Norfolk Council

Re-inspection of services for children in need of help and protection, children looked after and care leavers

Inspection date: 13 November 2017 to 24 November 2017

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Children's services in Norfolk requires improvement to be good		
1. Children who need help and protection		Requires improvement
2. Children looked after and achieving permanence		Requires improvement
	2.1 Adoption performance	Outstanding
	2.2 Experiences and progress of care leavers	Requires improvement
3. Leadership, management and governance		Requires improvement

Executive summary

After a faltering start following the last inspection of children's services in 2015, the last 12 months have seen a significant increase in the pace of change, with visible and effective interim senior leaders working purposefully to tackle critical weaknesses. This has allowed the current, permanent director of children's services to immediately pick up the momentum where others left off. The support for children looked after, care leavers and children with a plan for adoption has improved and most receive timely, effective help. However, these services still require improvement to be good. The service provided to children with a plan for adoption is outstanding.

Improvements in the services that support children in need of help and protection are less evident. Partners do not yet demonstrate a consistent understanding of thresholds, despite concerted efforts by the Safeguarding Children Board. Decision makers in the multi-agency safeguarding hub (MASH) apply thresholds appropriately, but the high volume of contacts, some of which do not meet the criteria for social care, hampers timely decision-making. The police action of sending high numbers of notifications about low-risk incidents exacerbates this.

Urgent safeguarding concerns referred to the MASH result in immediate action by decision makers. However, the response to lower-level concerns is much less timely. Inspectors identified over-complex systems and shortfalls in decision-making capacity in the MASH, which had led to delays in some contacts being progressed. When inspectors brought these concerns to the attention of the director of children's services (DCS), she took rigorous, corrective action. This has led to improvements, but there is more to do to ensure that systems support timely decision-making.

Most children in need of protective action receive effective support. Nevertheless, shortfalls in capacity, combined with rising referrals, have resulted in high caseloads in some assessment teams, and this impacts on the capacity to progress work in a timely manner. Relevant agencies do not always attend strategy discussions and there are gaps in recording decisions regarding the rationale for child protection enquiries. Most children with child in need or child protection plans are effectively supported and protected. However, there is a need to strengthen the oversight of assessments of children in private fostering arrangements to ensure that necessary checks are carried out before arrangements are approved.

The strategic response to children missing and at risk of sexual exploitation is underdeveloped. Operational systems are in place to manage the risks of children sexually exploited and those who are or at risk of going missing, but further work is needed to ensure a more consistent and joined-up approach.

Most children benefit from trusting relationships with social workers, who visit them regularly. However, a lack of staffing continuity has meant that some children have experienced too many changes of social worker.

Investment in services for children on the edge of care has resulted in a range of support that helps them to remain with their families where possible. When it is not

safe for children to remain living with their families, decisions for them to be looked after are timely and appropriate. Most children looked after live with good-quality carers who meet their needs. Nevertheless, senior managers recognise that there is more to do to try to ensure that children live close to home, where possible. Further work is needed to strengthen the needs analysis to inform the local authority's sufficiency and commissioning strategy, as well as working alongside partners in health to improve the timeliness of response to the assessment of children's health needs when they first become looked after.

Comprehensive assessments support early permanence planning for the vast majority of children. A high number of children have benefited from a highly effective 'foster to adopt' service, which ensures that children achieve permanence at the earliest opportunity. Highly effective support and assessment are provided both for children with a plan for adoption and for adopters.

Independent reviewing officers (IROs) are becoming more influential in driving children's plans but have more work to do to ensure that they are consistent in their challenge and in making sure that plans are progressed.

When children leave care, social workers and personal advisers work hard to keep in touch and provide the support needed to help them to make successful transitions to independence. Not all are provided with information about their health histories.

Strenuous efforts to build a stable, skilled workforce are beginning to secure positive results. Continued investment in Norfolk's Institute for Practice Excellence (NIPE) ensures good-quality support to newly qualified social workers when they start their employment in children's services. This programme has been effective in achieving a more stable workforce and is an example of good practice.

