioural needs in order to help them improve their outcomes.

30. For almost all children in care, there is regular consideration of their health needs, thorough assessments and dental and optician checks. Immunisations are also checked to be up to date. Social workers and managers are alert to the mental health and well-being needs of children and young people. They make good use of services such as First Steps and the Tavistock to inform their work with children. In most cases, this is consistent whether the children are placed in or out of borough.

31. The virtual school has changed the way in which it oversees personal education plans (PEPs) for children in care. Until recently, the virtual school did not attend many of the meetings to establish targets for pupils or to review their progress against those targets, and information about the PEPs of children in care was not gathered in a timely fashion. Inspectors found the quality of PEPs too variable, and some are not completed fully by the designated teachers in a timely way. The introduction of the electronic personal education plans (EPEPs) system is improving information-sharing, with an increased oversight from the virtual school, although the impact on improving the quality of PEPs is not yet evident. Inspectors found that the pupil premium grant was used well to support after-school activities, including access to a nurture group, extra mathematics and English tuition, and the provision mentors.

32. Children in care access a wide range of leisure activities, including horse riding, singing and dancing schools and football academies. The local authority supports funding to access local sports centres.

33. There is insufficient focus on permanence planning for children. Inspectors did not see evidence of those for children in residential care, other than to stabilise their placements, and for some it was not considered at all. Inspectors found several cases where children were waiting for their permanence plans to be endorsed. While these delays have not impacted on the stability of their placements, for example long-term fostering arrangements in place over several years, having permanence plans in place would help children to feel more secure. The local authority is aware that there needs to be a focus on early planning for permanence for all children and has recently revised systems to enable this to happen. It is too soon to see the impact of this work.

34. In most cases seen, contact plans were clear and well supported to ensure that children are able to maintain a relationship with their birth families. They reflect children's wishes and are changed in response to the child's views. In the majority of cases, brothers and sisters are placed appropriately together.

35. The majority of children in care in Haringey receive good care, support and placement choice that means that, in both the short- and long-term, they experience placement stability. The local authority is aware that short-term stability has declined in the last year. Plans are in place to increase placement sufficiency. However, more needs to be done to ensure that there are places available for vulnerable adolescents. Inspectors found several examples where

children had remained in the same placement for many years, and these placements met their needs well. Conversely, inspectors found examples where vulnerable adolescents had multiple placement moves and the local authority was struggling to find a suitable placement to meet their needs.

36. Most children placed out of borough receive the same standard of service as those in the borough, including health and education support to meet their needs. There was timely liaison with agencies in the area in which the children were placed.

37. Services for care leavers have improved since the last inspection and are now a significant strength. Care leavers receive support from experienced and enthusiastic staff, who are tenacious in their approach with the young people they work with. Having this continuity of worker enables the young person to develop trusting relationships. Pathway plans are clear, are reviewed regularly, and clearly evidence the views of the young person, often in their own words. Care leavers are made aware of their rights and entitlements. There are a range of opportunities for them to gain skills and confidence and to prepare for living independently.

38. A range of suitable accommodation is available, and support to secure tenancies is in place when young people are ready to move on. Workers are in touch with the vast majority of their care leavers and demonstrate continuous efforts when they are not. Care leavers themselves have participated in the recently refreshed pledge and in the development of the local offer. Health histories for young people are on file, and their health needs are discussed in pathway plan reviews. For young people with complex mental health needs, there is effective joint working, with mental health social workers and psychiatrists providing a robust package of support. Young people are supported to attend the not in education, employment or training (NEET) panel to understand realistic and achievable options to engage them in areas that interest them. This, and a focus on tracking individual cases, is ensuring that NEET figures are reducing.

The impact of leaders on social work practice with children and families: Requires improvement to be good

39. A succession of changes in the senior leadership team since the time of the previous inspection in 2014 have hampered the progress in improving key areas of practice. Not all actions taken to address practice improvements were sustained, as shown by findings in the subsequent JTAI of December 2017. A significant increase in pace and re-focus on plans to address identified priorities have been noticeable since the arrival of the current director of children's services earlier this year. She has a clear grip on presenting issues and is driving actions to make improvements. For example, she chairs the children's improvement board, the JTAI action plan group, quarterly performance meetings and the recruitment and retention board.

40. The local authority's self-evaluation and the priorities of the children's improvement board clearly show that leaders recognise where practice requires improvement and are putting plans in place to address these deficits. Since the last inspection, service areas where improvements are evident include the MASH, an effective designated officer service, and the care leavers' service, where there have been substantive improvements in practice. Since the JTAI findings, however, there has been insufficient focus by partners on other areas of practice, and this means that there is still more to do in key areas, for example the strategic overview of criminally exploited children and a greater focus on children with disabilities.

41. Governance arrangements have recently been aligned with guidance, and the DCS now reports directly to the chief executive. Senior leaders are committed and visible. The chief executive is leading the development of a youth strategy, and the well-informed, confident and aspirational lead member is fully involved across a range of committees and boards.

42. There is clear political and wider partnership priority to focus on children and families in Haringey. Elected members receive regular updates on performance and progress across a wide range of areas, and they demonstrate a good understanding of the needs of vulnerable children in their area. They appropriately challenge performance in areas of concern and request further information to improve their understanding of the issues, for example incidents of knife crime; issues relating to minority groups such as lesbian, gay, bisexual and transgender; and issues relating to children from specific ethnic communities. Members of the (corporate parenting) committee have attended presentations on the new safeguarding arrangements, and the local authority is at an early stage of discussion with partners about the implications for multi-agency working.

