Norfolk County Council

Inspection of services for children in need of help and protection, children looked after and care leavers

and

Review of the effectiveness of the Local Safeguarding Children Board[1]

Inspection date: 6 July 2015 – 30 July 2015

Report published: 19 October 2015

Children's services in Norfolk are inadequate
There are widespread or serious failures that mean the welfare of looked after children is not safeguarded and promoted. It is Ofsted's expectation that all children and young people receive the level of help, care and protection that will ensure their safety and help prepare them for adult life.

1. Children who need help and protection		Requires improvement
2. Children looked after and achieving permanence		Inadequate
	2.1 Adoption performance	Requires improvement
	2.2 Experiences and progress of care leavers	Inadequate
3. Leadership, management and governance		Requires improvement

[1] Ofsted produces this report under its power to combine reports in accordance with section 152 of the Education and Inspections Act 2006. This report includes the report of the inspection of local authority functions carried out under section 136 of the Education and Inspections Act 2006 and the report of the review of the Local Safeguarding Children Board carried out under the Local Safeguarding Children Boards (Review) Regulations 2013.

Contents

The local authority

Information about this local authority area[2]

Previous Ofsted inspections

- The local authority operates nine children's homes. Seven were good or outstanding in their most recent Ofsted inspection. Two were found to require improvement.
- The previous inspection of the local authority's arrangements for the protection of children was in January 2013. The local authority was inadequate.
- The previous inspection of the local authority's services for looked after children was in July 2013. The local authority was inadequate.

Local leadership

- The interim Director of Children's Services (DCS) has been in post since July 2013.
- The chair of the Local Safeguarding Children Board (LSCB) has been in post since February 2014.

Children living in this area

- Approximately 166,507 children and young people under the age of 18 years live in Norfolk. This is 19% of the total population in the area.
- Approximately 17 % of the local authority's children are living in poverty.
- The proportion of children entitled to free school meals:
  - in primary schools is 16% (the national average is 17%)
  - in secondary schools is 12% (the national average is 15%).
- Children and young people from minority ethnic groups account for 6% of all children living in the area, compared with 22% in the country as a whole.
- The largest minority ethnic groups of children and young people in the area are Mixed and Asian or Asian British.
- The proportion of children and young people with English as an additional language:
  - in primary schools is 8% (the national average is 19%)
  - in secondary schools is 6% (the national average is 14%).

[2] 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.

- A large Traveller and Eastern European population seek seasonal work in the agricultural parts of the county, but are not resident. Estimates show that between 1,000 and 1,200 Traveller children of school age either visit or live in Norfolk per year. This makes them one of the largest ethnic minority groups in Norfolk. Norfolk's non-white population is predominantly urban although migrant workers and Travellers are more likely to live in rural areas.

Child protection in this area

- At 30 June 2015, 4,534 children had been identified through assessment as being formally in need of a specialist children's service. This is a reduction from 7,361 at 31 March 2014.
- At 30 June 2015, 522 children and young people were the subject of a child protection plan. This is a reduction from 537 at 31 March 2014.
- At 31 March 2015, 17 children lived in a privately arranged fostering placement. This is a reduction from 20 at 31 March 2014.
- Since the last inspection, seven serious incident notifications have been submitted to Ofsted and eight serious case reviews have been completed or were on-going at the time of the inspection.

Children looked after in this area

- At 30 June 2015, 1,052 children are being looked after by the local authority (a rate of 63.2 per 10,000 children). This is a reduction from 1,150 (69 per 10,000 children) at 31 March 2014. Of this number:
  - 181 (or 17%) live outside the local authority area
  - 95 live in residential children's homes, of whom 25% live out of the authority area
  - 18 live in residential special schools,[3] of whom 55% live out of the authority area
  - 809 live with foster families, of whom 17% live out of the authority area
  - 28 live with parents, of whom 4% live out of the authority area
  - nine are unaccompanied asylum-seeking children.
- In the last 12 months:
  - there have been 103 adoptions
  - 30 children became subject of special guardianship orders
  - 484 children ceased to be looked after, of whom 6.4% subsequently returned to be looked after

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

- 125 children and young people ceased to be looked after and moved on to independent living
- 17 children and young people ceased to be looked after and are now living in houses of multiple occupation.

Executive summary

Following previous inspections, where services for the protection of children and looked after children were judged inadequate, the local authority implemented a wide-ranging series of improvements across the service for children and families. The systemic failures identified in these inspections led to the establishment of an improvement board in early 2013 and the appointment of a new interim Director of Children's Services in July 2013. A directions notice and the scope of improvements required were issued by the Secretary of State in December 2013.

The impact of the current senior leadership team and elected members has led to improvements in some parts of the service, most notably for children in need of early help and for those children at risk of harm and in need of protection. However, despite these efforts, widespread failings for looked after children and care leavers means that services in Norfolk remain inadequate.

Looked after children and care leavers do not receive a good enough service. Sixteen looked after children do not have an allocated social worker. Foster carers working hard on behalf of the children they look after spoke of their frustration at how hard it is to get a response to queries from some social workers. Delays and drift in planning for children are frequently seen in casework, with little evidence of challenge by the independent reviewing service. Planning for permanence, placement choice, health assessments, educational outcomes and access to advocacy services for looked after children remain weak and, while there is some evidence of progress, this has not been fast enough to secure improved outcomes for most children.

Support for care leavers is inadequate. At the time of the inspection the local authority had lost contact with 25% of its care leavers, including 26 of its most vulnerable children aged 16 and 17. The quality of pathway plans is poor and this contributes to difficulties the local authority has in supporting vulnerable young people leaving care. Health, educational and employment needs are not always adequately addressed.

The pace of improvement in services and outcomes for these children and young people has been too slow and, as a consequence, looked after children and care leavers do not consistently benefit from a range of services that meet their needs. This lack of progress remains a significant detriment to them. The authority recognises the need to drive improvements for looked after children and care leavers at a much swifter pace.

While improvements have been made in some parts of the service, the senior leadership team know that these are constrained by the scale of the work still required to do. The application of thresholds across the service, while improved, continues to be inconsistent and a critical area of concern. The quality of practice is too variable and ranges from inadequate to good. Assessments for children in need of help are not consistently completed and recorded promptly. Contingency arrangements to ensure children are safeguarded while child protection enquiries are underway are weak. Some child protection plans end too early with a higher number

of plans ceasing after three months; consequently, there is an increasing number of children needing further help and a plan for a second time. Return interviews when children go missing are not always completed promptly. Minutes from multi-agency sexual exploitation meetings are not always used effectively to inform planning.

A multi-agency safeguarding hub (MASH), including a dedicated child sexual exploitation team, has provided a single point of entry for all contacts and referrals. Co-location of partners and effective information-sharing provide a joined-up approach to children who go missing and child sexual exploitation, female genital mutilation and radicalisation. Management oversight is not sufficient to ensure assessments are consistently completed on time.

The 'Signs of Safety' approach to child protection practice is providing an established framework to help identify risk and protective factors and is beginning to achieve improvements in social work practice. Most children are seen and seen alone, and benefit from direct work by skilled practitioners. Children are engaged effectively in the child protection process and are supported to attend case conferences. Edge of care services are reducing the need for children to come into care.

An effective and innovative range of local-authority-run projects are in place across the county and are highly valued by those who use them. These include 'Look Forward', a project to support mothers who have had children removed from their care, and the successful NIPE project (Norfolk Institute for Professional Excellence), which is a dedicated service to recruit and develop newly qualified social workers.

Performance data remains unreliable. Outcomes from audits are not always used well to help identify and address training needs. Supervision and the rationale for decisions are not consistently recorded. However, better oversight and scrutiny by senior leaders and elected members and substantial financial investment in services have been made. Re-defining the council's priorities for children, organisational and workforce changes, improving partnership arrangements, prioritising early help and frontline social work are all examples of where sustained improvements can be demonstrated. The authority is more outward-looking; leaders and managers are learning from good practice in other local authorities.

The scale of the task and the journey towards improvement is illustrated well in the children's services improvement plan 2014–16. The local authority is able to chart the progress it is making and can demonstrate an upward trajectory for some parts of the service. The improvement board ceased in September 2014, and a joint venture between the Department of Education (DfE) and Norfolk County Council saw an improvement advisor appointed to further monitor progress.

Notwithstanding the improvements made since the last inspections and the progress achieved, widespread weaknesses remain in key parts of the service and, as a consequence, the overall effectiveness of the service remains inadequate.

Recommendations

1. Strengthen management oversight in the MASH to improve the quality of decisions being made, so that children who require a social work intervention are assessed quickly and assessment findings are recorded promptly (paragraph 25).

2. Ensure strategy discussions include a comprehensive interim plan and contingency arrangements so that children are safeguarded while section 47 enquiries are underway (paragraph 28).

3. Ensure that managers regularly review child in need and child protection plans to monitor the progress families and children are making and that risk is being reduced effectively (paragraphs 33, 34).

4. Ensure robust arrangements are in place when decisions are being made to step down children's cases from child in need and child protection plans at the early stages of intervention (paragraph 33).

5. Ensure that all children and young people who go missing from home and care have a return home interview and that the interview is recorded and used to inform subsequent risk assessment and planning (paragraphs 40, 41, 64).

6. Ensure that child sexual exploitation risk assessments and minutes from multi-agency sexual exploitation meetings (MASE) inform subsequent planning for children and young people (paragraphs 43, 63).

7. Develop robust arrangements to track the Public Law Outline process for individual children and ensure that work is timely and reviewed effectively (paragraph 51).

8. Implement the following areas for improvement from the previous looked after children inspection:

   - improve capacity within the Independent Reviewing Service so that caseloads are reduced and social work practice is better scrutinised to prevent drift and delay for children (paragraphs 58, 59, 127)
   - improve the timeliness and quality of health assessments for looked after children (paragraph 54)
   - improve the quality of personal education plans for looked after children (paragraph 55)
   - encourage more looked after children to take up advocacy to enable them to fully participate in their reviews (paragraph 60).

9. Ensure that permanence plans are identified by children's second reviews and that, where children need long-term foster placements, they are formally matched with carers (paragraphs 59, 66).

10. Improve the quality of analysis of the child's needs within child permanence records and undertake 'together or apart' assessments for brothers and sisters earlier in the permanence process, to ensure the right decisions are made for individual children (paragraphs 86, 89).