The interim senior leadership team has taken decisive action to speed up the pace of improvement. However, action to tackle recommendations from the last inspection have not yet led to improvements in all areas. The newly appointed DCS demonstrates strong leadership skills and commitment to drive the improvement required to the next stage. Acutely aware of the importance of recruiting a skilled, permanent leadership team, she has made this a top priority. She is confident in the support of the leader of the council, elected members and the chief executive, who demonstrate a strong commitment to improving children's services.

Strengthened performance management and quality assurance are providing increased scrutiny and challenge. As a result, senior leaders and elected members have a much-improved understanding of the strengths and areas for development, and are clear about where to focus their attention.

Elected members demonstrate a determination to provide quality services to children in Norfolk. They are committed corporate parents and have worked resolutely to improve services to children looked after and care leavers. There is shared ownership of the improvement journey across the council, promoted by the chief executive and leader of the council, supported by significant financial investment.

Contents

The local authority

Information about this local authority area[1]

Previous Ofsted inspections

- The local authority operates nine children's homes. Eight were judged to be good or outstanding, and one required improvement in their most recent Ofsted inspection.
- The last inspection of the local authority's children's services was in July 2015. The local authority was judged inadequate in respect of children looked after, care leavers and overall effectiveness, while adoption, care leavers and leadership, management and governance were found to require improvement.

Local leadership

- The director of children's services (DCS) has been in post since October 2017.
- The chief executive has been in post since August 2014.
- The chair of the local safeguarding children board (LSCB) has been in post since February 2014.
- The local authority uses the 'signs of safety' model of social work.

Children living in this area

- Approximately 169,296 children and young people under the age of 18 years live in Norfolk. This is 19% of the total population in the area.
- Approximately 18% of the local authority's children aged under 16 years are living in low-income families.
- The proportion of children entitled to free school meals:
  - in primary schools is 13% (the national average is 15%)
  - in secondary schools is 11% (the national average is 13%).
- Children and young people from minority ethnic groups account for 7% of all children living in the area, compared with 21% in the country as a whole.
- The largest minority ethnic groups of children and young people in the area are Mixed/multiple ethnic group and Asian/Asian British.
- The proportion of children with English as an additional language:
  - in primary schools is 10% (the national average is 20%)
  - in secondary schools is 7% (the national average is 16%).

[1] The local authority was given the opportunity to review this section of the report and has updated it with local unvalidated data where this was available.

Child protection in this area

- At 31 October 2017, 4,807 children had been identified through assessment as being formally in need of a specialist children's service. This is an increase from 4,794 at 31 March 2017.
- At 31 October 2017, 543 children and young people were the subject of a child protection plan (a rate of 32 per 10,000 children). This is a reduction from 581 (34 per 10,000 children) at 31 March 2017.
- At 31 October 2017, eight children lived in a privately arranged fostering placement. This is an increase from five at 31 March 2017.
- In the two years before the inspection, 13 serious incident notifications have been submitted to Ofsted and four serious case reviews have been completed.
- There are six serious case reviews ongoing at the time of the inspection.

Children looked after in this area

- At 31 October 2017, 1,115 children are being looked after by the local authority (a rate of 66 per 10,000 children). This is an increase from 1,105 (65 per 10,000 children) at 31 March 2017. Of this number:
  - 207 (or 19%) live outside the local authority area
  - 98 live in residential children's homes, of whom 33% live out of the authority area
  - 7 live in residential special schools[2]
  - 848 live with foster families, of whom 17% live out of the authority area
  - 34 live with parents, of whom 12% live out of the authority area
  - 20 are unaccompanied asylum-seeking children.
- In the last 12 months:
  - there have been 81 adoptions
  - 60 children became the subject of special guardianship orders
  - 410 children ceased to be looked after, of whom 5% subsequently returned to be looked after
  - 46 children and young people ceased to be looked after and moved on to independent living.

[2] These are residential special schools that look after children for 295 days or less per year.

Recommendations

1. Ensure that children are able to establish and maintain meaningful relationships with their social workers and benefit from the consistency and continuity that a settled and stable workforce, with manageable caseloads, provides.

