Inspection of Havering local authority children's services

Inspection dates: 11 to 22 December 2023

Lead inspector: Claire Beckingham, His Majesty's Inspector

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

Since the last inspection in June 2018, when services for children in the London Borough of Havering were judged to be good overall, the progress children make, their experiences and the quality of the services they receive have significantly deteriorated. Poor management oversight and supervision across social work teams, coupled with a weak reviewing service, have led to widespread drift and delay for too many children. The majority of social workers in Havering have complex and high caseloads. These combined weaknesses have led to a small number of children remaining at risk or experiencing harm for too long.

The recently permanently appointed director of children's services (DCS) has quickly identified the areas that need to improve and has ensured that leaders have an accurate appraisal of the quality of service provision. With the support of corporate and political leaders, work is under way to strengthen services. While the scale and nature of the necessary improvements are well understood, and plans for improvement are in development, this is within a challenging context of increasing demand linked to marked growth in Havering's child population. Substantial resources are needed to deliver core statutory services. Services have been deteriorating over several years and only recently has action begun to address this.

What needs to improve?

- Further corporate and political investment in children's services, alongside increased social work capacity and consistency.
- The quality and consistency of management oversight and supervision.
- The oversight of, and the response to, vulnerable children who are privately fostered, children living at home under placement with parents regulations and children in supported accommodation.
- The quality and timeliness of social work assessments.
- The quality of planning and subsequent monitoring and review of plans for children in care, children in need and children subject to child protection plans, so that children achieve safety and permanence without delay.
- The quality of children's and care leavers' case records.

The experiences and progress of children who need help and protection: inadequate

1. Services for children and families in Havering who are in need of help and protection have declined since 2018, and weak practice is prevalent in longer-term work. The quality of practice in the assessment service and longer-term teams, including with disabled children, is not consistent. Some children benefit from committed social workers who are successfully improving children's safety and outcomes, but this is not the case for many children. Changes in social worker, high caseloads and a lack of management oversight impact on the quality of assessments, planning and interventions. Because of these factors, the delays in children's circumstances improving are widespread. The response to private fostering is particularly weak. Appropriate checks and risk assessments are not evident, and children are often not visited or seen at the required frequency. Leaders cannot be assured of the safety of children living in these arrangements. Early help and work in the multi-agency safeguarding hub (MASH) are stronger.

2. Most families receiving early help benefit from the support they receive, with a range of services making a difference to children's lives. A small number of children wait too long for support to be provided. As a result, some of these children experience statutory intervention that may have been avoided had the support been provided earlier.

3. The MASH is responsive and effective. Experienced and professionally curious social workers collect and evaluate information quickly and competently. They consider and record consent in the majority of cases, and historical information is appropriately considered to inform risk assessments. This means that risks to children are well understood and responded to appropriately. Management

oversight is evident at all stages within the MASH. Partnership-working in the MASH is effective and the co-location of services is a strength, with good information-sharing and early identification of urgent matters leading to a timely response for children at risk of harm.

4. When allegations of significant harm come into the MASH, strategy meetings are convened quickly and usually include all the relevant agencies. For children who are already open to statutory services, there is often a delay in strategy meetings being held, due to police capacity.

5. A significant minority of initial child protection conferences take place outside timescales due to insufficient capacity in children's services. In these instances, the quality and impact of interim safety planning are not consistent, and some children are not safeguarded effectively while awaiting conference.

6. For a small number of children, there are delays in their needs being assessed. Social worker availability and delay at the point of transfer between teams contribute to this. As a consequence, these children are left in a situation of unassessed risk for a number of weeks and can continue to experience harm.

7. The quality of assessment is inconsistent. Stronger assessments are timely, and children are seen promptly and frequently to understand their views and experiences. Weaker assessments take too long, children are often only seen once and there is a lack of curiosity, understanding and analysis of the child's world. This, as well as some assessments not being updated when children's circumstances change, hinders effective planning and safeguarding.

8. Some children, particularly more recently, benefit from creative direct work and relationship-building from thoughtful and curious social workers who know them well. For other children, changes in social worker have contributed to drift and an incomplete understanding of their experiences.

9. The quality of child-in-need and child protection plans is highly variable. Too many child protection plans are not clear about who is doing what and by when. Some are too long and do not focus on what actions should achieve for children. It is not always clear to parents, professionals or workers what the most important concerns are. While core group and review meetings take place, they do not always make a difference for children. A lack of management oversight, ineffective and infrequent supervision, and a lack of escalation from child protection conference reviewing officers contribute to this.