11. Where appropriate, ensure that the 'foster to adopt' initiative is considered at the earliest opportunity for children (paragraph 91).

12. Improve arrangements for keeping in touch with all care leavers (paragraphs 100, 101, 102).

13. Ensure that pathway plans have clear identified goals and actions, that risks are addressed and that plans appropriately monitor progress and are reviewed (paragraph 102).

14. Provide health passports to ensure care leavers have easy access to their health information and history (paragraph 103).

15. Strengthen the commissioning and sufficiency strategy to improve placement choice (paragraph 117, 120).

16. Improve the accuracy of performance data (paragraph 124).

17. Use quality assurance audit findings to help identify and address training and development needs of the workforce (paragraph 125, 128).

18. Further strengthen management oversight and supervision, so that the rationale for decisions that affect individual children's lives is consistently recorded and explained in their records (paragraph 128).

19. Evaluate the long-term impact and outcomes of the NIPE scheme for children and for staff, to share learning and continue to embed the culture of supported and reflective practice (paragraph 131).

Summary for children and young people

- Senior managers in Norfolk have worked hard to improve services for children and young people. Some parts of the service have improved since the last time the county was inspected in 2013, but services for looked after children and care leavers are still not good enough.
- Children and families can now get help from services when they first get into difficulties. This means that families are getting support more quickly, which stops problems getting worse and means that children do not need a social worker.
- Some social workers do really good work which children and young people say has helped them. This is an improvement, but there are still too many families who do not get the right help at the right time.
- Children and young people are not always taken into care quickly enough, so that some stay in neglectful situations for too long. Sometimes the council tries to keep children with their families when this is not the right thing for them. Once the council makes the decision to take children into care, it does this quickly.
- When children need to become looked after by the council, they go to live with carers who support them. However, there are not enough foster families from ethnic minority families for all the children who need them. This means that sometimes children and young people have to live with families from a different cultural background from their own.
- Children and young people who are looked after by the council usually go to good schools but their personal education plans are not good enough.
- Although carers look after young people and children well, the council is not quick enough at finding lasting families for children who cannot live with their own families any more. This means that children can be unsettled while they are waiting for a new, permanent family.
- The Norfolk In-care Council (NICC) has helped to organise celebration events for children and young people who are looked after and has helped the council to start improving services. This means inspectors are confident that children and young people are listened to.
- The council does not keep in touch with enough of the young people who have left care. This means that they might not be getting the support that they need and are entitled to.
- Nearly all of the care leavers who are in touch with the service live in safe places and have a choice of places to live. Young people who go to university are well supported, but the same level of support is not offered to people going to college. This might put some people off going to college.

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

Summary

Early help services in Norfolk are becoming increasingly effective in supporting children and families before their needs reach the point of requiring social work intervention. The local authority is working closely with health visitors, school nursing, and the Family Nurse Partnership to provide a coordinated response to early help support for vulnerable families and children. Children requiring early help receive appropriate support; however, interventions and help are not always recorded in a family support plan.

Decision-making in the MASH for early help services or children requiring social work support is not yet consistently good and, as a result, some children do not receive intervention when their needs indicate this is required.

When children and young people are identified as being at immediate risk of harm, the response is timely and proportionate. However, some strategy discussions do not give sufficient consideration to interim protection arrangements or contingencies.

Child protection enquiries are carried out by social workers who see children on their own. Most result in a timely decision to progress to a child protection conference if unresolved risks are identified. Partner agencies participate in child protection conferences and core groups, which ensures that progress is regularly reviewed. Children and young people are effectively engaged in the child protection process and supported to attend meetings where appropriate.

Children in need are assessed and receive appropriate services, but their assessments take too long to complete. For some children, child protection plans are ended too soon, before sustained changes to reduce risk can be evidenced. In some circumstances, children in need and child protection plans have not been sufficiently robust in identifying or responding to the cumulative impact of neglect.

Children and young people are seen and seen alone and benefit from direct work in response to identified need or risk.

Risk of child sexual exploitation is identified well, but there are some inconsistencies in how risk assessment processes inform subsequent planning and intervention. Return interviews are taking place where children go missing, but they are not consistently recorded and are not always used to influence subsequent planning and risk management.

Inspection findings

20. Since the last inspection, leaders and managers have developed a well-conceived early help strategy that is being rolled out systematically across the county. Early help 'hubs' in each locality have effectively engaged a wide range

of partner agencies in delivering the early help offer. The co-location of local services is improving multi-agency working and providing a more diverse network of professionals who have oversight of children's welfare. The number of families who receive early help increased by 364 between June 2014 and June 2015 to 2,564.

21. The family support process (FSP) has replaced the common assessment framework (CAF). In most FSP cases sampled by inspectors, there is good oversight of children's welfare and improved access to support services for children and their families. When children's needs become more acute, family support workers rightly escalate these cases through to the MASH. The local authority has put in place processes to transfer cases between children's social care and early help as children's needs reduce or escalate but these processes are not consistently applied. Meetings prior to transfer do not always take place and as a consequence information-sharing is too variable. Current management information systems do not provide sufficient insight into the effectiveness of early help in universal services such as schools and children's centres. A new management information system is being introduced to ensure better recording and information-sharing between all those involved in delivering and supporting early help across the county.

22. Managers have improved the performance of the troubled families programme (Norfolk Family Focus Service) over the last year. To date, approximately 1,700 families have been supported and helped out of the 2,200 engaged. Smaller-scale programmes are also having a good impact on outcomes for children. The local authority is working with a local football club, which offers a programme of education and sport that strengthens family relationships. Outcomes include improved school attendance for children. The 'Look Forward' and peer mentoring programmes in Great Yarmouth support vulnerable mothers well, to build their capacity to parent when they have previously had children removed from their care. This has led to some children who have been in the care of the local authority being successfully reunited with their families.

23. The MASH acts as a first point of contact for members of the public, professionals and families where there are concerns about children's welfare. Key agencies are co-located in the MASH, including children's social care, adult social care, police, health, independent domestic violence advisory services, probation and a local project working with children and young people at risk of sexual exploitation. Housing, mental health services and education also provide a virtual link to the MASH to support more effective ways of information-sharing.

24. Co-location of services within the MASH is effective in ensuring information is shared swiftly between agencies and provides opportunities for a better joined-up approach to work in respect of missing children, child sexual exploitation, female genital mutilation and radicalisation. The multi-agency response is well developed, with clear procedures in place to support the development of this work. Norfolk is working closely with a national charity, using its expertise to

help raise awareness of the issues locally. A plan to increase capacity in the MASH with a dedicated worker aims to enhance further the council's approach to female genital mutilation.

25. The quality of threshold decision-making is not yet consistently good. A wide range of agency checks is undertaken by social workers in the MASH and consent is consistently sought from parents for information to be shared. A small minority of children in need referrals seen by inspectors should have resulted in an assessment or further action where a decision was made by managers in the MASH for no further action. Examples were also seen where parents were left to set up support through early help arrangements themselves when their children were identified as not meeting the threshold for social work intervention. The local authority has sought to strengthen this by providing additional managerial capacity, training staff and placing an early help partnership assistant in the MASH. These improvements have not yet brought a consistent response to all referrals.

26. A large number of contacts to the MASH result in no further action being taken after initial screening. This impacts on capacity within the MASH. The police make the highest number of contacts, of which only a small minority (17% in June 2015) result in a referral. Supported by the Norfolk Safeguarding Children Board (NSCB), children's services had already undertaken work to address this with the police before the inspection. As a result of this proactive work, from August 2015, the police plan take responsibility for screening their information to ensure that contacts which progress to children's social care services are more appropriate.

27. The Norfolk multi-agency threshold guide sets out referral pathways and levels of intervention. It is evident that some professionals across the partnership are not yet clear in applying thresholds, given the high proportion of contacts that do not progress to referral or are stepped down too early. Social work advice is available in the MASH to support professionals regarding threshold decisions.

28. When children and young people are identified as at immediate risk of harm, the response by the MASH is timely and proportionate. The MASH convenes a strategy discussion and includes the duty team, which takes responsibility for the subsequent child protection enquiry. Strategy discussions convened by the MASH include appropriate agencies. Risk and protective factors are highlighted and actions identified, but interim protection and contingency arrangements while child protection enquiries are being undertaken are not yet good.

29. Child protection enquiries are carried out by social workers who see children on their own and carefully consider their experiences. The Signs of Safety framework is used well to consider risk and protective factors and social workers respond appropriately to those children in need of help and protection. Enquiries include the key agencies. Where enquiries identify a need for an initial child protection conference, this is timely in most cases. The local authority has made significant progress in this area, improving performance from 59% of

initial conferences being completed within 15 days of a strategy discussion in 2013–14, to 86% in June 2015.

30. The assessments of children in need of support are not timely. In June 2015, only 48% of assessments were completed within appropriate timescales. This is an area in which the local authority has struggled to make progress, despite the recommendations of the previous inspection. Most children are seen in a timely manner by duty teams when they are first referred, and they are accessing services, but their assessments are often written up late. The impact of this is that some families wait too long to know the outcome of the assessment and in a small number of cases experience some delay in receiving services. The local authority recognises this is an area that requires improvement and is taking steps to improve it with the introduction of the single assessment and increasing the capacity within the assessment teams in the planned restructure of the service in September 2015.

31. Although too many assessments take too long to complete, it is evident that progress has been made to improve their quality. Many assessments seen are now of a good quality, use the Signs of Safety framework and include an effective analysis of risk and protective factors to support effective planning for children to better target their individual needs. They evidence individual need, the child's and the parents' views (including non-resident parents) and family history, and they consider children's ethnicity and their cultural needs.

32. Direct work with children and young people is consistently evident across the service. Inspectors saw some examples of effective work to help reduce problems. Children are contributing well to their plans. A range of direct work was seen in the children with disabilities team, carried out with the support of parents and professionals, such as occupational therapists, to ensure an holistic approach to identifying and addressing children's needs. Most social workers demonstrate a good understanding of children's circumstances and build trusting relationships with them.