2. Ensure sufficient capacity and effective systems in the MASH to support timely decision-making in response to contacts and referrals.

3. Ensure that the right agencies are involved in strategy discussions, that they clearly set out whether child protection enquiries are needed and that the rationale for such decisions and the next steps are recorded.

4. Strengthen the response to children who go missing and/or are at risk of sexual exploitation by ensuring that:

   - governance arrangements are clear and understood by all
   - actions from multi-agency sexual exploitation (MASE) meetings are recorded on children's files
   - return home interviews are consistently well recorded and that the intelligence from them informs risk management for children.

5. Progress work with health partners to ensure the timely assessment of children's health needs when they first enter care and that care leavers are consistently provided with information about their health histories.

6. Ensure that the sufficiency action plan is specific, measureable and underpinned by an accurate assessment of need to effectively inform strategic commissioning intentions.

7. Implement a system for ensuring that the authorisation of private fostering arrangements includes oversight of core checks and that the managers' rationale for decisions is clearly recorded.

Summary for children and young people

- When Ofsted last inspected Norfolk children's services in 2015, it found that children were not always receiving the help and support that they needed.
- Following the inspection, leaders across the council acted upon what Ofsted had told it and developed a plan with other organisations to improve the support that children receive.
- Over the past year, senior leaders have begun to make more progress in tackling the things that needed to be improved. Many children in Norfolk, including children looked after and care leavers, now receive better support than they did before.
- More children and families are being supported by early help services when they first need it, but decisions are not always made as quickly as they need to be when children are first referred to children's social care services.
- When children need to be protected, social workers help to keep them safe, supported by other professionals such as police officers, teachers and health staff.
- Social workers visit children regularly and listen to what they have to say about the help that they want. Advocates support children to ensure that their views are taken seriously when they need it.
- When children cannot live with their families, foster carers look after them well and help them to succeed. Social workers do an excellent job of finding families for children who need to be adopted. This happens very quickly and, when children go to live with their adoptive families, they are happy there.
- There is more to do to ensure that children receive the help that they need when they are finding it hard to manage their feelings or emotions, and to make sure that children's health is checked when they first come into care.
- If children go missing, social workers and other professionals visit them when they return and try hard to understand why they run away, to help to stop it happening again. Not all of these visits are written down on the children's recording system.
- Young people who leave care are well supported by their social workers and personal advisers, who work hard to stay in touch and help them to live independently and to follow their career or further education choices.
- Managers are trying hard to improve the quality of services for children, but they have found it hard to make sure that there are enough social workers. Sometimes this means that children have many changes of social worker. Children told inspectors that they find this hard.

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

Inspection findings

8. Despite some progress since the last inspection, the pace of change is not as evident for children in need of help and protection as it is in other parts of the service. More needs to be done to ensure that all children receive the consistent and timely response that they need.

9. Early help services, provided through a range of interventions, are increasingly reaching children when needs are first identified and result in effective support. When risks escalate, children's cases are appropriately stepped up to children's social care. However, the recording within the family support process is of inconsistent quality, and the processes to oversee how quickly children are seen and to measure impact are underdeveloped. The local authority recognises these weaknesses and has already commissioned a new electronic recording system to strengthen record-keeping going forward.

10. Serious concerns about children's welfare that are referred to the MASH receive a robust response and result in timely protective action. However, inspectors found that systems and processes in the MASH were not effective in ensuring timely decision-making in response to all contacts. A lack of capacity in decision-making roles contributed to this. The DCS and the senior leadership team took immediate action to implement a more rigorous system when these concerns were brought to their attention. These are significant improvements, although further work is needed to simplify the processes to support timely decision-making. (Recommendation)

11. Decision makers in the MASH understand and appropriately apply thresholds. However, the high volume of contacts sent to the MASH, some of which do not meet the criteria for statutory intervention, hampers timely decision-making. The Safeguarding Children Board has sought to strengthen the understanding of thresholds across the partnership, but there is more work needed to ensure that partners are confident about when to refer. The police action of sending through large volumes of notifications regarding low-risk incidents adversely impacts on decision-making capacity. The quality of the recording of these notifications makes it difficult to ascertain if a child was present at the incident, and this means that it takes longer to make a decision.