10. When children's lives are not improving, Public Law Outline (PLO) pre-proceedings are initiated. Some children wait too long for these to be initiated and others are subject to these interventions for too long. For the most recent escalations into pre-proceedings, assessments have been commissioned in a more timely way.

11. The quality and impact of return home interviews, an area for improvement in 2018, remain variable. Recent interviews undertaken by two newly appointed return interviewers show an improvement in the timeliness and quality.

12. There is a clear protocol in place for children aged 16 and 17 who Havering has established to be homeless. These children are informed of their rights and accommodated swiftly in appropriate placements. Data in respect of all those who present as homeless is not sufficiently collated to track the experiences and outcomes reliably.

13. Disabled children in Havering receive an inconsistent service. Some families wait too long for an assessment before they receive a service, including those seeking to access short breaks. Social workers see disabled children regularly and at the frequency they need. Some disabled children's lives improve because of the help and support they receive. For others, there are delays in improvements being achieved.

14. The out-of-hours service, hosted by another London local authority, responds to children's and families' needs in a timely and proportionate way.

15. Local authority designated officer arrangements in Havering are effective in managing allegations against professionals who work with children in a timely and robust way.

16. The local authority maintains clear oversight of children receiving elective home education. If concerns arise, they are dealt with swiftly and effectively. This includes concerns about children's safety or welfare. Leaders work effectively with a range of partners, including schools, the schools admissions team and children's social care, to swiftly identify children missing education. Leaders quickly and appropriately escalate concerns if children may be at risk or vulnerable.

The experiences and progress of children in care: inadequate

17. The quality of social work practice for children in care is variable, and too many children have a poor experience. Children return to the care of their parents without having risks assessed or mitigated and these plans are not always endorsed by senior managers. The safety and well-being of older highly vulnerable children in supported accommodation are not sufficiently monitored by social workers and their managers.

18. Some children do not come into care soon enough. They continue to experience harm in their home and, as a result, enter care in an emergency. This is an unsettling experience for children and makes it harder for them to be matched to the most appropriate placement.

19. Children have too many changes of social worker and, for these children, visits are not consistently purposeful or always at the frequency they require to form a trusting relationship with their new social worker. Practice when social

workers visit children is variable. In weaker examples, there are gaps in visits taking place or records are missing. Social work visits to children lack purpose. Some are completed by duty social workers and are of particularly poor quality. In stronger examples, visits are purposeful and based on what children would like and in a venue of their choosing. Creative and regular direct work is taking place with some children to capture their experiences of their journey in care.

20. The quality of care planning and reviews is poor. This means children's plans lack clarity or timely implementation, including for children subject to court proceedings, who wait too long for their permanency plans to be established, implemented or approved. The independent reviewing officer (IRO) service does not offer an effective quality assurance role and does not sufficiently escalate concerns. The quality of minutes of children's review meetings is highly variable and minutes are missing from some children's records. Most review records contain outdated historical information and actions; the density of these review records makes it harder for social workers, carers and children to know the priorities. IROs are not always ensuring that children's wishes are influencing their plans.

21. Children's records are often sparse and difficult to follow. This compounds the lack of continuity created by the turnover of social workers and weak management oversight. Children returning to read their records would not understand the reasons why they came into care or why decisions were made for them. For too many children, there is no rationale for delays in important aspects of their plans, such as permanency decisions or arrangements for them to see important family members.

22. There is variable social work practice for children achieving permanency, with some experiencing drift and delay. Inconsistent management oversight and irregular supervision mean that drift is not always identified and remedied effectively. This includes planning for children requiring adoption. Once adoption decisions are made, adoptive placements are thoughtfully considered against matching criteria.

23. Risks to children in care are mostly recognised and responded to. However, as not all children receive statutory visits when they should, this is not consistent. If children make allegations against their carers, these are responded to and children are safeguarded. Bullying by peers or at school is mostly well responded to by social workers. Children who go missing have not always been offered a timely return home interview and the quality of the return home interviews remains too variable, despite recent efforts to improve their quality.

24. Most children in care have up-to-date health assessments and eye and dental checks and their physical needs are well met. Strengths and difficulties questionnaires are used to support identification of services to support children's emotional and mental well-being. Some children are enjoying a variety of social activities and hobbies.

25. The systemic family therapist team interventions make a positive difference in helping improve carers' understanding of children's needs. Children's matching to permanent placements is not consistently informed by learning from their previous placement breakdowns.