33. Plans made for children in need seek to address key issues and involve a range of services being provided to improve outcomes. The local authority's performance data indicates some delays in child in need plans being reviewed, although in almost all cases seen by inspectors children had plans in place which had been reviewed regularly. Some child in need cases are stepped down or closed too early or with insufficient follow-up support in place. Children continue to experience difficulties and as a consequence some children are unnecessarily re-referred for services within a short period of time. Re-referral rates of 25% in May 2015 against a national average of 23% indicate that the authority's performance is not significantly worse than elsewhere. However, the local authority is closely monitoring re-referral rates to understand better the impact on children.

34. The quality of planning for all children in receipt of early help, children in need and children in need of help and protection remains too variable. Managers

quality assure most aspects of recording on children's electronic files and this is helping to improve the quality of recording and planning. Independent child protection chairs are responsible for developing and overseeing child protection plans. However, the majority of plans seen by inspectors are weak. Some do not sufficiently consider how change will be measured and lack clear timescales and contingencies. There is a quality assurance process in place to oversee the quality of the child protection planning but more work is required to strengthen this process. Independent chairs have very high caseloads, and this limits their capacity to track progress made between reviews and influence the quality of work undertaken.

35. Child protection conferences and core groups take place regularly and are well attended by professionals from across the partnership. Parents and, where appropriate, children and young people, are routinely invited. All children and young people over 10 years who are the subject of a child protection conference are referred to the advocacy service to support their participation. This service was reaching 88% of these young people in February 2015. Inspectors saw good examples where children had been supported to attend conferences, or to have their views reflected via their advocate. This is having a positive impact for some young people.

36. In the majority of cases, authoritative and timely action is taken where the risk of harm remains or intensifies. However, inspectors saw a very small number of cases where the cumulative impact of neglect was not recognised and so did not result in escalation. In these cases children remained for too long in harmful situations. At September 2014, over two thirds (67%) of children with a child protection plan had a plan as a result of neglect. This was substantially higher than both the statistical neighbour comparator level at 41% and the England average at 43%. While there has been a reduction, with the most recent single month's figure at the time of the inspection at 60% for June 2015, neglect continues to account for a very high proportion of child protection plans. The local authority has identified this as an area of weakness and has taken steps to address this by introducing the Signs of Safety framework as a model of intervention across the service. Further training on the graded care profile is also planned to strengthen practice in this area. Some 80 neglect champions have been identified across different council departments, including housing, to support early identification of neglect when visiting families. This role is relatively new and needs to be further developed, but the benefits the authority anticipates are likely to support good practice in the early identification of neglect.

37. A third of those children whose child protection plans ceased in 2013–14 had only been subject to a child protection plan for three months or less. Inspectors found a very small minority of these cases had been stepped down from child protection plans prematurely. While inspectors saw no cases where this had resulted in harm, this practice could expose children to further risk. This is an issue that the local authority is aware of, having noted a high proportion of children becoming subject to a child protection plan for a second or subsequent

time during 2015. This was at 23% in June 2015 against a national average of 16%. It is too early to suggest that this is a trend, as the rolling 12-month figure to the end of June 2015 is 17%, but the issue requires careful monitoring.

38. The local authority has a good understanding of the prevalence of domestic abuse, parental drug and alcohol misuse and the impact of parental mental ill-health. A range of services are in place to support children and their parents experiencing domestic abuse, including a local domestic abuse charity and a women's centre which provides a 'one-stop shop' for domestic abuse services. Arrangements are in place across the partnership to support the coordination of services for medium- and high-risk victims of domestic violence through the multi-agency risk assessment conference process (MARAC). Minutes seen by inspectors show that these meetings involved the appropriate agencies. Services are also in place to support parents with drug and alcohol problems and mental ill-health. The parent and infant mental health service attachment project is a good example of partnership working between children's social care and mental health services. This service is beginning to demonstrate evidence of impact in preventing children becoming looked after and in promoting better quality relationships for children.

39. There are 162 children missing education in Norfolk. There are well-established and robust processes for identifying and tracking them and those who are electively home educated. The local authority maintains an up-to-date list of children missing education and the circumstances of children are well known. The local authority undertakes all reasonable checks to establish the whereabouts of children missing education, including with health, housing and social care services, the Department for Work and Pensions and the UK border agency.

40. Cases of children who go missing are initially considered at the daily MASH meeting. The police missing children service is linked with the Safer Schools Partnership, and information-sharing is managed proactively through linked police officers and police community support officers. Police undertake safe and well checks and a commissioned service undertakes return interviews, unless children and young people are open to children's services, in which case their return interviews are undertaken by their allocated social workers. Return interviews are taking place but they are not consistently recorded and information from them does not always effectively inform subsequent planning and risk management.

41. Between 1 April 2015 and 5 July 2015, a total of 160 children and young people were identified as missing from home in Norfolk, of whom 50 received social work intervention. At the time of the inspection, there were no young people missing from home for more than 24 hours. Young people missing from home or care are supported through a commissioned project, which aims to reach out to vulnerable young people by engaging them with services through return home interviews. Where young people do not engage in return interviews,

project workers attempt to follow up through writing to the young person and their parents. In addition, project workers provide a range of support to young people including direct work, befriending and signposting.

42. Professionals across the partnership have a good understanding of child sexual exploitation and understand the steps they need to take when concerns are identified. A specialist multi-agency child sexual exploitation team is located in the MASH and undertakes screening of all young people identified as at risk of sexual exploitation. A total of 264 children and young people living at home were subject to screening between 1 April 2015 and 5 July 2015. At the time of the inspection, no children were identified as at high risk and 10 were identified as at medium risk.

43. Through a coordinated range of support and services across the partnership, children at risk of sexual exploitation are protected well. All cases of young people identified as at medium or high risk trigger ongoing intervention by children's services and are reviewed at a multi-agency sexual exploitation meeting (MASE). Some examples were seen by inspectors where young people had been subject to MASE meetings but the minutes and action plans arising from the meetings are not always evident on young people's files. Where concerns regarding child sexual exploitation are identified, social workers can identify the risks to the young people they are working with but not all could locate the risk assessment that had been completed in the MASH or articulate how the risk assessment and risk management plan take account of changes in the young person's situation.

44. Recent work by the police has provided a profile of victims of sexual exploitation, linked to missing children and perpetrators, and has effectively identified hot spot areas around the county. Work with the night-time economy, including taxi firms, licensing renewals by the district councils and hoteliers to raise awareness of child sexual exploitation is underdeveloped.

45. A range of services are available to support young people at risk of child sexual exploitation in Norfolk. A local project undertakes direct work with young people providing one-to-one befriending, awareness-raising and advice in order to reduce the risk of sexual exploitation. The local authority has also commissioned additional capacity through the voluntary sector to provide workers who will join social work teams in September 2015. This will enhance the assistance and expertise available to safeguard those young people most vulnerable to sexual exploitation.

46. Effective arrangements are in place to assess 16- and 17-year-olds who present as homeless in Norfolk. No young people were placed in bed and breakfast provision at the time of the inspection. A joint protocol for homeless 16- to 17-year-olds is well supported by the district councils and clearly identifies the process for assessing and meeting the needs of this vulnerable group. Young people presenting as homeless are assessed to consider appropriate accommodation options where a return home is not achievable, including

accommodation into the care of the local authority. A youth mediation service is supporting over 25 young people to remain at home or return home where they have been assessed as being on the edge of care or at risk of homelessness. Requests for accommodation are discussed at a transitions panel, established to provide the local authority with an overview of needs and ensure young people are aware of accommodation available to them.

47. The designated officer service responds to situations where allegations are made against professionals who work with children. The service was subject to a review by the local authority in 2014 and this led to clear governance and line management arrangements that are independent of children's social work services. The service provides a timely response to concerns and is responsible for chairing strategy discussions where cases fall within its remit. The quality of minutes and action plans is good and the officers involved are knowledgeable and appropriately questioning and challenging. Close partnership working was seen in cases sampled and the designated officer's role is well embedded.

48. The local authority has undertaken a range of work to raise awareness among the children's workforce of private fostering, although the number of notifications has remained in line with previous years, with 44 notifications in 2014–15. Oversight from a dedicated steering group and the implementation of a private fostering action plan has improved the help children receive once they are identified. The response to notifications is prompt and assessments of children and carers are of a consistently reasonable standard, although not all assessments are completed quickly enough. The local authority treats every privately fostered child as a child in need. Inspectors could see that this approach has benefited young people by making it easier for them to access services. The voice of the child is evident in the work seen and children and young people are visited regularly. The local authority has undertaken positive work to secure permanence for privately fostered children when it is in their best interests.

The experiences and progress of children looked after and achieving permanence	Inadequate

Summary

Outcomes for looked after children and care leavers in Norfolk are inadequate. The progress and pace of change, well evidenced in other parts of the service, have been too slow to deliver tangible improvements for looked after children. Too many recommendations from the 2013 Ofsted inspection have not been addressed adequately. While there are emerging and already realised strengths in the service, these are outweighed by some widespread and serious shortfalls in practice and service delivery.

Inconsistent application of thresholds for instigating the Public Law Outline means that some children spend extensive periods in the pre-proceedings stage with no review or progress against agreed actions. As a result, a small number of children and young people remain in unsuitable and unsafe situations, while other children have remained the subject of statutory orders for too long.

At the time of the inspection, 16 looked after children did not have an allocated social worker. In one team, 13 children remained unallocated for three months. In a number of these cases, serious delay and drift had occurred in progressing key meetings and decisions. Visits to looked after children are not always timely and in some cases undertaken by a duty worker so children are not always able to develop meaningful relationships with a named social worker.

Care plans are not based on a robust analysis of need, including consideration of permanence arrangements. For a small number of children, the initial decision for permanence through adoption is not made early enough. Independent reviewing officers' (IRO) caseloads are too high. Reviews are timely in the majority of cases but the level of drive, scrutiny and challenge from IROs is not sufficient to ensure that plans progress with pace. A legacy of poor planning for permanence means that not all children who need an adoptive family have had that opportunity. Recent practice has improved and a total of 103 children have been adopted in the last 12 months.

The educational attainment and progress of looked after children remain too variable. Educational plans are poor and do not identify how children will get the best possible chance to achieve at school. Children's and young people's access to timely initial health assessments remains poor.

The local authority is not in touch with 25% of its care leavers. It does not know what needs they have and is not safeguarding and supporting them well enough. Pathway plans for care leavers lack appropriate actions to ensure their needs are being met. Risk, health, education and employment needs are not adequately prioritised.