12. The response to referrals received by the emergency duty team is timely and proportionate to the identified risk. Case recording is thorough, with a clear rationale for decision-making resulting in effective liaison between out-of-hours and daytime services.

13. High caseloads within assessment teams, compounded by delays in decision-making within the MASH, impact on the timeliness of subsequent action in some children's cases. While this was most evident in the Norwich assessment team, where caseloads are higher, pressures are evident in this part of the service across the county. The quality and timeliness of assessments are improving, although they are not yet consistent. The majority of assessments seen by inspectors considered the history, articulated the risk and protective factors and included an appropriate level of analysis. However, a small number of assessments lacked consideration of the individual needs of children, in particular when there were several children in the family.

14. Strategy discussions do not consistently include all relevant professionals. Consequently, not all information is available to inform decision-making. There is insufficient clarity regarding the function of the strategy discussion in deciding the threshold for child protection enquiries, with gaps in recording the rationale for these important decisions. (Recommendation)

15. Child in need and child protection plans vary in their quality. Not all are as specific and measurable as they need to be, although the majority appropriately identify the risks that need to be addressed. Partner engagement in child in need and child protection planning is good. Information sharing is appropriate. Regular attendance by agencies at child in need reviews, child protection conferences and core groups means that children's progress against their plans is clear. The use of risk scaling by agencies demonstrates an increasingly common understanding of the local authority's casework model. Most child protection plans are regularly reviewed and conference chairs provide appropriate challenge to ensure that plans progress.

16. Effective use of pre-proceedings ensures that parents are clear on what they need to do differently when concerns increase about their children's welfare. Letters before action make it clear what will happen if change is not achieved. However, the tool used to track pre-proceedings processes does not record outcomes other than whether proceedings are issued, and this is a missed opportunity for managers to understand any patterns and trends.

17. Response to the identification of children at risk of child sexual exploitation and 'missing' episodes is not yet consistently good. Inspectors saw some examples of clear plans to address identified risks, informed by child sexual exploitation risk assessments and analysis of return home interviews. However, the information from return home interviews is not always recorded and therefore does not always inform subsequent planning. Actions from multi-agency sexual abuse (MASE) meetings, that also consider cases of children who are missing, are not consistently recorded on children's case files and, in some cases seen, these actions are not effectively progressed. There is a lack of analysis at a strategic level of overall patterns and trends to inform coordinated actions. (Recommendation)

18. Management oversight of private fostering arrangements is not sufficiently rigorous. While the timescales for visits to children have improved, not all assessments are informed by agency checks prior to sign off. (Recommendation)

19. Effective arrangements are in place to assess 16 to 17-year-olds who present as homeless. District councils work closely with the local authority to undertake these assessments, and young people receive clear information on their options, including their right to become looked after by the local authority.

The experiences and progress of children looked after and achieving permanence	**Requires improvement**

Inspection findings

20. Children on the edge of care receive an extensive range of support to enable them to live in the care of their families, where possible. When it is not safe for children to remain in the care of their families, the local authority takes appropriate and decisive action for them to become looked after.

21. The local authority has a robust approach to permanence. From the moment that children become looked after, social workers are thinking how best to achieve permanence for them. Parenting and viability assessments are undertaken and completed promptly. Decision-making is timely. The average length of care proceedings is 29 weeks (year to date). As a result, children do not experience unnecessary delay or lengthy periods of uncertainty.

22. The local authority has introduced a 'no detriment' policy, which means that long-term foster carers who go on to care for children through special guardianship orders (SGO) or staying put arrangements are financially no worse off. This frees them up to focus on the potential benefits for the children and young people in their care. The option of staying put is considered at the earliest opportunity, when long-term foster placement matches are first approved. The number of children looked after who achieve permanence through an SGO is increasing.

23. The local authority's commitment to kinship care is tangible. The 'no detriment' policy aims to ensure that family members who bring up a relative's child do not experience financial hardship as a result. This is making it possible for more children to live with family or friends.

