Suffolk 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: 23 November 2015 – 17 December 2015

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Children's services in Suffolk County Council are good.		
1. Children who need help and protection		Requires improvement
2. Children looked after and achieving permanence		Good
	2.1 Adoption performance	Good
	2.2 Experiences and progress of care leavers	Requires improvement
3. Leadership, management and governance		Good

[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.

Executive summary

Suffolk County Council is led by dynamic and capable leaders and managers and is delivering a good service overall to children and their families. Leaders have a comprehensive understanding of what needs to be achieved and have made sustained progress since the inspections of services for children looked after in 2010 and child protection in 2013, which were both judged to be adequate. Services for children looked after are particularly strong for younger children and in securing permanence, with some aspects showing outstanding performance.

Services for children in need of help and protection require improvement. While some aspects of these services have considerable strengths and many have improved, outcomes are not consistently good. Improvement is required to ensure that children in need and children on a child protection plan benefit from consistently good assessment and planning, and that this is evident in case records. Services for care leavers require improvement to ensure that they are all in suitable and stable accommodation and have clear plans for their futures. The majority of actions from previous inspections have been addressed or are in progress. Senior managers are aware of the areas where progress still needs to be made and they are working rigorously to ensure consistency across all services for children.

Very clear governance arrangements are in place and the senior leadership team has been successful in engaging partners to drive continued improvement. The Chief Executive ensures that services for children have a high profile within the council and she is ambitious for children and their achievements. There is a clear and committed understanding of corporate parenting and the Lead Member is well engaged and very active in planning for and consulting with children. A determined and aspirational Director of Children's Services has been ambitious in her drive to transform services for children and families and has, along with her equally determined senior management team, planned for large-scale and long-term change. They are well on their way to achieving this.

Children and their families in Suffolk receive a timely and comprehensive early help service. Assessments are undertaken promptly and children receive a service that suits their needs. There is a clear process to monitor step-up and step-down arrangements when risks change, and in cases seen by inspectors, children received the right level of support. For children who require protection, action is taken promptly and risk is well understood. The majority of children are safeguarded well. However, the quality of assessment and the planning for children in need and in need of protection are not yet consistently good for all children. These require improvement to ensure that targets and timescales are clear and that progress is made for all children. While inspectors did not see a detrimental impact on children's well-being, written plans, assessments and records do not clearly demonstrate the work that is being undertaken, or how and why decisions are made.

The local authority is appropriately identifying those children who are at risk of child sexual exploitation and has developed strong cooperative working relationships with the police to maintain a clear strategic overview. Effective oversight is provided

through clear, multi-agency meetings and an appropriate and flexible range of support services is in place. The offer, timeliness and recording of return home interviews for children who go missing from home require improvement to ensure consistency and a full understanding of risks for each young person. The intelligence available from all return interviews is not being used to full effect. Senior managers are aware of this and appropriate resources have been put in place for this to happen.

Children looked after by the local authority receive a good service, with a range of permanence options being secured in a timely way for almost all children. The local authority provides an individualised permanence plan for each child and is successful in achieving this outcome for the vast majority of children. Court work is timely and of a consistently very high quality; the local authority acts with urgency in initiating proceedings and during proceedings. The adoption service is well managed and offers a good recruitment and family-finding service. It is offering an exceptional service to children who can benefit from prompt placements through foster to adopt and concurrent placements.

The local authority is continuing to tackle the challenges presented by a small group of older looked after young people with complex needs, which includes poor educational performance at Key Stage 4. The local authority has put in place appropriate plans to offer improved coordinated multi-agency services, including: changes to the virtual school in establishing a virtual governing body that reports to the Corporate Parenting Board, a comprehensive child and adolescent mental health service transformation plan, and a new joint therapeutic residential option under the Innovations Programme. The implementation of Raising the Bar, a programme to improve levels of educational attainment for every child in Suffolk, demonstrates the local authority's priority and determination to improve educational outcomes.