Inspection findings

49. The local authority's efforts to improve services have not yet had a meaningful and sustained impact on the experiences and progress of children looked after and achieving permanence, which remain inadequate. In particular, inspectors found poor oversight, inconsistent care planning, unallocated cases, insufficient attention to children's health and education, an overloaded independent reviewing officer service and very poor support for care leavers.

50. The application of thresholds and management decisions to look after children and young people in Norfolk are inconsistent. In a small minority of cases seen by inspectors, children remained in unsuitable and risky situations for too long before the local authority took appropriate action.

51. The inconsistent application of thresholds for instigating the Public Law Outline by children in need and safeguarding teams means that the majority of children subject to pre-proceedings letters spend extensive periods at this stage with no review or progress against agreed actions. The local authority has recognised the need to improve practice and oversight for these children and is working to strengthen pre-proceedings letters and track these cases more closely. However, this has not yet secured a more effective approach. At the time of the inspection, 32 cases (60 children) were subject to pre-proceedings, and 80% of these had not had a review of their circumstances. A lack of robust tracking, poor management oversight and inconsistent planning hamper timely decision-making about applications for legal orders. Delays at the pre-proceedings stage mean that some children experience unnecessary drift and delay in achieving permanent care arrangements.

52. A recent management review of looked after arrangements for 292 children and young people identified 20 children accommodated under section 20 of the Children Act 1989 for far too long where legal meetings or proceedings should have been instigated earlier to secure their status. A further 21 children and young people are living at home under Placement with Parents regulations and are waiting for the discharge of statutory orders. Six (20%) have been living with their parents for a number of years, remaining subject to statutory orders and looked after children regulations unnecessarily. The local authority has recently commissioned a local law firm to progress this work. The review has identified 35 children in care whom it would be appropriate to reunite with their parents, but just seven have successfully returned home so far. As a result, some children and young people live away from their families for too long.

53. At the time of the inspection, 16 looked after children had no allocated social worker. The majority of these children (13) were in one team in the north of the county and had been without their own allocated social worker for three months. A series of duty workers, who did not know or fully understand the care histories of these children, ensured they had visits in line with statutory requirements. However, these arrangements limit the opportunity for children to develop trusting relationships. In a number of these cases, serious delay and

drift had occurred in progressing key meetings. For example, in one case a four-month delay in convening a legal meeting following a decision to revoke a five-year-old child's placement order led to further delays in permanence planning. In another, a statutory review went ahead without a progress report or a social worker attending.

54. The timeliness of initial health assessments is poor. Only 9% of newly looked after children had a health assessment within 20 working days in the six months before the inspection. This means that for the vast majority of children and young people their health needs are not known or fully understood by the adults caring for them in the early days of their placement, and are not sufficiently considered in early planning. In 2013–14, performance in ensuring timely annual health assessments stood at 84% – just below the statistical neighbour average of 86% and an England average of 88%. According to Norfolk's own figures, performance has since declined further, with only 79% having an up-to-date assessment in June 2015. The proportion of Norfolk children with up-to-date dental checks was also low at 77% in 2013–14, compared with 81% for statistical neighbours and an England average of 84%. The authority's performance has improved slightly, with 81% of children having an up-to-date check in June 2015. The overall quality of the vast majority of health assessments viewed by inspectors was inadequate, with important information missing and plans not specific about what needs to be done, by when or by whom. It is recognised that improving performance in this area is a whole-system issue and that recent difficulties recruiting designated health professionals may have hindered progress. However, this remains a serious and significant weakness in the authority's ability to meet the health care needs of looked after children.

55. The quality of the vast majority of personal education plans (PEPs) is also poor. Information about attainment history is missing and targets are not specific or challenging enough. Children's and young people's views are not always evident. This suggests that PEPs are not used effectively to plan and evaluate support for children's education and to promote and raise children's aspirations. The local authority's own audit of PEPs (May 2015) identified a number of areas in which it is not meeting its statutory duties in this respect.

56. The local authority's own data demonstrates that one in 10 looked after children do not see their social worker as often as is required by statutory regulations. In a small minority of cases, the quality of social work support was poor, with long gaps between visits and an overall lack of purpose, leading to slow progress against the plan for the child.

57. The large majority of social workers spoken to know the children they were working with well and could articulate children's and young people's wishes, feelings, needs and any specific risks. However, written assessments and care plans do not always reflect this. Most care plans outline objectives for children, but are less specific about timescales for the work and the roles and responsibilities of agencies involved.

58. The independent reviewing service does not have the capacity to provide a good enough service for looked after children. Caseloads of individual IROs, at an average of 92 cases, significantly exceed the recommended average. This limits their capacity to effectively scrutinise, challenge, escalate and follow through identified deficits in care planning.

59. Most looked after reviews are timely. However, IROs are not developing consistent relationships with children and young people. They do not sufficiently influence the quality of practice or give enough consideration to permanence for looked after children at their second review. The local authority's own audit (April 2015) identified that care plans are not yet specific enough about actions and required progress. In June 2015, 60% of looked after children had attended their reviews, although this figure fluctuates and has been as low as 45% in two of the last nine months. More work needs to be done to ensure children and young people are encouraged either by attending or otherwise participating in their review, so that they contribute to their own care planning arrangements.

60. Looked after children have access to commissioned independent advocacy services, which help them express their views and influence decision-making. However, take-up is low with only 47 children and young people currently receiving advocacy services. Independent visitor services have reached capacity; 36 young people have an independent visitor, but a further 22 are waiting for a service. The use of advocacy in complaints is low, with advocates involved in only 27% of cases. The local authority is aware of this and has allocated additional funding to double the amount of advocates available, re-commissioned the advocacy service and is raising awareness of advocacy through social media, foster carers, social workers and the IRO service.

61. Management decision-making is evident in the majority of case files, but the rationale for the decisions is not clear. This means that important information about the reasons for decisions being made will be unavailable to children who wish to read their care files later in life. Chronologies are nearly always in place, but do not consistently provide a good overview of children's circumstances, diluting their usefulness to inform assessments, planning and reviews. Key documents, such as risk assessments, legal minutes, chronologies and health assessments, are not easy for social workers to find, with many not being available.

62. A high number – 334 (31.6%) – of looked after children live 20 miles from their home, a reflection of the largely rural nature of the county, with 181 (17%) living outside the county. One young person placed out of county was visited by an inspector and seen to be making good progress. However, the provider did not initially receive timely information from the local authority to inform risk assessments and planning. Nineteen children and young people living outside Norfolk have not had an annual health assessment and 13 have not had a timely review of their looked after arrangements.

63. The potential risks linked to children missing from care and child sexual exploitation are considered. The MASH completes all risk assessments for children at risk or potential risk of child sexual exploitation. At the time of the inspection, 41 looked after children had risk assessments. These had identified five looked after young people at high risk of child sexual exploitation, 13 at medium risk and 26 at low risk. In a minority of cases seen by inspectors, social workers found it difficult to locate key documents relating to the completed risk assessments. This dilutes the effectiveness of these critical documents in reducing risks and protecting children.

64. In the majority of cases, social workers complete return interviews following missing from care episodes, although these are of variable quality and do not sufficiently consider push and pull factors or use information to update care plans. Specific risks to children and young people and the actions needed to reduce repeat incidents are not always included in care plans. The local authority's own data identifies that between 1 April 2015 and 5 July 2015 there were 92 missing from care episodes involving 45 young people (34 Norfolk children and 11 children living in Norfolk placed by other local authorities). Twenty-four (53%) of these young people were living in residential care. When children have been missing more than three times in a 42-day period formal arrangements are in place to trigger a strategy meeting. However, social workers, particularly in the children in need, safeguarding and looked after children's teams, do not always follow these arrangements. As a result, children experience drift and delay in assessment and planning to identify and reduce the dangers associated with going missing.

65. The Admissions to Care Panel and the Children's Case Advisory Service Panel (CCAS) provide oversight of children entering care, designing packages to help them return to their parents' care or to do well in their placement. Where the care plan is for the child to return home, assessments consider risk. Reunification plans include a range of services to support families but do not routinely include contingency planning or a written format detailing the support plan.

66. Placement stability is in line with national averages, with the large majority (68%) of children remaining within the same placement for at least two years, affording them stability and security. For some children, short-term foster placements have drifted into long-term placements by default rather than as a result of decisions being based on a clear assessment. To support planning, the local authority intends to introduce a permanence panel to formally recognise these placements, where it is the best option for the child.

67. Norfolk operates four fostering panels across the county, each with an experienced chair. However, records of these meetings do not always reflect the detailed discussions held by panel to ensure that foster carers are able to meet the needs of children. As a result, there have been some missed opportunities to develop the skills of foster carers. The agency decision-maker

has not demonstrated enough scrutiny of these minutes to ensure the service has picked up themes and trends from panel minutes.

68. The local authority has developed effective working arrangements with the local court and the Children and Family Court Advisory and Support Service (Cafcass). When legal action is necessary, the timeliness of court proceedings is good at less than 23 weeks on average.

69. Inspectors saw positive examples of children and young people benefiting from contact arrangements to help them maintain relationships with people important to them. Family support workers supervise contact where necessary and provide reports to social workers. Some creative and persistent work by social workers has enabled looked after children to enjoy contact arrangements where relationships had previously broken down.

70. The local authority uses a strengths and difficulties questionnaire to identify children who may benefit from additional support. A looked after children's child and adolescent mental health (CAMHS) worker provides an effective consultation service to social workers and foster carers. At the time of the inspection, 90 looked after children were receiving a CAMHS service on a one-to-one basis, with the COMPASS project working with a further 26 children. Examples of effective work with children and young people were evident in cases sampled by inspectors.

71. The number of looked after children who have been cautioned for, or convicted of, an offence has fallen. In 2009–10, 6% of looked after children had been cautioned or convicted. In 2013–14, the figure was 4%. The local authority attributes this reduction to joint working with targeted youth services.

72. A range of responsive services is available to support children and parents and carers to prevent family breakdown. Edge of care services in Norfolk are having a positive impact in reducing the need for children to come into care. Close links have been established with a number of local boarding schools to widen options for those children on the edge of care where the risk of placement breakdown is of concern. Currently 23 children and young people are helped by the use of these schools. The local authority's outreach service has worked with 286 children and young people since August 2014. A very large majority of these (97%) remained in the care of their families. Other services, such as the Parental Infant Mental Health (PIMH) and COMPASS project, demonstrate effective support in keeping children in the care of their families.

