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Mr Michael Rosen
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Nigel Parkes
Her Majesty's Inspector
East of England

Dear Mr Rosen

Monitoring visit to Norfolk local authority children's services

Following my monitoring inspection visit on 16 and 17 June 2016, I write on behalf of Her Majesty's Chief Inspector of Education, Children's Services and Skills to confirm the inspection findings. Thank you for the help you gave during the monitoring visit and for the time you made available to discuss the actions that you have taken to improve services.

This was the first monitoring visit since the local authority was judged inadequate in October 2015. Inspectors found serious and widespread failings in services for children looked after and care leavers at that time.

Areas covered by the visit

During the course of this monitoring visit, the inspector reviewed the progress made in the area of children looked after, with a particular focus on permanency planning, the use of the Public Law Outline, the capacity and effectiveness of the independent reviewing service, the timeliness and quality of health assessments and the recording of return home interviews with children and young people who go missing from care. The inspector also reviewed progress made in the area of care leavers, with a particular focus on the effectiveness of arrangements for keeping in touch with care leavers, the quality of pathway plans and the use of health passports.

During this visit, the inspector analysed a sample of children's and young people's cases. He considered a range of evidence, including electronic case records, improvement and other action plans, performance management reports and case audits undertaken at Ofsted's request by the local authority. In addition, the inspector spoke to a range of staff, including

managers, social workers, other professionals and administrative staff.

Summary of findings

- Senior managers and leaders have responded positively to the outcome of the last inspection and are making reasonable progress in addressing the serious and widespread shortfalls that the inspection identified. However, as the local authority recognises, there is still a considerable way to go to achieve the lasting and sustainable shift required in the quality of services that children and young people receive. The pace of improvement needs to increase to make this happen.
- The local authority has changed the way its children's social care services are structured since the last inspection. As part of these changes, it has established a discrete leaving care service. In contrast to what inspectors found at the last inspection, every child and young person looked after and care leaver had an allocated social worker or personal assistant at the time of this monitoring visit.
- There has also been an improvement in the proportion of care leavers in regular face-to-face contact with the service.
- Data available to help managers monitor the delivery and quality of services that children receive is improving. The introduction of more robust systems, processes and procedures means that managers and staff are clearer about what is expected of them and have the tools they need to evaluate their own and their teams' performance.
- In the majority of cases seen, the quality of social workers' assessments of children's needs, and of care plans and pathway plans made for children and young people, is not good enough. Greater pace and progress are needed to improve practice and management oversight in this area of work.
- Social workers' caseloads remain manageable. With the exception of those based in the two Norwich assessment teams, most staff have responsibility for 20 or fewer children's cases. Senior managers are aware of the service pressures in Norwich and are taking action to address them.
- The establishment of additional independent reviewing officer (IRO) posts since the last inspection has brought the average number of children's cases that each IRO is responsible for overseeing down to the level suggested in national guidelines.
- Staff who spoke to the inspector were highly motivated, talked about being well supported and were clearly determined to improve outcomes for children and young people.

Evaluation of progress

The quality of assessments and care plans evaluated by the inspector is too variable: in some cases, there is too much narrative and not enough analysis. Not enough progress has been made to address this issue identified at the time of the last inspection. Very few of the plans, including the inspection improvement action plan, are sufficiently specific or measurable. This makes it difficult to monitor progress or

evaluate impact. For some children and young people, this contributes to delays in them getting additional help and support in response to their assessed needs. Contingency plans, which are largely formulaic, are weak.

The local authority has developed a much sharper focus on permanency, and a more child-centred approach to permanency planning, since the last inspection. This is evident in the work of both the permanency planning group (PMG) and the permanency planning panel (PPP). To date, the PMG has considered the permanency plans for 974 children and young people. A further 319 children and young people are due to have their plans reviewed shortly. So far, 18 children and young people have been matched with their long-term foster carers. In one case tracked by inspectors, it was clear that the PMG had brought forward the child's review because of concerns about possible drift. There was also evidence of 'together or apart' and parenting assessments being used effectively in another of the tracked cases.