24. Social workers know their children well and their practice is child-centred. They are creative and imaginative in the way that they try to engage and

work with children. Inspectors saw some excellent examples of direct work. Nevertheless, in the last 12 months, a combination of staff turnover, sickness and absence, and difficulties in filling vacant posts has been problematic. Repeated changes of staff make it difficult to establish and maintain meaningful relationships. Foster carers talked about the frustration that this causes. Children spoke about how unhelpful this was for them. (Recommendation)

25. The quality of assessments has improved since the last inspection. Most are at least good enough. Some are very good. Care plans are also improving. The vast majority are outcome focused and reasonably specific, but they are not always measurable. The local authority's practice standards are yet to bring consistency in practice.

26. The fostering service is well resourced and managed. Fostering panels provide regular, robust and effective independent scrutiny and challenge. Foster carers understand their delegated responsibilities. Placement stability is good. Contact arrangements, in most cases, are well managed and carefully considered. Children live with foster carers who are well trained, well supported and well supervised.

27. 'Fostering friends' is an excellent example of the creative use of social networking, which enables carers to support one another through a secure social network site. Foster carers describe it as an invaluable source of support and information: 'It helps you to realise that you are all in the same boat.'

28. However, lack of placement choice is an issue and results in too many children being placed either out of, or at the opposite end of, the county. Lack of placement choice is also an additional strain on already stretched social work resources. On occasions, it contributes to placement breakdowns. The local authority recognises that too many children aged 11 or under are living in residential settings. It has also identified that a disproportionate number of children from black or minority ethnic groups are placed out of county, and it is taking action through its sufficiency strategy to address this.

29. The local authority has taken determined action to improve educational outcomes for children looked after. Decisions about which schools children attend are well considered and made in their best interests. Better collection and scrutiny of data mean that the virtual school knows where to focus its improvement activity. It intervenes quickly to support and challenge schools. The quality of personal education plans is generally good. The pupil premium is used effectively to increase the attainment of children looked after. No children looked after have been permanently excluded this year, after concerted efforts to reduce exclusions last year. However, there are still too many fixed-term exclusions. At secondary school, the attainment of children looked after is improving, but at primary school the gap between them and their peers is too wide.

30. Children looked after benefit from regular and timely reviews. IROs now have time to meet with children before their reviews. IROs are becoming increasingly effective in providing critical challenge when needed. Most reviews demonstrate good attention to detail, include appropriate consideration to children's wishes and feelings and clearly record decisions and outcomes.

31. More children are participating directly in their reviews. Some have even started to chair their own reviews. Access to, and the take-up of, independent advocacy support has also increased.

32. The number of children who go missing from care is low. When they do, most receive a return home interview, but social workers do not always record the interviews on the child's case file. (Recommendation)

33. Children's health is prioritised, but not all children receive a timely assessment of their health needs when they first become looked after. This is largely a product of limited capacity on the part of healthcare providers. A change to the way in which health services for children looked after are commissioned is intended to address this issue. Senior managers take appropriate action to ensure that the health needs of children placed out of county are met by enforcing a regional protocol. (Recommendation)

34. There is a clear strategic focus on the emotional well-being and mental health of children looked after. While the service that child and adolescent mental health services (CAMHS) provides is good, children looked after do not always receive the help that they need when they need it. Waiting times vary considerably across the county. Agreement has been reached that children looked after will receive preferential treatment while CAMHS is being recommissioned.

35. Members of the Children in Care Council played a significant role in the development and introduction of health passports and helped to shape the sufficiency strategy. The local authority's plans to create a network of locality-based groups reporting and feeding into the overarching Children in Care Council are not yet fully developed. This limits the Children in Care Council's reach and influence.

The graded judgement for adoption performance is that it is outstanding

Inspection findings

36. Children with a plan for adoption receive an outstanding service. Social workers actively consider adoption at the earliest opportunity for all children who need permanence outside of their birth families. Once a decision for adoption is made, highly effective planning enables children to live promptly with their adoptive parents. Norfolk ranks in the top 10% in the country for timeliness, according to the 2013–16 scorecard, and in the 12 months prior to inspection it has seen a further improvement and reduction in timescales.