73. Some good examples were seen of direct work with children supporting them to express their views. However, life story work is inconsistent, with some children in long-term care foster care still waiting for support to help them understand their childhood experiences and their histories, and what led them to be in care.

74. Equality and diversity issues such as ethnicity and faith are mostly well considered by social workers but are not always evident in assessments.

Inspectors saw examples of sensitive efforts to address children's cultural and religious needs. In one case, a young person was supported to visit their homeland to maintain contact with their extended family.

75. The Norfolk In-care Council (NICC) is a vibrant, well-supported group of young people who are fully involved in the development and commissioning of services. Children and young people were involved in a service pledge (The Promise) which helps to reinforce the rights of Norfolk's looked after children. A DVD entitled 'The Promise' is available for young children to help them understand what is happening to them. Children and young people spoken to by inspectors said they understood their rights and entitlements, and know how to make a complaint. Children and young people spoke positively about their relationships with their social workers and foster carers. Their achievements are celebrated. This gives them the opportunity to meet others and socialise, and enables them to build their confidence and self-esteem in group settings.

76. In the last 12 months, 30 children have left care through Special Guardianship Orders (SGO). For some children for whom the plan is special guardianship with family members, arrangements for temporary foster care approvals are not clear. Assessments to determine whether or not these arrangements are right for children and young people are not of consistent quality, and the status of some carers lacks clarity. The local authority supports over 200 children and young people under SGOs, residence orders and child arrangement orders.

77. Too many foster carer reviews are not being undertaken with the frequency required, with a small number being substantially outside the time limits set by the local authority. The voice of children and young people within foster carer reviews is absent. The lack of any representation of children and young people at foster carer reviews does not allow for a robust review process. Children and young people are not given the opportunity to comment on their care, and the local authority is missing an essential part of feedback to ensure carers are providing the best possible care.

78. A recently formed Fostering Advisory Partnership is working closely with the fostering service to support a number of policy and procedural changes, improve communication between foster carers and social workers and revise the training offer. The group ran a highly successful conference earlier in the year, inviting prominent experts in the field to support the development of the service.

79. Norfolk provides a range of task-centred fostering resources, with short-term, long-term and short breaks services. The local authority has also recruited specific carers within its foster care service for young people who would otherwise be held overnight in police cells (known as PACE beds). For children who require emergency accommodation through the out of hours service, there is a sufficient resource due to the local authority identifying spare capacity in some foster care placements. Foster carers have appropriate delegated authority to make day-to-day decisions for the children in their care and report

that while they feel confident about the limits of delegation they are not always sure that social workers understand the process, particularly around overnight stays.

80. Attainment and progress of looked after children vary between year cohorts and subjects. The local authority's own data shows that an increasing proportion of children in the Early Years Foundation Stage reached a good level of development in 2013/14. However, the proportion achieving this was still low at 28%. In 2013/14, children at Key Stage 1 achieved well in reading, writing and mathematics, generally better than looked after children in similar areas. Between 2012/13 and 2013/14, an increasing proportion of looked after children achieved the expected level of attainment in reading and writing at Key Stage 2, but a declining proportion in mathematics. The attainment of children at Key Stage 4 has declined over the last three academic years. In 2013/14, just 8% achieved five GCSEs including English and mathematics compared with statistical neighbours at 13.8% and the England average at 12%. This corresponded with an increasing proportion of children at Key Stage 4 with a statement of special educational needs.

81. The attainment gap between looked after children and their peers is not closing consistently, although some progress has been made. At Key Stage 1 the attainment gap closed well in reading, writing and mathematics between 2012/13 and 2013/14, for example by 10 percentage points to an 11 percentage points gap in reading. At Key Stage 2 the attainment gap between looked after children and their peers has reduced well each year for three years in reading and writing but it has grown in mathematics. At Key Stage 4 the gap in attainment between looked after children and their peers remains wide; indeed it has increased in the last three years.

82. Individual needs are considered well when placing children in schools, and the stability of children's education placements is good, with 90% of newly looked after children being able to maintain their education place throughout the academic year 2014/15. Only alternative education providers registered as good providers are used for the small proportion of looked after children who attend alternative provision. Increasing proportions of looked after children attend a good or better school, with 84% doing so this year.

83. The local authority's own data shows that the attendance of looked after children is comparable to all children in the county at 95.1%. Improvements in attendance for looked after children since the introduction of welfare calls has seen the percentage of sessions missed reduce, from 4.7% in 2012/13 to 3.8% in 2013/14. Persistent absences have also reduced from 4.8% to 3.7% over the same period (both lower than statistical neighbour and England averages). However, fixed-term exclusions for looked after children are increasing year on year. These are monitored through welfare calls. The virtual school is actively engaged in working with schools to reduce fixed-term exclusions and ensure a swift re-integration back into class.

The graded judgment for adoption performance is that it requires improvement

84. A history of poor planning for permanence through to adoption has led to some children staying in care for too long. Practice is significantly improving, and in the last 12 months 103 children have been adopted. A further 50 children have been placed or matched with potential adopters. The local authority has been successful in placing for adoption a higher number of younger children aged five years and under and recognises that progress has been too slow for older children, with only 11 children aged six to nine years being adopted in 2014–15. The proportion of children adopted who were aged five years or over based on a three-year average was 4% for 2011–14 and was below statistical neighbours at 6% and the England average of 5%.

85. In the last 12 months, almost three quarters (73%) of the children adopted were placed with their adoptive families, with an adoption order in place, within the national target of 487 days. Planning for young babies is also undertaken promptly, with a small number of very young children being placed with their adoptive parents and secured by an adoption order within 12 months. However, there is still too much variability in the timescales taken for progressing adoption in a number of individual cases. These range from 16 to 809 days from children entering care to moving in with an adoptive family.

86. In most cases, decisions on permanence are made within six months of the child entering care. For a small number of children, the initial decision to pursue legal permanence through adoption is not made early enough to progress their plans for adoption at the optimal time. This has taken over a year for six children.

87. Performance against the 2011–14 adoption scorecards shows an improving trajectory for the three-year average and one year performance for both the length of time between a child entering care and moving in with their adoptive family and between the local authority receiving authority to place and deciding on a match. It is better than the England average for both indicators although slower on average than statistical neighbours. This is a positive picture in relation to the number of children being adopted, with few children waiting to be matched.

88. The proportion of children adopted who were from minority ethnic backgrounds based on a three-year average was 13% for 2011–14. This has increased over time, albeit slowly, and was below statistical neighbours (17%) but higher than the England average (8%).

89. The quality of practice is too variable. The large majority of child permanence reports and adoption placement reports seen by inspectors lack sufficient depth and analysis to find the right families and inform good matching of children

with adopters. Realistic and important information about the impact of trauma and children's presenting behaviour are not always covered in sufficient depth. Assessments of whether brothers and sisters should remain together are not consistently carried out. These weaknesses highlight the need to strengthen management scrutiny and oversight of the quality of reports.

90. A legacy of poor decision-making in matching children with families has seen a recent rise in adoption disruptions with a small number (six) of very young children experiencing potentially avoidable disruptions in the last 12 months. Inspectors saw some examples of a few young children who had been placed for adoption without thorough preparation. They had not undergone any therapeutic intervention to enable the correct permanence plans to be considered. The local authority is aware of the lessons that need to be learnt from these disruptions to improve practice and inform future matching arrangements. However, this is not yet consistently evidenced within too many matching reports.

91. Fostering to adopt is underdeveloped. Over the last 12 months, only two children of the 103 adopted have benefited from this arrangement and only two foster to adopt families have been approved. Inspectors saw some examples of very young babies who should have had the opportunity to live with their adoptive family at a much earlier stage avoiding a placement move from foster carer to adopter. The local authority is now actively promoting and exploring foster to adopt arrangements and this can be seen in prospective adopter reports and adoption panel minutes.

92. Family finding for very young children whose assessed needs are for adoption is proactive and successful for most children. Referrals to the National Adoption Register are carried out quickly where there are no in-house adopters available who can meet the needs of the child. This is assisted by early identification of these children through adoption tracking and involvement of family finding staff early in the planning process. The adoption service uses activity days, referrals to the consortium and profiling campaigns to promote adoption and has an informative website that enables prospective adopters to make enquiries online. Adopters spoken to by inspectors say that they received a timely and welcoming response from the agency to their enquiries. Assessments of prospective adopters seen by inspectors are informative, analytical and offer a well-rounded picture of how the family would meet the needs of a child. There is, though, a lack of urgency in completing assessments of the majority of prospective adopters. In the last 12 months, only two fifths of assessments were completed within six months.

93. The adoption panel chair is experienced, well qualified and able to demonstrate an evaluative and analytical approach to the role. Panel training is focused on relevant issues. The adoption panel provides feedback to the local authority, but there is a need to strengthen its oversight to ensure reports are of consistently good quality to inform matching. There are shortfalls relating to the recruitment of more diverse panel members, such as from minority ethnic

groups, and appraisals being out of date for panel members. Plans are in place to address these. Minutes of meetings give sufficient detail for the agency decision-maker (ADM) to scrutinise recommendations. Recommendations are considered by the ADM and decisions are made in a timely manner.

94. Some adopters are waiting too long to be matched to children. In 2014–15, over half of approved adopters waited more than four months from the time of approval for a child to be matched with their family. There are currently 74 adopters without a placement. Approved adopters are diverse, with single families, dual heritage families and same-sex families available to meet the needs of a range of children.

95. Most initial adoption support plans lack sufficient detail. This means that it is difficult for adopters to see immediately where they can get support from and who to make contact with, should they require additional help. Good support plans are developed following an assessment of need and give a much greater level of detail relating to the specific needs of individual children and their families.

96. The adoption support service provides a wide range of support to children and their families. There is a waiting list of 20 children and their families requiring assessment for adoption support. While no families had waited longer than four months at the current time, caseloads within the support team are too high to meet the demand for assessment and services. The delay means that the local authority cannot be confident about the potential risk of breakdown in families whose support needs have yet to be assessed.

