

London Borough of Newham

Inspection of children's social care services

Inspection dates: 11 February 2019 to 22 February 2019

**Lead inspector: Dawn Godfrey
Her Majesty's Inspector**

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

There has been a significant deterioration in children's services since the previous inspection in 2014. Inadequate progress has been made in response to the areas of improvement identified both then and in the focused visit of 2018. Significant practice deficits remain in key areas, and leaders are failing in their duties to children in care and care leavers. Leaders have not created an environment for social work to flourish, and there has been a distinct lack of ambition for children.

Children in need of help and protection in Newham receive services which range in quality from requires improvement to be good to poor. Early help and family support services are not fully developed to be effective, particularly for older children and adolescents.

Most children in care and care leavers are not supported well enough. Services for care leavers have deteriorated and the needs of too many young people are not met, or even known, because there is a lack of contact from the care leavers service.

What needs to improve

- Senior leadership urgency in progressing the improvement plan to address deficits in social work practice.
- Senior managers' interaction with social workers to enable staff to feel listened to.
- The accuracy and reliability of the existing quality assurance and performance management system.
- Opportunities for children to participate in their planning and influence wider service development.
- The regularity and quality of staff supervision and management oversight and the quality and impact of decision-making.
- The quality and timeliness of social work assessments, so that they consistently inform plans.
- The quality and effectiveness of safety planning for children at risk of exploitation.
- The take-up of return home interviews and the effective use of information to identify and mitigate emerging risks.
- Permanence planning for children to ensure that permanence is achieved for all children without delay.
- The quality of life-story work for all children.
- Care leavers' experience of leaving care services and access to outreach workers who know and understand their needs.

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

1. When children in Newham are identified as being in need of help and protection, they are appropriately safeguarded. Effective work is undertaken with them to reduce risk and address their needs. When children's circumstances do not improve, timely action is taken by social workers to safeguard their welfare. This includes good use of the public law outline (PLO). However, too many children with less acute needs experience delays in receiving a response from children's services. This means that some children

wait for assessments and interventions and do not receive timely support to meet their needs. Although the vulnerability of some specific groups is recognised and appropriately responded to, further work is required to identify and support children at risk of all forms of exploitation. The quality of help and protection provided by the disabled children's team is a strength.

2. The early help offer is not well understood and is too limited in scope. Universal early help services are largely offered through schools and children's centres. The quality of response and support to children and families depends on the work of individuals, and when cases are moved to universal support, practitioners are not always confident that universal services can deliver the support required. Services for older children are under-developed. Although the early help partnership was set up as a service for 0- to 19-year-olds, it only offers a direct service for 0- to 5-year-olds, and the early help partnership has not yet engaged services for older children effectively. Support delivered by the 'Families First' service is more effective, and families welcome the systemic approach to supporting them. Some families experience delay in receiving early help services because there is a lack of understanding of the service offer by practitioners in the multi-agency safeguarding hub (MASH).
3. The MASH has been established for some time, but the different ways of contacting the MASH result in the duplication of work, and hinder a clear understanding of referral routes to children's social care. There are a good range of partners based in the MASH who are well engaged, and information-sharing by partners is generally timely following a request. Consent is not routinely obtained before checks are made, and too often consent is dispensed with, without a clear rationale being given.
4. Thresholds for services are inconsistently applied. Partners describe thresholds as unclear and at times unpredictable. This increases some partners' lack of understanding and the threshold document is not used effectively to inform decisions about making referrals.
5. Children at risk of immediate harm are quickly identified, and strategy discussions take place on the same day or within 24 hours. These result in priority actions being taken quickly to protect children. The vast majority of initial strategy discussions only involve the police and social care, and the only involvement of the wider professional network around the child is at review strategy meetings. This means that the recording of strategy discussions does not always show that a full discussion of information has taken place to

inform risk analysis, and the recorded rationale for decisions made is not always clear.