The authority has increased the range of permanency options available for young children who cannot return to their birth families, with better use of foster to adopt arrangements. In the 12 months leading up to the inspection in October 2015, only two foster to adopt placements had been approved. By March 2016, seven such placements had been made.

The introduction of a well-structured tracker tool since the last inspection has strengthened management oversight of the use of the Public Law Outline (PLO). As a result, the pre-proceedings process is being used effectively in a range of different situations, leading to positive outcomes for children and young people. In four of the five cases of families involved in the PLO with start dates before 31 December 2015, there was evidence of the timely use of letters and meetings to address issues and concerns in order to affect positive change in the lives of children and young people. However, letters to parents sometimes use jargon, which means that they are not as accessible as they need to be.

Since the inspection in October 2015, four additional full-time equivalent IROs have been appointed. This has addressed the problem of excessive caseloads. Average caseloads are now in line with national guidance. However, the challenge provided by IROs is not yet consistently effective. In one case tracked by inspectors, a failure to challenge delays in providing much-needed therapeutic support and in producing a child's education, health and care plan had contributed to drift and delay.

Health partners have responded very positively to the findings of the last inspection and have improved the quality and timeliness of health assessments. Significant progress has been made, not only in ensuring that annual health assessments are timely but also in developing a more robust, and meaningful, approach to assessing the health, including the emotional well-being and mental health, of children and young people looked after and care leavers. There is no longer a backlog of children and young people waiting to be assessed and, while in May only 61% of requests for initial health assessments (IHAs) were completed within five days of a child coming into care, there is clear improvement. The local authority is taking action to ensure

that social workers in the family intervention teams understand the significance and importance of IHAs for children looked after.

When children and young people go missing from care, children's social care services are notified promptly and there is a clear expectation that return home interviews (RHIs) will be completed within 72 hours. RHIs sampled by the inspector were clear and comprehensive. They were also conducted more promptly than many of those seen at the time of the last inspection. Good use is made of the simple but effective template on young people's electronic case records to register missing episodes, assess the risks, record RHIs and, where appropriate, identify the need for protective action. However, when children and young people go missing from children's homes in Norfolk, rather than from foster care, paper copies of their RHIs completed by a voluntary sector provider are not routinely uploaded to the child's electronic case file. This has the potential to limit management oversight.

The leaving care service, established in September 2015, is not fully effective. Capacity has been an issue, with some teams not being fully staffed until February this year. In late 2015, the local authority completed a comprehensive review of its data on care leavers and, following the introduction of a care leaver keeping in touch form, it can now accurately report that it is in regular face-to-face contact with 80% of its former relevant care leavers. This is better than at the time of the last inspection, at which point the authority had completely lost contact with 25% of its care leavers and could neither assure itself that these young people were safe nor that it could promote their welfare through the provision of services to which they were entitled. However, more needs to be done. The local authority is not yet able to provide regular performance monitoring reports on the 95 care leavers who do not have face-to-face contact with the leaving care service (20% of the total), even though many keep in touch by way of Skype, telephone or text messages. In both of the cases tracked by the inspector, there was evidence of purposeful involvement with the care leavers concerned.

There has been some improvement in pathway planning for care leavers. At the time of the last inspection in October 2015, only 75% of the care leavers the authority was in touch with had a pathway plan. This has improved, with 90% of relevant care leavers, and 92% of former relevant care leavers, now having pathway plans. However, the quality of those plans is not yet good enough. A recent audit of 25 pathway plans found that 17 (68%) required improvement, and that eight (32%) were inadequate. Many of the young people supported by the leaving care service have care plans as well as pathways plans. This risks duplication and is potentially confusing for the young people and those responsible for supporting them.

New health passports, designed in consultation with children and young people, were due to be launched on 4 July. The plan is to provide all care leavers, and children looked after who are of school age or above, with a health passport. This means that they will be able to access comprehensive information about their, and their families', health histories quickly and easily.

I am copying this letter to the Department for Education. This letter will be published on the Ofsted website.

Yours sincerely

Nigel Parkes HMI
East of England

cc Eleanor Schooling, National Director Social Care
Kate Lyons, Department for Education, Interventions Unit Child Protection and LA Performance