97. When direct adoption support is provided, it is of a high quality. Direct therapeutic work, such as 'Theraplay', is available through the adoption support team, helping children to make and sustain positive attachments and enabling adoptive parents to meet their child's needs more effectively. Where more individualised packages of specialist intervention are needed, they are provided through commissioned services and finance is not a barrier. Services are available both pre- and post-order where there is an assessed need. A total of 45 children and their families received direct adoption support in the last 12 months. One adopter stated 'the quality of aftercare is impressive', with adoption social workers easily contactable and 'on hand for support'.

98. The local authority offers adoption help to birth parents through commissioned services. Inspectors saw evidence of birth parents routinely being offered counselling and support. Direct and indirect contact are facilitated well, with 20 children and their birth families being supported directly with contact and almost 1,108 letterbox exchanges taking place over the last 12 months.

99. Not all children and their families are provided with life story books and later life letters as soon as they need them. When these are provided, they are of a high quality, personalised with the child's story and journey to adoption. They are attractively presented and sensitively written in a way that suits the child's

stage of development. One adopter spoken with by inspectors described their child's book as 'just lovely, it explains it so well, and is well presented'.

The graded judgment about the experiences and progress of care leavers is inadequate

100. The local authority is responsible for 766 care leavers. Of these, 576 have an allocated family support worker or social worker. The local authority is not in touch with the remaining 190 young people and as a consequence does not know what, if any, support they currently need. A lack of analysis of their circumstances, needs and risks means that the local authority cannot assure itself that 25% of its care leavers are safe or promote their welfare through the receipt of services to which they are entitled. This is a widespread and serious failure, given the local authority's responsibility as corporate parents for these young people.

101. Of the 190 care leavers the service has lost touch with, 26 (27.3%) are young former looked after children aged 16 and 17 years. The local authority does not know if they are at risk, in education, employment or training, living in suitable accommodation, or able to access healthcare services.

102. The local authority's performance in June 2015 shows that 76% of care leavers the service is in touch with have an up-to-date pathway plan, an improvement of 8% from the previous month. While performance is improving, the quality of pathway plans is poor. Most plans seen by inspectors were not informed by a robust assessment. Plans lacked identified needs, specific actions and timescales. Risk assessments are not evident in plans, so action needed to address and reduce risks is not clear, including where young people may be at risk of sexual exploitation. In cases seen by inspectors, pathway plans were reviewed. However, the lack of clear actions with timescales, and an inconsistent approach to recording, makes it difficult to fully assess any progress young people are making.

103. In the majority of cases seen, care leavers either did not have up-to-date health assessments or they were not being used effectively to inform pathway plans. For some young people this means their health needs are not met, prioritised or fully understood. Within the plans considered by inspectors descriptions of health needs were generalised and not specific enough for the individual young person to understand their importance. Care leavers do not receive support to access and understand their full health history via a health passport and do not fully access health services appropriate to their needs. A significant number of care leavers have mental health needs that are not being appropriately assessed, and so they do not receive the help they need. Young people who have been in care since their early years do not always have access to information about relevant family medical history including birth information.

104. Family support workers and social workers are actively engaging with those care leavers who are in touch with the service. They know them well, see them regularly, and are strong advocates and work hard to ensure that they receive the support they need. Care leavers spoke positively about individual workers, describing positive and trusting relationships that were helping them meet their goals and achieve independence.

105. Of those care leavers aged 19 or over with whom the local authority has kept in touch, over half (59%) are not in education, employment or training or their education, employment or training status is unknown. The proportion of young people of whose status is not known, at 20% (80 young people), is higher than in Norfolk's statistical neighbours (12%) and the England average (17%). As a result, the local authority does not know if these young people can access appropriate opportunities to develop skills and confidence to live productive and meaningful lives. Care leavers in full-time further education who have part-time jobs are not provided with financial assistance for housing and this is a disincentive to young people's participation. In contrast there is a good financial package of support for those at university.

106. Partnership working with HM Revenue and Customs has been effective in helping the local authority promote apprenticeships for young people. Additional funding to top up their apprenticeship wage without them incurring tax or national insurance costs is available. Twenty new apprentices are due to start new apprenticeships in September 2015. There are some good opportunities for work experience; examples were seen of placements in charity shops that are supporting young people to develop their confidence and work-related skills.

107. Local authority data shows that 59 care leavers who are in touch with the local authority are considered to be in unsuitable accommodation. At the time of the inspection eight young people were considered to be homeless. Three were in emergency accommodation, and one was in emergency bed and breakfast accommodation. Seventeen care leavers were reported to be in houses of multiple occupation. In cases seen, inspectors saw that risk was appropriately considered and support given by personal advisers to help young people find accommodation that is more suitable. A joint protocol with district councils and housing providers is beginning to improve care leavers' access to a full range of accommodation appropriate to their needs. However, for the 59 care leavers currently residing in unsuitable accommodation progress has not been swift enough to enable them to secure better living arrangements. A weekly transition panel now offers advice directly to young people and a dedicated looked after children and care leavers placement service coordinates applications and access to suitable accommodation. In one case seen a care leaver with moderate learning difficulties was helped to develop skills in cooking, budgeting and self-care by a carer, which enabled her to work towards achieving her own tenancy.

108. Twenty-six young people have remained with their foster carers beyond 18. Care leavers spoken to were positive about these arrangements and one reported that they felt very much as if they were her 'family', who were supporting her and her sibling through university.

109. Through an active NICC, care leavers have been consulted on how the care leaving service could be improved. They suggested a link worker to support them in their transition from being looked after to being a care leaver. The proposal was agreed and has recently been adopted with the purpose of providing additional support to them. It is too early to assess the impact of the role; however, it shows that young care leavers are consulted and listened to and can make a difference to the service they receive.

110. Care leavers who met inspectors were generally aware of their entitlements and felt they had received appropriate support in gaining access to records and assistance in gaining employment and training. However, there is wide variation in the extent to which young people's records confirmed their awareness of their rights and entitlements. As such, there was little evidence that this was routinely considered. Good examples were seen of care leavers securing full financial packages to support their university places, although assistance in making applications to university was varied, with some young people saying they did not get practical help in completing the necessary forms.

Leadership, management and governance	Requires improvement

Summary

Since the previous inadequate judgements for the protection of children and looked after children in 2013, the local authority has been able to demonstrate progress in a number of key areas in children's services. Leaders have ensured that governance, scrutiny and commissioning arrangements have been strengthened. Challenge and service development are based on better information being available to senior managers and elected members and task and finish groups are developed to focus on service improvement.

However, while progress and improved outcomes have been achieved for some children, this has not been as effectively translated into improved services for looked after children and care leavers. At the time of the inspection, 16 children did not have an allocated social worker, statutory visits were not always timely and reviews not always undertaken with a social worker present. The local authority had lost touch with a quarter (190) of its care leavers, including 26 of the most vulnerable 16 and 17 year olds. The pace of improvement to adequately address their needs has been far too slow and, as a consequence, children and young people in receipt of these services are left vulnerable. These services remain inadequate.

Where progress has been effective, the local authority is able to demonstrate better outcomes for children. A major organisational restructure in the last 12 months has changed how services are delivered to children and families and the emergence of a more integrated approach to social work practice is evident across the service. The final phase of the restructure will see a dedicated care leaving service come on stream in September 2015. While performance in key areas dipped as a result of the re-organisation, social workers report being clearer about the direction of travel.

A much improved early help offer has seen more children and families accessing early help services. The family support plan (FSP) is being used more consistently by other professionals across the county. Robust performance management arrangements, effective quality assurance processes and a better suite of performance data mean there is sharper focus on, and better scrutiny of, practice and service delivery.

Partnership arrangements are improving. The Signs of Safety project is enabling the partnership to develop a more consistent approach to identifying risk. The senior leadership team cites these as tangible efforts to provide a baseline on which to build a more effective service for all children.

Inspection findings

111. There has been significant progress made under a new interim senior leadership team. Improved governance arrangements, a clearer organisational structure and better oversight and scrutiny mean there is a sharper focus on services for children. However, while effective progress is being made in some service areas, particularly in early help, children in need and child protection arrangements, services for looked after children and care leavers are significantly weaker and remain inadequate.

112. The interim Director of Children's Services (DCS) appointed in July 2013 undertook a considered piece of leadership work to inspire and refresh the improvement agenda. Supported by the elected members, she established Getting in Shape, a programme of organisational and cultural change for children's services in Norfolk.

113. A significant development in recent months has been the appointment of a permanent DCS who takes up post in September 2015 and the permanent appointment of a new senior leadership team. This will bring to an end the reliance on interim arrangements and provide stability to take service developments forward. Social work is now provided under one line management structure and separate line management is in place for roles that require a degree of independence, such as the designated officer, the principal social worker and the independent reviewing service. Managers know that while extensive organisational changes have taken place and provided clearer lines of accountability, changes to previously accepted ways of working will take longer to embed.

114. The new DCS, already part of the senior leadership team, is well versed in the issues that have been identified in previous inspection reports. He has a clear view of the progress made and where more effective management oversight and grip are now required. A new and experienced safeguarding board chair was appointed in January 2014 to revitalise the work of the board and the partnership. A new Managing Director (Chief Executive) took up post in August 2014.

115. Morale is improving and staff report generally being much happier working for Norfolk County Council. Staff spoken with understood the rationale for the restructuring and felt that the senior management style is enabling and visible. Engagement with staff has been helped by newsletters 'Improving Times' and 'Future Voices – Young People Divulge', written by young people. April's edition focused on child sexual exploitation including promoting Chelsea's Choice, a theatre production raising young people's awareness of abuse and exploitation.

116. The focus on a 'whole systems leadership' approach has shown benefits in working relationships across the senior leadership team, with the Norfolk Safeguarding Children Board (NSCB) Chair, the Lead Member, the Managing Director and with partners, particularly the police. The Managing Director has

regular meetings with the DCS and the NSCB Chair and is responsible for the annual appraisal of the NSCB Chair.

117. In April 2014, a 'New Governance Model for Norfolk County Council' was introduced, including a dedicated Children's Services Committee. The introduction of the Children's Services Committee has provided a clearer focus for children and stronger scrutiny arrangements. This is reinforced by 'task and finish' groups where elected members identify and focus on issues of concern. Recent task and finish groups have concentrated on children's centres as part of the early help offer and on looked after children, demonstrating elected members' awareness of priority areas where improvements are still required. Evidence of impact can be seen in the thought and planning in the commissioning process for work in children's centres, but is not yet evidenced in services for looked after children. Although outside the remit of the task and finish group, it did pick up on the need to focus on services for care leavers, and a new task and finish group has been established. It will now support managers in progressing improvements for these young people.