6. Child protection enquiries appropriately reduce risk to most children. The variability in quality at times reflects the lack of robust, consistent management oversight to challenge poorer practice and the inconsistent application of thresholds. At times, there is a disproportionate response to presenting issues, which results in some families being subjected to inappropriate child protection enquiries. In a small number of cases, child protection enquiries are not always started when they should be.
7. Inspectors identified some issues with police engagement in child protection enquiries. In some cases when a joint investigation is agreed, inspectors found examples where this agreement wasn't followed, and social care conducted a single agency enquiry. Inspectors also found a small minority of examples where police officers started interviews with children without a social worker present. This means that children have to tell their story on more than one occasion.
8. Many children benefit from good-quality assessments, although the quality is variable, and some assessments are poor. Better assessments are informed by research, family history and direct work with both parents and children so that an accurate analysis of need can be made, as well as appropriate recommendations. They involve relevant professionals in the family network to form a triangulated view of each family's needs and capacity for improvement. However, the role of the extended family in a child's life is not always considered. This results in a lack of understanding of who is important in a child's life and the influence they have on children's day-to-day lives. Significant events during an assessment do not always inform the risk analysis, which results in flawed conclusions and recommendations. Too often, children's experiences are not well articulated in early assessments, and these are insufficiently child-focused.
9. Stronger work was found in the Disabled Children and Young People Service (DCYPS), where most of the assessments seen were of a good quality, were child-focused, and evidenced a proportionate approach taken where there were no safeguarding concerns. Children and parents are well engaged, and positive outcomes are achieved for children, with good support for parents.
10. Direct work with children is improving, and social workers know their children well. Children are seen regularly and alone and social workers are tenacious

in their work with families who move between London boroughs. A high number of cases need an interpreter, which means that direct work is less dynamic than workers would want. Inspectors found some good examples in the safeguarding and intervention teams of social workers working creatively to engage children and making a positive difference to their outcomes.

11. Child protection and child in need plans are not yet consistently good enough. The quality of plans improves as children move into longer-term planning, and, for these children, positive progress can be seen over time. There are realistic contingency actions to protect children. Parents are helped to engage by social workers, who are clear about parents' achievements and who keep them motivated. In some cases, plans lack detail and clarity about what is expected to be achieved and how it will be done. This leads to some child in need plans remaining open for too long without a clear plan for step down or closure.
12. When children are no longer able to live safely at home, statutory powers are used appropriately to safeguard and protect them. The PLO is often used well, and realistic timescales are set for parents to demonstrate progress. Plans are regularly reviewed to avoid drift, and decisive action is taken when there is a failure to improve parenting within a child's timescales.
13. Children benefit from regular core groups, multi-agency meetings and reviews. The majority of these are timely, and parents have an opportunity to engage and contribute fully in meetings. Multi-agency engagement is good, but reviews are not consistently preventing drift or securing improved outcomes for all children. Planning and core group activity do not always link the work done to have an impact on children.
14. Management oversight and decision-making are variable and not consistently effective in driving up the quality of social work practice. Gaps in recorded supervision or management oversight and direction contribute to drift and delay in progress for some children. Actions do not always have timescales, nor are they regularly reviewed. There is little evidence of reflection and how managers are supporting social workers in line with their skills and experience.
15. The work of the designated officer is a strength. The designated officer robustly oversees allegations and challenges agencies and professionals at a senior level to ensure concerns are pursued with vigour. The provision of

training to relevant agencies is comprehensive and promotes timely and appropriate consultations and referrals.

16. There is much improved strategic oversight and coordination of children who are identified as at risk of exploitation or who go missing. However, for individual children, this does not always translate into effective operational planning in response to their needs. For these children, risks are not always effectively identified, and protective and disruption action is not consistently being instigated to safeguard children. Existing screening tools and return interviews are not used well to inform planning or identify wider associations and risk.
17. The management and oversight of elective home education are good. Tight, well-established systems are in place. The local authority has rightly identified the link with 'off-rolling' and has provided schools with information about this practice. Professionals act quickly and determinedly to follow up any concerns about children who are out of education. Risks such as forced marriage, to pupils who are known to have moved abroad, are well recognised. They are placed at a high level of concern and a clear risk assessment process is used to ensure that pupils who are known to social care are escalated timely and appropriately.

The experiences and progress of children in care and care leavers: Inadequate

18. Children in care and care leavers in Newham receive inadequate services. Permanence planning and tracking is ineffective. Children often drift into permanent placements rather than their placements being proactively planned. Planning is done sequentially, and permanence is not considered early enough, with twin tracking not being embedded in practice. 'Silo' working is contributing to poor practice in this area, with permanence not well understood at the early stages of a child's involvement with social care. Permanent matching for long-term fostering is poor. There is significant delay and drift for most children who require this. For some children, this results in placement instability and confused messages for them.
19. Care leavers in Newham receive a poor service. It is of significant concern that a high number of young people open to the leaving care service were found not to be in receipt of services at the time of inspection. The leaving care service does not become involved with children in care early enough, resulting in poor preparation and planning. The service is not child centred in

the way it is set up, for example being based in a building which does not allow young people access. It is an omission that there is no handover between the social worker and outreach worker before transfer of cases or joint introductory visits.