37. A stronger emphasis on achieving early permanence for children across children's social care is evident, with proactive intervention in relation to 'foster to adopt' placements. The local authority now has an established and highly effective system that has resulted in increased numbers of 'foster to adopt' placements, year-on-year. At the time of the last inspection, there was one such placement. Since then, 27 children have benefited from placement with 'foster to adopt' carers and 17 have secured adoption orders. The difference that this is making to children's lives is powerfully illustrated by the case of a baby who had been cared for by her 'foster to adopt' carers just hours after her birth, ensuring continuity of care. Photos and videos of the baby with both her birth parents and 'foster to adopt' carers, captured by the social worker, will provide a valuable, lasting memory.

38. Managers robustly track the progress of all family-finding activity to minimise delay. They have been rigorous in their attempts to identify adoptive families for older children (23% are over five years of age) and children with complex needs, including several groups of brothers and sisters. Family-finding profiles are thoughtful and well written to balance the positive characteristics of the children with realism about the challenges that they face. Thinking about specific children with specific adopters starts early. Potential matches, often identified during proceedings, have led to children being placed quickly. The service works hard to identify culturally appropriate matches according to the identity needs of children.

39. Work in conjunction with the local university has transformed the quality of transition support for children moving from their foster carers to adoptive parents. This sensitive and considered approach provides a powerful example of how to safely transfer a child's attachment to their new family. Plans are individualised according to the needs of each child, with a focus on continuity of environment and relationships. Foster carers are supported both emotionally and financially to help children to make a quick and appropriate move to their adoptive family. The impact of this approach is making a significant difference to children, particularly those experiencing trauma and

separation anxiety, who make successful and rapid attachments to their adoptive parents.

40. Post-adoption support packages are comprehensive and individualised to the specific and often highly complex needs of children. Highly skilled, trained and motivated workers, including sessional specialists if needed, deliver these well. Support is well coordinated and intensive work by therapists prevents adoption from breaking down. There is imaginative and effective use of the adoption support fund. The local authority matches funds of complex packages for children with a high level of needs. Vulnerable birth family members receive sensitive help to engage in letterbox contact and are signposted to further support and counselling services, if appropriate.

41. Norfolk receives a high number of enquiries and applications from prospective adopters, and it approves a higher proportion of applicants than the England average. In 2016–17, 60 applications resulted in 43 adopters being approved. The local authority welcomes diversity and, as a result, it approves adopters to meet the wide range of cultural and complex needs of children with an adoption plan.

42. The adoption panel reports on the progress of life-story work. Examples seen are of a good standard, and adopters have a draft copy when the child first goes to live with them and a completed copy by the time of the adoption order. The quality of prospective adopters' reports is consistently good, well written and analytical. The risks and benefits of 'foster to adopt' are thoroughly explored in the assessments, and this is followed up in a second-opinion visit. All adopters spoken to report a very positive experience of the adoption panel process and of Norfolk as an adoption agency.

The graded judgement about the experience and progress of care leavers is that it requires improvement

Inspection findings

43. The care leaver service has made steady progress since the last inspection. Social workers, personal advisers and their managers astutely judge the level and the nature of the support that care leavers need, often maintaining daily contact where the complexity of need requires it. They encourage care leavers to take responsibility for their own actions and go to great lengths to maintain contact with those who are particularly vulnerable. Social workers and personal advisers are now regularly in touch with a high proportion (94%) of care leavers, a considerable improvement on previous years.

44. Social workers and personal advisers prioritise care leavers' safety. They make good use of their influence with specialist hostels, substance misuse agencies and the police, to enable young people to stay safe.

45. Aided effectively by their managers, social workers apply discretion in supporting care leavers financially for day-to-day contingencies, including, for example, travel to enable attendance at church or the provision of mobile phones to keep safe. Care leavers who are parents receive the support that they need to live independently and care for their children.