118. Progress has been made in relation to governance and the role of the corporate parent. The Managing Director and the Lead Member understand the recent history and what action needs to be undertaken to address past failures. Elected members now understand their responsibility as corporate parents and a corporate parenting policy sets out what they are required to do. Their understanding of the corporate parenting role has been further developed by a presentation from the Norfolk In-care Council to elected members.

119. The Lead Member is committed to the role and has an awareness of what needs to change to improve outcomes for children in Norfolk. The role is embedded in key strategic functions including the Health and Well-being Board, the Norfolk In-care Council and the Corporate Parenting Board.

120. The local authority's 2014 'Getting in Shape' strategy provides a clear path for continued improvement and there is a helpful commissioning and sufficiency strategy that provides an overview of requirements. However, the action plan on key aspects of sufficiency, such as placement choice, lacks adequate focus.

121. A key achievement for the local authority has been the development of an early help service, addressing a significant gap highlighted at the previous inspection. While there is more work to be done, there is a clear early help offer for children and their families and this is being further developed through some innovative project work. For example, Discovery Cafes in children's centres are engaging parents in children's learning and the Virtual Residential School is supporting children to stay in education.

122. One of the three key priorities of the Health and Well-being Board is to promote the social and emotional well-being of pre-school children, with a steering group that oversees and monitors implementation. The Parent Infant Mental

Health Attachment Project's help for families in the high-risk child protection cases is one example of work being overseen by the Board.

123. Norfolk's joint strategic needs assessment is now a suite of assessment documents available to assist planning. A clear link can be seen from assessed need to service provision, for example the setting up of the Domestic Abuse and Sexual Violence Board with a domestic abuse change coordinator.

124. Significant progress has been made in developing a performance and monitoring framework. Data reporting to performance manage staff and inform elected members is now common practice across the service. It still requires more work to improve the style and presentation of information and the accuracy of the data to inform planning. Frontline managers need to be supported and assisted in using reliable data to manage and monitor services to children better and address any gaps or delays in provision. Children's services performance is now a standing item at the bi-monthly Children's Services Committee.

125. The local authority's audit process demonstrates an improving impact on case work. Capacity to undertake more audit work will be further strengthened by two additional staff members in the audit team. Cases seen by inspectors showed generally improving practice, with a stronger emphasis on direct work with children, although evidence of their voice being heard remains inconsistent. The local authority should ensure clear linkage of audit outcomes to the training and development needs of the workforce.

126. Caseloads in most teams are generally manageable and staff spoke of managers being supportive and approachable to assist them if their caseloads become challenging. However, in one looked after children team, inadequate management oversight meant that 13 children did not have an allocated social worker for three months following the departure of a member of staff. These cases were managed by a series of duty social workers, which seriously impacted on the authority's ability to effectively plan for these children. Children's statutory visits were undertaken by duty social workers who did not know the children and, in one case, a child's review was undertaken without a social worker being present.

127. Independent reviewing officers have much higher caseloads than the level recommended in guidance. This seriously impacts on their ability to provide an effective service to children in care, challenge practice and promote timely decision-making. As a consequence, some children being looked after experience too much delay and drift. Senior managers are aware of this and have a plan to improve capacity within the independent reviewing service.

128. Staff report receiving regular supervision but there are gaps in its recording and it is not always reflective. An audit on supervision in 2014 showed weaknesses. In response, a new supervision document provided clear expectations and helpful 'how to' guidance to assist in the development of good-quality

supervision. Management oversight was consistently seen on cases sampled and should be developed further to include management rationale for the decisions taken that impact on individual children's lives.

129. In October 2014 Norfolk was successful in its bid to be one of the 10 local authorities to pilot 'signs of safety' as a model to engage and empower families. The local authority has a clear timeline for the implementation of the model, with some basic training provided for over 600 council and partner staff from December to June 2015. The inspection saw early evidence in casework, case recording and supervision of this model providing a clear and analytical approach to social work. Social workers reported it being helpful in their practice. The 'signs of safety' project runs from October 2014 to March 2016 and work is still required to embed the principles underlying the model and to bring all partners on board for a consistent approach.

130. The recruitment of experienced social workers remains a particular challenge for Norfolk because of its geographical location. Children's services currently have 70 agency staff with an overall turnover rate of 11%. Norfolk has made an investment in increasing social work posts by 42 in the new structure, with 12 new posts and 30 currently temporary posts made a permanent part of the establishment. Sufficient funding has been made available for additional agency staff, although the impact of these changes will only be fully seen when the new structure is in place.

131. Norfolk has been successful in recruiting new staff through the innovative NIPE (Norfolk Institute for Professional Excellence) project that started in June 2014. This dedicated service recruits newly qualified social workers and provides additional management and peer support, an extensive induction with very low, highly supported caseloads for the first six months. Staff spoken with by inspectors have benefited considerably from being part of the NIPE team and the initiative may provide a long-term solution to recruitment. Recruitment for the fourth cohort in July 2015 has resulted in 40 newly qualified social workers being offered roles in children's services through one of the NIPE teams. Given the early strong benefits seen, Norfolk should evaluate the long-term impact and outcomes of this creative scheme for children and for staff, to share learning and continue to embed the culture of supported and reflective practice.

132. Progress made with the Integrated Children's Services (ICS) computer system has shown demonstrable benefits. Staff report having a more readable system and one that better supports assessment. However, this is not consistent across the service as, for example, the designated officer is not currently able to easily access overview management reports about their service.

133. Many improvements have been made. However, the impact of these improvements seen on children who are looked after and care leavers is limited and insufficiently evidenced. While this reflects a local authority working through each service area, progress needs to be accelerated. The local authority is aware of these as priority areas and is taking steps to address them

through a looked after children 'task and finish' group, the setting up of a dedicated leaving care service and the investment of two additional principal social worker posts, one of which will focus specifically on looked after children.

134. There is a clear Children's Services Involvement Strategy drawn up by the Lead Member, the council and young people. Inspectors saw clear evidence of this strategy in operation. One example is the input of young people into making an animated DVD for children under seven, 'The Promise', to explain to them what they can expect. Young people have been consulted actively in designing new services; for example, young people with disabilities visited potential new short break providers.

135. There is evidence that, in addition to improving core services, Norfolk is being ambitious in trying to tackle some hard-to-address areas of practice through innovative partnership working. Examples of this include the Parent Infant Mental Health Attachment Project's work on high-risk child protection cases, offering intensive assessment and therapeutic intervention for families through a multi-agency team.

136. For older children, the Compass Outreach project referred to earlier in this report has been set up in April 2015 as part of the Department for Education's Innovation Programme. This demonstrates a positive example of partnership working between social care, mental health colleagues and a voluntary organisation. Although part of the early help offer and on the 'edge of care', it includes looked after young people who are placed out of authority, those who require support to move from residential care to foster care and those who require intensive support to return home. Young people were involved in designing the specification for the service.

137. Ambitious and innovative work is also being undertaken on anti-bullying and cyber-bullying initiatives, including anti-discriminatory work resulting in Norfolk achieving fourth place in Stonewall's education equality index.

The Local Safeguarding Children Board (LSCB)

The Local Safeguarding Children Board requires improvement

The arrangements in place to evaluate the effectiveness of what is done by the authority and board partners to safeguard and promote the welfare of children require improvement.

Executive summary

The Norfolk Safeguarding Children Board (NSCB) was found by Ofsted in 2013 to be underdeveloped. Leadership and governance arrangements across the partnership were weak. The appointment of a new independent chair in January 2014 has accelerated improvements. Governance arrangements for the NSCB are good. The Chair of the Board has facilitated a culture of openness and challenge leading to many positive changes.

Partners increasingly hold each other to account, ensuring that the responsibility for safeguarding is central to the work of the Board. Improvements have been considerable, but the drive for continuous progress is hampered by the scale of work required by the Board and partner agencies.

The establishment of a senior leadership group and multi-agency advisory sub-groups has improved communication, engagement and accountability for shared priorities, which are set out in the business plan. The Board is actively reviewing the plan to ensure that all actions are systematically acted upon to increase the pace of change. Delays in implementing the revised threshold guidance, progressing the 'signs and safety' framework and the delayed introduction of the graded care profile are examples of where the Board needs to sharpen its oversight and monitoring responsibilities to ensure the impetus for change across the partnership is accelerated.

Performance data is used more effectively to understand how services across the partnership are improving outcomes for all children, including children looked after, those placed out of county and care leavers. However, information is primarily focused on children's social care; data and performance information from other agencies are not routinely available.

The work of the child death overview panel is underdeveloped and, as a result, there is a significant backlog of reviews to be undertaken. The Board has strengthened its multi-agency auditing of frontline practice, ensuring that improvements linked to its five priority areas are evaluated. Serious case reviews are undertaken and published appropriately. An enhanced learning and development framework linked to local and national issues ensures that learning from serious case reviews is becoming embedded in practice.

Recommendations

138. Ensure that children and young people in care and those leaving care, including those placed out of the county, are afforded the same priority and scrutiny by all partner agencies as other groups (paragraph 149).

139. Improve reporting arrangements to ensure that all actions arising from the work of the board and its business plan are systematically followed through and completed, including monitoring the implementation of the revised threshold guidance, the 'Signs of Safety' framework and the graded care profile (paragraph 148).

140. Hold health partners to account for the lack of consistent clinician attendance at the Child Death Overview Panel; complete the backlog of reviews and ensure that learning from modifiable factors is analysed and shared (paragraph 158).

141. Ensure that monitoring and performance information from all agencies is routinely available and analysed by the Board (paragraph 155).

142. Ensure that findings regarding children missing from care, home and education are considered in order to understand and support the analytical profiling of those at risk and victims of sexual exploitation (paragraph 150).

143. Complete the review of the Board's threshold guidance and monitor its application across the partnership to ensure compliance and challenge when required (paragraph 148).

