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4 March 2019

Ms Anne Canning
Group Director of Children, Adults and Community Health Services
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Dear Ms Canning

Focused visit to London Borough of Hackney local authority children's services.

This letter summarises the findings of a focused visit to the London Borough of Hackney local authority children's services on 5 and 6 February 2019. The inspectors were Kate Malleson, Her Majesty's Inspector, and Brenda McLaughlin, Her Majesty's Inspector.

Inspectors considered the local authority's arrangements for children in need and those made subject to a child protection plan. Specifically, inspectors considered the application of thresholds and the effectiveness of practice when responding to risk. They also considered the effectiveness of assessment and planning and the quality of managerial oversight. Inspectors reviewed a range of evidence, including children's case records, as well as case performance management and quality assurance information. Inspectors also held case discussions with social workers and their managers.

Overview

Since the last Ofsted inspection in 2016, when services for children in need of help and protection were judged to be good, the quality of practice for a substantial number of vulnerable children considered by inspectors has not been sustained. Most social workers know their families well and strive to fully understand and support parents to care for their children at home. However, too many children in too many cases seen are subject to multiple assessments and interventions, sometimes over several years, which do not improve outcomes for children quickly enough. This means that a high number of children continue to live in situations of significant harm for too long. In some cases, the determination of workers to work alongside families to achieve change, combined with an overly optimistic assessment of parental ability or willingness to change, has led to overly adult-focused work. In such cases, the child's lived experience is not given sufficient consideration. Work with avoidant parents, or where disguised compliance is a feature, lacks timely action, and inspectors saw the damaging impact of this drift and delay on children in the majority of the cases considered.

Inspectors also found some examples of strong analytical assessments, including pre-birth assessments, and the more timely escalation of actions to address concerns for some children. In the majority of cases, social workers and managers have a thorough understanding about family dynamics, and records are clear and up to date.

Managers recognise that performance management systems to track whether children in need are visited within prescribed timescales are insufficiently robust.

Staff morale is good. A stable workforce has access to a range of relevant training and benefits from regular supervision. Social workers report to inspectors that their caseloads are manageable and that working in small social work units helps to ensure that the team is well supported. Senior managers have created a culture in which staff feel valued and safe.

Throughout the visit, senior managers were open, reflective and responsive. They accept many of the findings of the visit and are committed to acting swiftly to improve the service they provide for all vulnerable children.

Areas for priority action

The local authority needs to take swift and decisive action to address the following areas of weakness in child protection:

- the timeliness and effectiveness of social work practice and interventions to safeguard children from harm

- the quality and effectiveness of managerial oversight and supervision to ensure that children's circumstances improve within their timeframe.

What needs to improve in this area of social work practice

- children's daily lived experiences to be central to all work
- the application of thresholds to protect children on child in need plans when risks escalate or children's circumstances do not improve within children's timeframes
- performance data regarding the timeliness and impact of social work practice to improve children's circumstances
- plans to be more specific and detailed about what needs to change and by when
- the greater consideration of men, including abusive partners, in risk assessments.

Findings

- Children and family assessments vary in quality and timeliness. In stronger examples, they are comprehensive, detailed and analytical. The local authority has achieved some success in reducing timescales for the completion of assessments, but during this visit, it recognised that the dispensation given to it by the Department for Education in relation to assessment timescales has unintentionally reduced the sense of urgency required for their completion. Inspectors found a significant number of cases where the decision to convene statutory child protection conferences should have been taken earlier.
- Assessments mostly take account of earlier concerns and consider the likelihood of change and the work needed to effect change. While there is evidence of professional curiosity, risk is too often diluted by an overemphasis on mitigating the power imbalance between the social worker and the family. There is insufficient focus on what this means for the child who spends every day living in that family, waiting for their parents to make changes. Consequently, a significant number of children continue to experience harm. Thresholds are too high and decisions are too slow for too many children living in circumstances of pervasive neglect and domestic abuse, and they wait too long for adequate help and protection.
- Social workers know their children well, and while great care is taken to understand parental and family histories, in too many cases considered, the resulting work is adult-focused. Disguised compliance is either not identified or addressed quickly enough. This area for improvement was previously identified

through thematic audits. This has led to a service-wide practice development day and has been embedded into training programmes. However, the impact of this activity in improving children's experiences was not evident in a significant number of cases considered by inspectors.

- Most children benefit from regular multi-agency child in need or child protection core group meetings, and progress is updated against the plan and further actions identified. However, for some children known to the local authority for many years, actions and analysis of progress are not specified. These plans lack clear timeframes and are not sufficiently detailed about expectations to improve children's circumstances or to help parents understand what they must do differently. Follow up, review and oversight of plans needs to be strengthened to better evaluate children's progress. In some cases, the impact of referrals to other agencies is not considered in advance of planned reviews, and services are not provided promptly enough. This contributes to further drift and delay.

- In cases seen, risk assessment of males or dominant partners is not sufficiently robust or is not completed quickly enough. Assessment of the ability of women at risk of exploitation and abuse to protect themselves and their children is not adequately understood or is overly optimistic. In the most serious case example, this over-optimism led to the wholly inappropriate use of a safeguarding agreement for a very young mother who was at significant risk of harm herself.

- Children who go missing or who are at risk of sexual exploitation are visited promptly by specialist police and social workers to establish that they are safe and to understand the reasons for these episodes of going missing.

- Families benefit from access to a wide range of resources, including an integrated clinical team that supports the practice of systemic social work. It provides a range of evidence-based therapeutic help to children and families. Intensive therapeutic support is also available through the innovative Family Learning Intervention Programme, which enables intensive residential assessment of family dynamics, improves communication within the family and was observed to prevent breakdown of a special guardianship order.

- Current performance management systems to track whether children in need are visited within prescribed timescales are insufficiently robust for managers to have adequate oversight of all the children for whom they are responsible. Managers have had to devise their own different and varied systems to track this. Senior leaders were already addressing this issue and are in the process of implementing a new system.

- Social workers receive regular one-to-one and 'unit' supervision, and inspectors observed thoughtful reflection, analysis and deliberation about risks to children in the minutes of these meetings. However, despite this, management oversight is

not having sufficient impact on children's progress in the majority of cases seen and it is not preventing drift and delay for these children.

- Independent chairs are beginning to monitor cases between conferences, but the impact to improve outcomes is not consistent. Review minutes for children in care are written to the child in simple language, and this really helps children to understand what will happen if they are unable to live safely with their birth families.

- The embedded use of a systemic social work model has created an environment in which social workers feel listened to and are supported to develop their skills and knowledge. Staff morale is good, social workers feel valued and safe, and, as a result, the social care workforce is stable. Clinical practitioners provide training and reflective practice groups for social workers, who do not feel overwhelmed by complex cases. The focus on learning and professional development is a strength. Social workers report that caseloads are manageable.

- The local authority has a strong focus on auditing and self-evaluation to improve practice. A particular strength is the inclusion of service-user feedback. While audits are detailed and comprehensive and identify relevant themes for special review, the majority of audits are overly optimistic, with too much focus on process and not enough focus on the child's experience.

Where a focused visit results in an area for priority action, we require you to submit an action plan within 70 working days of receiving the final focused visit letter. We would usually also ask you to share a draft of your action plan within 20 working days of receiving the focused visit letter. This is so we can be assured that the local authority is taking action with the urgency commensurate to the seriousness of the findings. You have already submitted an action plan. We anticipate that you will want to review that action plan in the light of this letter.

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

Yours sincerely

Kate Malleson

Her Majesty's Inspector