20. Decisions for children to come into care are not always based on up-to-date assessments or made in response to escalating risk. Too often, children come into care at a time of crisis, even where there is ongoing social care involvement. The recent introduction of the 'Keeping Families Together' team is designed to support and enable young people to remain or return to their families safely, but the impact of this is yet to be seen.
21. Assessments and plans are generally up to date, with many reflecting changes in children's circumstances. They are not always insightful on risks and barriers to progress, which hinders their usefulness in care planning. Some plans are overly long and unclear on what is to be achieved, how it is to be achieved, and by when. This contributes to drift and delay. Better examples include things that are important to a child, such as activities, and contact plans are reviewed well, considering the impact of changing circumstances.
22. Most children live in appropriate placements which meet their needs, and which are matched to their culture and religion. There is little evidence that proactive wider matching of need takes place, and this sometimes results in numerous changes of placements at short notice. There are no dedicated in-house foster carers for emergency placements, and often the available in-house foster carers are only able to take children up to two years old. Assessments of brothers and sisters and whether they should be placed together or apart were rarely found by inspectors.
23. Formal reviews are timely and they appropriately consider a broad range of children's needs. However, the records do not always demonstrate discussion of risk issues or the impact on children of the failure to achieve permanence quickly. Review recording relies heavily on professionals' and carers' reports and views and does not always capture children's voices. The proactive engagement of children by independent reviewing officers is not evident in most cases, and their challenge to progressing plans and addressing drift is not sufficiently robust.
24. Social workers visit children regularly and children are routinely seen alone. This includes those children placed at a distance. The 'Mind of my own' app

has been used well in some cases to aid children's participation and express their views, but its use is not yet embedded. There are some good examples of how activities are supporting a child to express their views and feelings and older children regularly attend and contribute to their reviews. Inspectors found evidence that, for some children, both advocacy and the need for independent visitors are appropriately considered and provided.

25. The Children in Care Council meets regularly and is supported by a children's rights worker who is highly valued by the children who attend. This group is used as a means of support by a number of children and, in this respect, it is valued and valuable. However, there is little evidence of it having a broader impact on service provision.
26. Children in care are helped to improve their health. The timeliness of health assessments is improving, and a flexible service is offered to all children in care. The children in care health team works with children within 20 miles of Newham and ensures that those children who live further afield have their health needs met by the relevant local authority. Children in care have access to their health histories via health passports at the age of 16 years. However, some care leavers informed inspectors that they are not aware of their health histories and do not have access to them.
27. Children's emotional and mental health needs are understood and met. A specific child and adolescent mental health team (CAMHS) for children in care offers a timely response to referrals. A CAMHS worker is based in the looked after teams on a weekly basis, providing consultation and advice. This is improving social workers' confidence and skills in working with children and allows easy access to specialist support when required. Information from strengths and difficulties questionnaires informs discussions and planning effectively with CAMHS colleagues, as well as consideration of specific and additional support and interventions.
28. The virtual school team is effective in its work. It has an accurate understanding of the children in care in Newham. Personal education plans provide a strong profile of the child, fully representing children's views in a meaningful way. The education targets for children are generally sharply focused on specific outcomes, and the good use of the pupil premium results in measures to improve impact. Education outcomes for children in care show strong progress in both the primary and secondary phases and are good when compared with the national figures and those for all London boroughs. Robust record-keeping by the virtual school enables swift intervention where

progress is slower, and effective support from the virtual school staff has resulted in no permanent exclusions of children in care over the last year.

29. Children receive good care from their foster carers, who are assessed and supported effectively. There is an established training and support offer and good use of feedback to revise and review the offer regularly. As a result, more attachment-based training, which would help improve foster carers' understanding of children with complex needs and attachment difficulties, is being considered. It is an omission that this is not already in place. Recruitment is well organised, and there are good systems in place to follow up contacts efficiently. Good data collection by the service aids targeted recruitment. Support to carers out of hours is limited to the emergency duty team. This raises anxiety for some carers in providing placements for children with more complex needs.
30. Life-story work is under-developed and was rarely found for children whose plan is not for adoption. It is not taking place with most children, despite them being in homes where they will remain for the rest of their childhood. This means that children's understanding of their life history and experiences is not consistently being developed to aid their development and sense of identity.
31. There are very low numbers of children who are adopted, but for those children whose plan is for adoption, there is much better practice. Family finding and matching are good, including for those children with complex needs. The adoption support offer is good, and dedicated workers, including a systemic psychotherapist, support placement stability well. There is an exemplary contact model which is being taken forward by the East London regional adoption agency, supported well by the Pause team, the impact of which can be seen in its work with birth mothers and helping children move and settle in their adoptive families.
32. Care leavers with an allocated outreach worker have regular contact with them. These workers are persistent in ensuring the care leavers remain in contact and see them regularly. For this group of care leavers, visits are purposeful and responsive to the young people's changing circumstances. Where young people do not have a named, active outreach worker, however, contact is sporadic and too many of this group of care leavers are not seen for significant periods of time. Their needs are not understood and therefore cannot be met.