26. The participation group run for children in care is valued by children who attend. They enjoy meeting others and taking part in activities. Children are able to share some of the things they have been doing to influence service development, but they are not being supported to help shape services effectively. Independent visitors are used appropriately to assist children in sharing their views and wishes about where they live.

27. Unaccompanied asylum-seeking children receive regular visits, with positive relationship-based work, so that they are able to build trusting relationships with their workers.

28. Personal education plans (PEPs) have effective targets, which are reviewed appropriately. There is variability in the timeliness of completion of PEPs due to changes in social worker, and some tasks are left incomplete. The virtual school makes effective use of pupil premium funding to support children to achieve and to ensure that support is accessed without delay where tasks and PEPs are awaiting social worker actions. The virtual school also ensures that education plans incorporate the views of children in care. The virtual school works in close partnership with schools to support children's education, and many children in care make strong progress from their starting points.

29. While assessments of foster carers are thorough, it is not consistently clear how any vulnerabilities identified in their assessments feed into the training, support and action plans for carers. Foster carers mostly feel well supported, but communication between foster carers and supervising social workers and children's social workers is often fragmented, which hampers care planning and support for children.

30. The arrangements with the regional adoption agency (Adopt London East) are working well. There is effective recruitment of adopters that meets the needs of children who require adoption as their plan. Assessments of adopters are generally completed in a timely manner, but do not always clearly and comprehensively consider how vulnerabilities identified will be mitigated.

The experiences and progress of care leavers: requires improvement to be good

31. Children in care do not have the opportunity to build trusting or stable relationships with their personal adviser (PA) prior to transfer at age 18. Most care leavers are positive about the support received from their PAs once allocated and most Havering care leavers are accessing support from the service. Many are also being helped to reconnect with family and friends.

32. A good proportion of care leavers benefit from living with their foster carers after the age of 18, in 'staying put' arrangements.

33. PAs keep in touch with care leavers, including those up to, and sometimes over, 25 years of age where this is wanted and needed. This is a strength in Havering. The recording, quality and frequency of visits to care leavers are variable. Most are visited at a frequency that meets their needs and there is persistent communication and checking in with care leavers via text messages and email. For a small number of care leavers, visiting is not reflective of their needs and is not consistently evident on the system. This includes recording whether they were seen face to face or virtually.

34. The quality of pathway plans is variable. Although most plans are regularly reviewed, too many are basic and do not fully reflect young people's needs and abilities. Plans are not sufficiently tailored to the unique and individual needs of care leavers.

35. Care leavers' basic health needs are met, although records do not consistently capture detailed information in this area. Care leavers with more complex mental health needs do not receive timely and effective support. Leaders have plans in place with partners to reduce waiting times and provide earlier intervention. Care leavers have access to their health histories, with PA support, via their GP.

36. Most care leavers are living in suitable accommodation that meets their needs. Care leavers are supported to develop their independent living skills before they take on their own tenancy, but most pathway plans do not include detailed information about the help and support provided. Most care leavers are provided with key personal and identification documents.

37. Care leavers who were formerly asylum-seeking children are living in appropriate accommodation and support is generally meeting their needs. Care leavers who are parents are appropriately supported to access parenting classes, family centres and universal services. There is mostly effective support, visiting and oversight for those care leavers in custody.

38. Most care leavers are encouraged and supported into education, employment or training, supported by Havering's employment and skills service. This includes help with travel and equipment.

39. Care leavers have access to recreational and social opportunities to help maintain positive relationships and feel part of a wider community. Care leavers speak warmly about the value of 'The Cocoon', a safe space where they come together for support, social events and to access practical facilities.

40. The corporate parenting board consults with care leavers but leaders have not gone far enough to involve them in shaping and improving services.

41. Most care leavers are aware of their rights and entitlements; they know how to complain and access advocacy support when needed. The local offer sets out the statutory support and expectations for care leavers. Most care leavers are accessing the offer, but this is not consistently evidenced in records. There is confusion from workers and some care leavers about what is available in the written offer.

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

42. Since the last inspection of Havering local authority children's services in 2018, the service provided to children by Havering has deteriorated. All areas for improvement identified at the last inspection remain areas for improvement, with further deterioration in some seen at this inspection. Over a sustained period of time, there has been a lack of effective management oversight, support and challenge across the local authority, from frontline managers through to senior, corporate and political leaders. This has meant that some children have been left at risk and too many children are subject to plans that drift.