46. However, not all areas of practice are yet good. In most cases, young people are well prepared for independence. Nonetheless, inspectors saw examples where young people were transferred too rapidly to the leaving care team, without adequate preparation. The restructure of the service resulted in a large volume of transfers in a short period. Pressures in staffing capacity in the receiving team meant that key actions, such as visits to young people, assessments and pathway plans, were not timely. (Recommendation)

47. Pathway plans are generally of good quality, and contain appropriate targets and contingency arrangements. The timeliness of pathway plans has improved, but it has some way to go before it is consistent.

48. Most care leavers spoken to by inspectors had registered with general practitioners and dentists. They knew about their health history, but not all, especially those aged 18 and over, possessed written health histories. (Recommendation)

49. Increasingly effective and targeted support has brought about a reduction in the proportion of care leavers who are not in education, employment or training (NEET). Over the past six months, there has been an increase from 63% to 66% of 16 to 25-year-old care leavers in education or employment. Apprenticeships and work experience opportunities are available through the county council, but more needs to be done to promote increased opportunities within the council and its larger contractors. A higher proportion of care leavers than in comparators move on to university.

50. The proportion of care leavers who are supported to 'stay put' with their foster carers has steadily increased. Nevertheless, there are some challenges in finding suitable accommodation, with a particular shortage of accommodation for the most complex and often vulnerable care leavers. Not all district council housing departments are sufficiently responsive to the needs of care leavers. Senior managers fully recognise these weaknesses, and the children's services improvement plan identifies key actions to improve the accommodation offer for care leavers.

51. Young people are aware of their entitlement to a care-leaving grant and other forms of financial support, which they access readily. The '16-plus promise' sets out clearly care leavers' financial entitlements, pathway-

planning arrangements and information about the support provided to them. It reminds care leavers of the complaints and advocacy procedures. An annual celebration event provides an opportunity to celebrate a host of achievements by care leavers over the year.

Leadership, management and governance	**Requires improvement**

Inspection findings

52. Continued changes to the senior leadership team since the time of the inspection of children's services in 2015 have hampered the local authority's progress in tackling critical weaknesses. Progress has accelerated over the past 12 months, under the leadership of a new interim DCS and with a more focused improvement plan. The newly established improvement board, chaired by the chief executive, has been effective in ensuring shared ownership of the actions across the partnership to improve services for children.

53. Effective and purposeful relationships are in place between the chief executive, lead member, DCS and the chair of the Norfolk Safeguarding Children's Board. The corporate parenting board and children's committee focus on children's experiences and provide challenge. However, recent changes to the structure and membership of these important decision-making forums mean that work is not sufficiently far progressed to demonstrate impact.

54. Children have a consistently high profile across the council and there is cross-party political support for children's services. A corporate initiative to promote permanence has been effective in securing children's long-term stability with their kinship or foster carers through the 'no detriment' policy. The local authority's commitment to 'foster to adopt' arrangements, which enable children to be cared for by prospective adopters at the earliest opportunity, has been successful in securing timely permanence for children.

55. Senior and political leaders have worked resolutely to respond to the recommendations of the last inspection but have not successfully delivered all the changes required. Inspectors identified ineffective systems and shortfalls in capacity in the MASH, resulting in delays in some contacts being progressed.

56. The strategic response to child sexual exploitation and children who go missing is underdeveloped. Operational systems are in place to manage the risks of children who are sexually exploited and those who go missing. However, governance of the strategic groups overseeing child sexual

exploitation is not yet sufficiently clear. MASE meetings, where the cases of children who are missing are considered, take place, but these do not always inform day-to-day planning for the child. Return home interviews take place but are not consistently recorded. These weaknesses mean that the approach to managing risk for these children is not yet consistently effective. The senior leadership, in conjunction with partners, is aware of these weaknesses and is currently reviewing this aspect of services. (Recommendation)

57. Commissioning arrangements and sufficiency strategies are not fully aligned to ensure that services meet the needs of children and families. Sufficiency planning lacks a comprehensive needs analysis to inform the development of commissioned arrangements. A wide range of commissioned services are in place, but the commissioning strategy is not underpinned by an action plan and lacks a clear framework for measuring impact to inform future work.