33. Pathway plans are highly variable in quality. Some are too long and repetitive and are not always updated when young people's circumstances change significantly. When pathway plan reviews do take place, these often involve the young person, and their views are reflected in action planning.
34. Care leavers' health needs are understood and met. However, not all workers understand their responsibilities to inform young people about their health histories or provide them with a copy of this. There is a strong support offer to those care leavers in higher education, and there is a high number of care leavers accessing higher education. However, there are fewer opportunities for other young people and this area is under-developed.

The impact of leaders on social work practice with children and families: Inadequate

35. Since the last inspection, there has been a lack of child focus by senior leaders, meaning that the standard of social work practice in Newham has deteriorated significantly. This failure of leadership has resulted in serious failures in practice, which were identified during the inspection, most notably for children requiring permanence and for a high number of care leavers.
36. All areas for improvement from the previous inspection in 2014 still require attention. These include required improvements to the accuracy of recording, the quality of management oversight and supervision and the development of effective quality assurance and performance management. Similar areas of development were also identified in the focused visit of 2018. Management oversight and focus is still poor throughout all tiers of children's services.
37. Leaders have neglected their duties as corporate parents in Newham. This has resulted in services for children in care and care leavers being overlooked and disregarded. A new focus on children in care and care leavers and higher aspirations and ambition has been recently articulated by elected members. This is to be reflected in a refreshed children in care and care leavers' strategy but is yet to produce tangible improvements to the experiences of children in care.
38. There is no embedded learning culture in Newham. Inspectors found little evidence that senior managers and leaders actively listen to children and families and use feedback to improve services. A number of staff reported to inspectors that they feel disconnected from senior leaders. The social work practice advisory group has been established to provide a direct line of

communication from frontline staff to senior managers, and to consult on and raise key issues that affect them. Evidence of impact is limited, and, at the time of inspection, is a missed opportunity for senior leaders to engage effectively with frontline staff.

39. Performance information remains under-developed, and this, coupled with concerns about its accuracy, means that performance data cannot be wholly relied on. This impedes senior leaders' accurate understanding of frontline practice and their ability to effectively prioritise areas for improvement. There remain some key areas of practice without sufficient oversight, for example care leavers and permanence planning for children in care.
40. Senior leaders speak about their vision for an embedded performance culture, but acknowledge that progress has been too slow. The performance management and quality assurance frameworks are yet to fully align, and the quality of audits is not yet meeting expectations. The role of the new quality assurance team is starting to show some positive impact, and staff who have benefited from this direct input speak positively of it. There remains a culture change challenge in moving from process compliance to focus on the impact of services to improve children's outcomes.
41. Supervision of social workers and support staff is mostly regular, and staff report that they feel well supported. However, the record of supervision is too task-focused and provides limited reflection, which is a missed opportunity to provide clearer direction to social workers who are working with challenging and complex families. Overall, social workers are not working in an environment in which good social work is encouraged and able to develop and flourish. Progress has been made in reducing caseloads of staff, but these remain too high in several teams to enable good social work to flourish. Most staff report feeling supported by their teams and the local authority's wider training and support package.
42. There is a focus on increasing stability in the workforce. Positive engagement with Frontline and 'Step Up to Social Work' programmes and a strong recruitment offer, including keyworker accommodation and additional payments, is resulting in an increasing number of newly qualified social workers joining Newham and connecting well with the systemic practice model.
43. The sufficiency strategy is still in draft form and is yet to be fully developed in conjunction with a commissioning strategy. This lack of forward planning

means that there are not always the right placements to meet children's needs.

44. Political and corporate support has recently been strengthened alongside substantial investment in children's services. This scrutiny and challenge is vital to support improvement to children's services in Newham.



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