Inspection findings – the Local Safeguarding Children Board

144. Norfolk Safeguarding Children Board (NSCB) has been improving from a very low base. It was found by Ofsted in 2013 to be underdeveloped; leadership and governance were ineffective with evidence of agencies focusing on separate responsibilities. The Board lacked clear priorities and attendance was inconsistent. It was ineffective in meeting its statutory responsibility to coordinate the work of safeguarding children and young people locally.

145. The Board benefits from having an experienced Chair; his appointment in January 2014 has accelerated improvements. Governance arrangements for the NSCB are good; priorities are clearly defined and shared across agencies. The Chair has facilitated a culture of openness and challenge. Partners spoken with by inspectors confirmed that the Board is inclusive, with all agencies given an equal voice and increasingly held to account for delivering their shared priorities, for example to improve the protection of neglected children and young people and those at risk of sexual abuse or sexual exploitation.

146. The Board is correctly constituted, with representation from a range of partner agencies including the voluntary sector. Its priorities are aligned and attendance and participation at the Board have improved. The Board has one lay member and is recruiting a second. Board members are able to commit resources to the work of the Board and to achieving its priorities within their own organisations, due to their senior positions. Policies and procedures are up-to-date and all partners have clearly identified senior officers with specific responsibilities for leading the safeguarding agenda in their respective agencies.

147. The NSCB is active and is increasingly becoming more influential in informing planning for children and young people at a strategic level, for example through the Norfolk Public Protection Forum and the Children and Young People Strategic Partnership. Locally, it is influencing services through the work of its Local Safeguarding Children Groups (LSCGs). It has successfully led a regional innovation bid for work with Eastern European communities. The Chair, working collaboratively with the Director of Children's Services (DCS) and the chief executives from partner agencies, has set out a vision of a 'whole systems' approach to safeguarding underpinned by the adoption of the Signs of Safety principles and practice.

148. Improvements, although they are being made, are hampered by the scale of work required by the Board. For example, a review of its threshold guidance, identified as an area for improvement by a peer review in February 2014, has not been completed. The inconsistent application of thresholds across children's social care and with other partners continues to be a key area for concern. It is a priority for the Board to effectively monitor and respond to this challenge. The coordination of the multi-agency safeguarding hub (MASH) response and consistent use of thresholds across all partners, together with the implementation of the Signs of Safety framework, the graded care profile and the development of the early help offer, are examples where the Board needs to demonstrate consistent challenge to agencies to improve practice in a timely manner. The Chair recognises that it is vital to 'pull together these pieces of work' to ensure that the new locality structure, the Signs of Safety approach and the revised guidance are aligned effectively.

149. More work is needed by the Board to hold the partners to account for the experiences and progress of looked after children and care leavers. For example, there has been insufficient challenge to the local authority on the number of care leavers it has lost contact with, including potentially vulnerable 16- and 17-year-olds.

150. While the Board receives reports on children missing from home and care, which can help partners understand trends linked to child sexual exploitation, this needs to be consolidated to ensure a more joined-up approach across the partnership. Recent work by the police has provided an analytical profile of victims of sexual exploitation, linked to missing children and perpetrators, to support further devolvement of this work and oversight by the Board.

151. The establishment of a leadership group and advisory sub-groups is strengthening the ability of the Board to hold partners to account for their performance. All sub-group chairs are members of the Board and they report their performance activity to the Board's Performance Information and Quality Assurance Group (PIQAG). Multi-agency audits and data provide the NSCB with a clear understanding of the quality and deficiencies of frontline practice.

152. The child sexual exploitation sub-group has been instrumental in leading improvements in risk assessment for children and young people at risk of sexual exploitation. Practice has now developed to ensure that all referrals, where risk of child sexual exploitation is identified, are tracked by the specialist team in the MASH. The Board has looked critically at the area's strategic and operational response to children and young people at risk of sexual exploitation. The Chair meets regularly with the DCS and the Chief Constable to ensure that Norfolk's response is fully co-ordinated and specific pieces of work are aligned to an overall approach to combating sexual exploitation. This strategic overview has been informed by national learning.

153. Partner agencies' awareness of child sexual exploitation is improving. For example, the commissioning and roll-out of Chelsea's Choice, a theatre production to raise awareness of child sexual exploitation, was successful with 56 schools – including mainstream secondary, academy, special and independent schools – included in the performance schedule.

154. The District Council Safeguarding Advisory Group linked to the NSCB reports regular attendance from all seven district councils. This ensures that each district council is integrating safeguarding into its services and assessing these against Board priorities (for example, child sexual exploitation and taxi licensing), taking a consistent approach to safer recruitment checks, disseminating learning from serious case reviews and involvement in the Board's local safeguarding children's groups. There is an escalation process in operation for any issues that cannot be resolved within these groups and the Board has a challenge log that is regularly reviewed by the Chair and the Board's business manager.

155. A learning and development framework has been in place since November 2014. This provides structure to the Board's work but some aspects, such as the scheduling of reporting and multi-agency compliance with data, are not fully embedded. In consequence, some actions arising from the work of the Board and identified in the business plan are not systematically implemented. The Board has strengthened its multi-agency audit process of frontline practice, ensuring improvements linked to its five priority areas are evaluated. Themed audits carried out in the last 12 months focused on child sexual abuse enquiries that resulted in no further action, MASH contacts and referrals, the quality of work with sexually exploited children and the journey of the child through the system. Learning from audits is beginning to be disseminated down to practitioners to help support improvement in practice. For example, a recent

audit of child sexual exploitation cases was undertaken and identified where practice needs to be strengthened.

156. Serious case reviews (SCRs) are undertaken and published appropriately. The current processes are clear and effective. The level of activity – seven SCRs in total since 2013 – is a departure from previous reliance on discretionary multi-agency reviews. Decisions by the Chair have been validated by the National Panel of Independent Experts (NPIE). Findings from SCRs have informed the Board's priorities and the neglect and child sexual abuse strategies. A composite SCR action plan, taking forward the learning from current SCRs, is updated by the Board every quarter.

157. SCRs are published with relevant action plans and presentations are provided for partner agencies to use to disseminate learning to their frontline practitioners. Between April and May 2015, six road shows led by the Board were carried out across the county with multi-agency presentations. The Chair has met with frontline staff who reported positively on the impact of these events. Practitioners spoken with during the inspection confirmed they were aware of the findings from SCRs and using them to inform their practice.

158. The work of the Child Death Overview Panel (CDOP) is underdeveloped. The panel's 2013–14 annual report was not completed and inconsistent attendance by clinicians meant that a third of meetings were cancelled. As a result, there is a backlog of child death cases that have not yet been reviewed (84 children). This delay undermines the work of the panel to raise awareness of modifiable factors. Effective challenge has been made to health partners by the Chair of the NSCB. A newly appointed CDOP Chair, who is also a clinician, will take up post in September 2015.

159. The Board ensures that section 11 audits are undertaken. In February 2015, all partners completing these audits were invited to a 'challenge day' with the Chair. This process has been used effectively by Board members to identify and improve safeguarding practice.

160. The Board commissions an external provider to run its multi-agency training programme. The training is accessible through the NSCB website and is managed by the NSCB support team, which shortlists applicants to ensure that the courses are delivered to staff across the partnership. A comprehensive range of training is available, responsive to agency needs and aligned to the Board's priorities. This included, for example, regular multi-agency courses on child sexual exploitation, information-sharing and child sexual abuse.

161. Bespoke 'Safer Programme' training meets the needs of voluntary, community and private sector providers of early help services. Attendance data is monitored and reported quarterly to the NSCB's Workforce Development Group (WDG). The WDG also considers wider workforce training needs and the challenges faced in ensuring all staff are trained to an appropriate level. To

support this, the NSCB has a validation panel that scrutinises the content and quality of single agency training packages at lower levels.

162. Training is well attended by partners and evaluation returns indicate that it is highly valued. Practitioners who spoke with inspectors during the inspection reinforced this. A joint NSCB and Norfolk Family Justice Board (NFJB) conference was held this year on evidencing neglect in care proceedings.

163. Training is effectively evaluated. Focus groups to establish the impact of training on frontline staff were carried out between April and June this year. This detailed qualitative assessment has provided valuable information on the positive impact of multi-agency training on practice, for example increased knowledge when risk-assessing neglected children.

164. The NSCB Children and Young People Shadow Board has, until recently, been proactively involved in the work of the Board, for example facilitating and presenting to 309 people at the child sexual exploitation conference in November 2014, in partnership with police cadets. As a result of this event, the Norfolk In-care Council (NICC) has developed training for foster carers and adopters to raise awareness of vulnerability to grooming and exploitation. The Board remains committed to involving young people in the safeguarding agenda. However, recruitment and retention at the Shadow Board has struggled over the last six months. Plans are in place to address this by working with schools, using workshops developed and led by young people for young people, to reach a wider audience and engage children directly in the conversations about what makes them feel safe.

165. The NSCB annual report 2013–14 provides a clear overview of the Board's progress following the Ofsted inspection in 2013. It sets out the Board's priorities and its aspirations for safeguarding children and young people. It covers the work of the restructured sub-committees, including improvements to the SCR process. The report provides a comprehensive analysis of the many challenges for safeguarding children and young people in Norfolk. It provides sufficient analysis about the extent of improvement work required across the partnership and in particular children social care.

166. The Board's business plan has not been reviewed and a number of actions have yet to be completed.

Information about this inspection

Inspectors have 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 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 have tried to understand 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 who 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.

The review of the Local Safeguarding Children Board was carried out under section 15A of the Children Act 2004.

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 nine of Her Majesty's Inspectors (HMI) from Ofsted.

The inspection team

Lead inspector: Helen Cawston HMI

Deputy lead inspector: Louise Hocking HMI

Team inspectors: Donna Marriott HMI, Linda Steele HMI, Tina Shepherd HMI,

Marcie Taylor HMI, Anji Parker HMI, Jon Bowman HMI, Brenda Mclaughlin HMI

Senior data analyst: Stewart Hartshorne

Quality assurance manager: John Mitchell Senior HMI

Any complaints about the inspection or the report should be made following the procedures set out in the guidance *Raising concerns and making complaints about Ofsted*, which is available from Ofsted's website: www.ofsted.gov.uk. If you would like Ofsted to send you a copy of the guidance, please telephone 0300123 4234, or email enquiries@ofsted.gov.uk.

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 looked after children, 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 publication is available at www.gov.uk/government/organisations/ofsted.

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/government/organisations/ofsted