43. Inspectors were impressed with the committed and capable staff who they met during the inspection. Staff are positive about working in the authority. Reflecting the diversity of the local population, social workers have a sophisticated awareness of diversity and how cultural, religious and other factors underpin children's sense of identity, as well as how they impact on need and risk. Inspectors found this was an integral and core part of everyday practice for social workers.

44. The local authority, as corporate parents, focuses on the key issues in order to improve services for children in care and care leavers. Staff receive regular briefings and training to enable them to understand, clarify and exercise their corporate parenting responsibilities effectively. The members of the committee undertake regular visits to a wide range of services, so that they can hear direct feedback about the impact of services. They ensure that there is a joined-up approach to tackling the issues that affect the young people for whom they are responsible. For example, they appropriately widen their

consideration of issues to include community safety, youth unemployment and placement stability.

45. Local strategic multi-agency arrangements to manage and keep abreast of the complex risks of gangs, violence and criminal exploitation of children are under developed. Robust operational practice and systems are in place to manage the risks to these children. However, the governance through strategic groups to oversee this are not yet sufficiently clear or aligned. Insufficient partnership resources mean that there are limited opportunities for analysis to inform planning to minimise the risks that these children face. The number of return home interviews undertaken is low, therefore information to inform strategic plans from this source is limited.

46. There is a wide range of opportunities for children to participate in the evaluation of services and service design. The local authority actively seeks creative ways to engage young people and receive feedback. They use this well to revise policies, review services and improve practice. An example is the implementation of 'MOMO (mind of my own) Express' to engage those young people who are more difficult to reach, and the involvement of children in the recruitment of designated nurses for children in care. Members of ASPIRE (the children in care council) attend formal committee meetings with the support of a youth worker. A dedicated participation officer has effectively helped young people to meaningfully participate in the development of a comprehensive and accessible 'local offer' for the care leavers service.

47. There is insufficient focus on the impact of the service to improve all children's outcomes. Audits have been overly focused on process. The quality of audits has not reached the local authority's own expectations, in part hampered by a lack of resource. The introduction of practice week in September and a programme that has closer alignment to performance data have been helpful in focusing on the quality of practice. The local authority recognises the need to improve, and plans are in place to further develop the quality assurance framework.

48. The local authority has a wide range of performance information and, in some areas, this is used well. This includes a successful drive to improve the timeliness of assessments, service improvements in the care leavers team, and use of real-time information in the MASH to ensure the effective progression of contacts and referrals. However, this practice is not yet used consistently across all service areas and is not fully utilised to drive the improvements required.

49. The local authority has developed a children looked after and care leavers strategy that includes commissioning intentions. This was informed by a gap analysis of placement sufficiency. This is new and at too early a stage to have had a significant impact. This means that the more challenging areas of

placement sufficiency, for example those linked to older and more vulnerable adolescents, are not yet matching the needs of all young people.

50. Inspectors found inconsistent senior management oversight of practice. For example, systems are not yet established to enable them to have a strong oversight of permanence planning for children in care.

51. The local authority keeps robust data on their workforce in terms of vacancy rates and turnover and these are monitored through the recently developed recruitment and retention board. While there are plans in place to increase the number of permanent staff and reduce vacancy rates, some children experience delay in progression of their plans because they experience frequent changes of social worker.

52. Through the provision of additional capacity to progress work and plans for children, there has been a gradual reduction in caseloads. Staff report feeling supported by their managers and the local authority's wider training and support package. In teams where there is a more stable staffing and manageable caseloads, the positive impact is clear, with regular visits and social workers engaging in direct work and building trusting relationships with children.

53. There is currently no collated data on the skills and experience of the workforce. This means that the learning and development strategy has not been informed by knowledge of the workforce's skills in order to meet identified gaps. This information has just started to be collected. A central record is kept on the in-house courses attended, including the local authority's model of practice, which is successfully embedded.

The Office for Standards in Education, Children's Services and Skills (Ofsted) regulates and inspects to achieve excellence in the care of children and young people, and in education and skills for learners of all ages. It regulates and inspects childcare and children's social care and inspects the Children and Family Court Advisory and Support Service (Cafcass), schools, colleges, initial teacher training, further education and skills, adult and community learning, and education and training in prisons and other secure establishments. It assesses council children's services, and inspects services for children looked after, safeguarding and child protection.

If you would like a copy of this document in a different format, such as large print or Braille, please telephone 0300 123 1231, or email enquiries@ofsted.gov.uk.

You may reuse this information (not including logos) free of charge in any format or medium, under the terms of the Open Government Licence. To view this licence, visit www.nationalarchives.gov.uk/doc/open-government-licence, write to the Information Policy Team, The National Archives, Kew, London TW9 4DU, or email: psi@nationalarchives.gsi.gov.uk.

This publication is available at www.gov.uk/government/organisations/ofsted.

Interested in our work? You can subscribe to our monthly newsletter for more information and updates: http://eepurl.com/iTrDn.

Piccadilly Gate
Store Street
Manchester
M1 2WD

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

© Crown copyright 2018