43. Havering's self-assessment accurately identifies most areas for improvement. The DCS has brought a more rigorous focus and vision to children's services and has provided a realistic appraisal of the quality of the service and practice for children in Havering. Although this inspection highlighted some areas for improvement that the local authority was not fully aware of, the immediate response has been decisive and robust. Governance has recently been strengthened; the DCS has the confidence and support of the chief executive and political leaders. They have a clear line of sight regarding the challenges facing the service. Corporate and political leaders have worked together to understand the needs of children and have begun to invest in children's services. However, significant further financial investment is needed to deliver core statutory services. Leaders recognise the scale of improvement needed, which now requires whole-system change through comprehensive plans for restructuring and improvement. The DCS and key members of the senior leadership team are simultaneously implementing multiple plans to improve outcomes. Most have only recently been agreed or established and, while the changes target areas where improvement is most needed, it is too early to see impact in practice for children. The implementation of a robust senior leadership team structure to increase capacity and effective oversight for this work has been slow and is still not fully in place.

44. Strategic partnerships are starting to become more effective. Partner agencies hold Havering and the DCS in high regard and appreciate the straightforward and honest approach to problems and solutions. Constructive and mature relationships contribute to a sense of shared accountability. Leaders in Havering repeatedly escalated issues regarding police capacity impacting on children's safety until the police were able to secure agreement to additional resources, to be implemented in January 2024. Through the integrating of commissioning

teams with the integrated health board, Havering is pooling resources to create joint funding initiatives. Leaders are aware that more progress is needed to overcome challenges in relation to increased demand, complexity, need and resources, particularly the provision of mental health services for children and care leavers. The operation of early help services is a good example of strategic partnerships enabling effective multi-agency help to vulnerable families.

45. Havering's approach to corporate parenting is underdeveloped and, while there is a commitment to hearing children's voices, this has not been consistently acted on.

46. Alongside multiple changes in social worker, children experience multiple changes in IRO. The safety net and consistency that IROs can provide where social workers are inconsistent is missing. Very few children have effective reviews or plans. Havering's self-assessment recognises the issue and the DCS has taken decisive action to rebuild the service and has recently secured agreement to recruit permanent IROs at a suitably experienced level, with recruitment anticipated in the January 2024 whole-service restructure. Strengthened senior leadership oversight of placement moves has resulted in placement stability improving for children.

47. Strengthened performance information through the recently redeveloped quality assurance programme in Havering is translated into learning, which is used to target areas for service improvement and learning for individual social workers. However, capacity at an operational level means actions identified for individual children are not followed through sufficiently. Havering shares learning and themes from audits with the workforce via seven-minute briefings and practice-reflection discussions following audits; social workers value this opportunity to learn and receive case direction. In addition to quality assurance audits, Havering uses a range of analytics to understand performance and respond to any identified areas for improvement. Difficulties with the case recording system, alongside convoluted structures and processes for some teams and services, impede comprehensive and accurate oversight of practice.

48. Learning and development opportunities are encouraged and well advertised. Workers know how to access learning and development and regularly do so, however, this is hampered by workers' capacity issues. This investment in them develops their skills and helps to keep them working for Havering.

49. Social workers almost unanimously report feeling supported and guided through the complexities of their work. Despite this, recorded supervision and management oversight are areas of weakness in terms of both frequency and quality. For most, supervision notes are a summary of events, repeated history and confirmation of actions already taken by social workers. Actions are compliance-focused on next visits and updating relevant documents. They lack challenge, case progression and reflection. For many workers, there are exceptionally long gaps between supervisions and hence delays in work with children being reviewed. As a result, children are experiencing drift and delay

and social work practice deficits are not addressed. There is inconsistency in recording the rationale for casework decisions. Management oversight of frontline practice has been an area for improvement since 2018.

50. Havering has very recently increased capacity through extensive and targeted recruitment of social workers in their assessed and supported year of employment (ASYE) and recently qualified permanent staff. Some have recently started in post. More social workers have been secured for 2024. A reduction in agency staff, conversion of agency staff to permanent posts and a robust workforce strategy have seen an improving picture in staff turnover, and caseloads have started to reduce. However, caseloads are still too high and social workers are struggling to manage these effectively. There is a negative impact on the quality of work. Newly qualified social workers have complex caseloads and there is limited evidence of effective supervision progressing plans for children. Social workers report that they are expected to do too many administrative tasks following the loss of business support staff. This is directly impacting on their availability to undertake direct work with children and families. Despite the challenges, most social workers like working for Havering. They describe a highly visible and responsive leadership team; they know, and are loyal to, their leaders. This is impressive in the context of the demands on both workers and the leadership team.

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.

This report is available at https://reports.ofsted.gov.uk/.

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