Harrow Monitoring Group

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Harrow Monitoring Group - email

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Harrow Council is coasting while core services fail those who rely on them most

Harrow Council's response to serious failures in children's and adult social services since 2022 reveals a troubling pattern: not outright denial, but a persistent failure to grasp the gravity of what has gone wrong. Instead of confronting systemic weaknesses with urgency and humility, the council's leadership has repeatedly reframed poor inspection outcomes as near-misses, "learning opportunities" or technicalities. This narrative risks normalising failure in services where the human cost is profound - borne by children in care and care leavers, disabled adults and older residents who need not only lawful decisions, but compassion, reassurance and humane support. In practice, what many experience instead is a compliance-driven system that prioritises process over people, lacking the warmth and empathy that effective social care demands.

The clearest example lies in children's services. When Ofsted judged Harrow's children's services to be "inadequate", the finding should have represented a watershed moment. Instead, the narrative presented to elected members diluted the severity of the judgement. In a report to the scrutiny committee, the corporate director emphasised that children's services were graded "good" in two key areas for under-18s, claiming these outcomes were "unique" and particularly difficult to achieve. The overall "inadequate" judgement, members were told, stemmed from care leavers being graded "inadequate", a so-called limiting judgement that dragged down an otherwise positive inspection.

This framing fundamentally misses the point. Care leavers are not a marginal or technical aspect of children's services; they are among the most vulnerable young people the council is responsible for, often facing housing insecurity, poor mental health and limited family support. An "inadequate" judgement for care leavers is not an unfortunate footnote to an otherwise strong service, but evidence of a serious failure at the point where the council's responsibility arguably matters most. By presenting the inspection outcome as an anomaly rather than a warning, the council appeared more focused on defending reputation than confronting reality.

A similar pattern is evident in adult social care. In August 2024, the Care Quality Commission rated Harrow's adult social care as "requires improvement". The inspection identified long waits for assessments, weaknesses in carer support and inconsistencies in people's experiences of care and planning. These findings echoed years of complaints and Ombudsman decisions highlighting delays, poor communication and problems with charging and assessments.

Yet the council's official response again leaned towards reassurance rather than urgency. When Cabinet reviewed the CQC report in December 2024, it was described as a "learning opportunity", with members noting that Harrow was at the "top end" of the "requires improvement" band and close to a "good" rating. This language may be comforting internally, but it risks obscuring the lived experience behind the judgement. For adults waiting months for assessments, carers struggling without support and families navigating opaque systems, being "nearly good" offers little consolation.

To its credit, the council has launched an improvement plan and committed to developing a new, co-produced Adult Social Care Strategy, scheduled for Cabinet approval by summer 2025. But the timescale itself raises questions about pace and priority. Nearly a year after a critical inspection, residents were still being asked to wait for a revised strategy, while the same structural pressures continue to affect daily practice.

Taken together, the trajectories of children's and adult social care since 2022 suggest an organisation that is managing decline rather than arresting it. Inspection failures are reframed as technicalities, partial successes are foregrounded, and future strategies are promised, all while fundamental weaknesses persist. This is the essence of institutional coasting: acknowledging problems just enough to appear responsive, but not enough to drive radical change.

Public services at this level cannot be judged by how close they come to adequacy or goodness on paper. They must be judged by whether they reliably protect children leaving care, assess adults in need promptly, and support families before crises escalate. Until Harrow Council stops reassuring itself that it is "nearly there" and instead confronts the full implications of "inadequate" and "requires improvement", confidence in its ability to discharge its most serious responsibilities will remain fragile, and justifiably so.

Evidence

1. **Ofsted "Inadequate" judgement (Children's Services)**
   Ofsted rated Harrow's children's services *inadequate overall*, citing serious failings, particularly in services for care leavers.
2. **Care leavers graded "Inadequate"**
   The care leavers judgement was *inadequate*, triggering the overall rating and highlighting failures in safeguarding, planning and outcomes for vulnerable young people.
3. **DfE Improvement Notice**
   Following Ofsted, the Department for Education issued a formal improvement notice requiring urgent remedial action.
4. **Internal scrutiny findings (Care Leavers)**
   Council papers acknowledged poor-quality pathway plans, weak oversight, inappropriate case closures and unmanaged risks such as homelessness.
5. **Ombudsman fault findings (Children's Services)**
   The Local Government and Social Care Ombudsman upheld complaints against Harrow, finding maladministration and injustice in children's services cases.

6. **CQC "Requires Improvement" (Adult Social Care, Aug 2024)**
   The CQC rated Harrow's adult social care as *requires improvement*, identifying long assessment waits, inconsistent experiences and weaknesses in carer support.
7. **Cabinet framing of CQC outcome**
   Cabinet reports described the outcome as a "learning opportunity" and stressed Harrow was near the top of the "requires improvement" band and close to "good".
8. **High volume of adult social care complaints**
   In 2024–25, adult social care recorded 289 representations, including 139 formal complaints and multiple Ombudsman enquiries.
9. **Ombudsman fault findings (Adult Social Care)**
   The Ombudsman has repeatedly found fault in adult social care cases, particularly around assessments, charging and care planning.
10. **Delayed strategic response**
    A new Adult Social Care Strategy was promised following the CQC report but not scheduled for Cabinet approval until summer 2025.
11. **Pattern of downplaying seriousness**
    Across both services, council reports and leadership commentary have emphasised partial "good" elements or proximity to improvement, rather than the full implications of "inadequate" and "requires improvement" judgements.