58. Significantly strengthened performance information provides a much-improved understanding of what is happening for children across the service. The use of performance information is increasingly effective but does not yet capture all the information needed to drive service improvements. For example, the local authority does not yet monitor planned and emergency entries into care, yet this would provide valuable data to inform its needs analysis in respect of edge of care services. Managers are now effectively using performance reports to support them in driving children's plans. Performance and challenge surgeries bring a much-needed focus on performance and ensure a critical line of sight on practice for the senior leadership team. Managers of children's services are addressing capability and poor performance, when identified.

59. A comprehensive rolling programme of casework and thematic audit is now in place across children's services. However, there is work to do to strengthen the analysis of audits and to ensure that action plans focus on the right areas for improvement. Not all managers are undertaking audits in accordance with the expectations of the quality assurance framework, which means that the local authority does not yet have a holistic picture of performance across all localities and service areas.

60. Senior leaders have an accurate understanding of the strengths and weaknesses of the service, demonstrated in the local authority's self-assessment. They used this knowledge effectively to inform the implementation of the recent restructure. Although this is beginning to achieve results, there is some way to go to achieve consistency of practice across the service. Not all localities have yet embedded the changes, and this has led to instability for some children due to transfers of social worker. There has been success in reducing caseloads to more manageable levels, but caseloads remain too high in some parts of the service, particularly the assessment teams. Some teams, particularly the MASH, continue to have

high ratios of agency social workers, and there has been some churn and staff turnover. (Recommendation)

61. The local authority recruitment strategy is innovative and realistic, and it provides a framework to attract and retain social workers from a variety of sources. This focuses on 'Step-up to social work', newly qualified social workers, returners to social work and a benefits package to encourage relocation to Norfolk. This has assisted in the increased stability in the workforce. The NIPE has had, and continues to have, a very positive impact on recruitment and retention, and is driving up practice standards. Social workers who have come through the NIPE talk very positively about their experiences and the quality of support and supervision provided.

62. Social workers and managers enjoy working for Norfolk and appreciate the regular supervision that they receive and the support from senior managers, whom they describe as approachable and visible. In most children's cases seen by inspectors, managers provide regular supervision. However, not all supervision supports reflection well or provides sufficient direction to assist and challenge social workers to effectively progress children's plans.

63. Workforce surveys, audit findings, learning from complaints and serious case reviews inform training needs. A comprehensive catalogue of training is available through the Norfolk Social Care Academy and the Norfolk Safeguarding Children Board.

64. Children are effectively supported to make complaints, with the help of an advocate when needed. Norfolk Children in Care Council has been engaged in planning improvements for the service and has contributed its views to better inform practice to improve outcomes for children.

Information about this inspection

Inspectors looked closely at the experiences of children and young people who have needed or still need help and/or protection. This also includes children and young people who are looked after and young people who are leaving care and starting their lives as young adults.

Inspectors considered the quality of work and the difference that adults make to the lives of children, young people and families. They read case files, watched how professional staff work with families and each other and discussed the effectiveness of help and care given to children and young people. Wherever possible, they talked to children, young people and their families. In addition, the inspectors evaluated what the local authority knows about how well it is performing, how well it is doing and what difference it is making for the people whom it is trying to help, protect and look after.

The inspection of the local authority was carried out under section 136 of the Education and Inspections Act 2006.

Ofsted produces this report of the inspection of local authority functions and the review of the Local Safeguarding Children Board under its power to combine reports in accordance with section 152 of the Education and Inspections Act 2006.

The inspection team consisted of six of Her Majesty's Inspectors (HMI) from Ofsted.

The inspection team

Lead inspector: Donna Marriott

Deputy lead inspector: Mandy Nightingale

Team inspectors: Anne Waterman, Nigel Parkes, Marcie Taylor, Tony Gallagher

Senior data analyst: Matthew King

Quality assurance manager: Lynn Radley

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Piccadilly Gate
Store Street
Manchester
M1 2WD
T: 0300 123 4234
Textphone: 0161 618 8524
E: enquiries@ofsted.gov.uk
W: www.ofsted.gov.uk