Senior managers are aware that outcomes for care leavers are not good and have a clear vision for service improvement, supported by additional investment.

The strong progress of the local authority shows good outcomes for the majority of children across the range of services. Practice is particularly effective in services for disabled children (both as children in need and as children looked after), the risk assessment, protection and support of unborn babies, private fostering, unaccompanied asylum-seeking young people, female genital mutilation, young people involved with groups or gangs and services for children and young people on the edge of care.

The local authority is steadily embedding a new casework model as a tool to assist workers and support families. Workloads are manageable. Staffing has stabilised, the use of locum staff is decreasing and some help and protection teams have appointed additional staff to help manage work more effectively.

Contents

The local authority

Information about this local authority area[2]

Previous Ofsted inspections

- The local authority operates five children's homes. Three were judged to be good or outstanding in their most recent Ofsted inspection.
- The local authority's arrangements for the protection of children were previously inspected in July 2013. The local authority was judged to be adequate.
- The previous inspection of the local authority's services for children looked after was in December 2010. The local authority was judged to be adequate.

Local leadership

- The Director of Children's Services has been in post since February 2013.
- The chair of the Local Safeguarding Children Board has been in post since December 2014.
- The local authority has delegated social work functions to a registered charity in respect of children looked after aged 16 and over, and care leavers.

Children living in this area

- Approximately 151,332 children and young people under the age of 18 years live in Suffolk. This is 21% of the total population in the area.
- Approximately 15% of the local authority's children are living in poverty.
- The proportion of children entitled to free school meals:
  - in primary schools is 14% (the national average is 16%)
  - in secondary schools is 11% (the national average is 14%).
- Children and young people from minority ethnic groups account for 8% 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 (influenced by the presence of United States Air Force bases), 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%)

[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.

- in secondary schools is 6% (the national average is 15%).

Child protection in this area

- At 30 November 2015, 3,494 children had been identified through assessment as being formally in need of a specialist children's service. This is an increase from 3,277 at 31 March 2015.
- At 30 November 2015, 421 children and young people were the subject of a child protection plan. This is a reduction from 452 at 31 March 2015.
- At 1 December 2015, 33 children lived in a privately arranged fostering placement. This is an increase from 22 at 31 March 2015.
- Since the last inspection of local authority arrangements for the protection of children in June 2013, three serious incident notifications have been submitted to Ofsted. Two were subject to serious case reviews which have been completed or were ongoing at the time of the inspection.

Children looked after in this area

- At 30 November 2015, 758 children were being looked after by the local authority (a rate of 50 per 10,000 children). This is an increase from 730 (48 per 10,000 children) at 31 March 2015. Of this number:
  - 138 (18.2%) live outside the local authority area
  - 46 live in residential children's homes, of whom 26.1% live out of the authority area
  - nine live in residential special schools,[3] all of whom (100%) live out of the authority area
  - 572 live with foster families, of whom 17.8% live out of the authority area
  - 91 live in kinship placements, of whom 11% live out of the authority area
  - 481 live in other foster placements, of whom 19.1% live out of the authority area
  - 28 live with parents, of whom 17.9% live out of the authority area
  - 31 are unaccompanied asylum-seeking children.
- In the last 12 months (to 30 November 2015):
  - there have been 77 adoptions
  - 42 children became subject of special guardianship orders
  - 298 children ceased to be looked after, of whom 2.7% subsequently returned to be looked after

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

- 51 children and young people ceased to be looked after and moved on to independent living
- one young person ceased to be looked after and is now living in a house of multiple occupation.

Recommendations

1. Ensure that all children's plans, including children in need, child protection, children looked after, personal education plans and pathway plans consistently contain specific actions, measurable timescales and clear intended outcomes so that the child, their family and professionals know what needs to be achieved.

2. Improve the quality of assessments to ensure that the voice of the child is fully integrated and that their case histories are fully considered.

3. Improve the offer, take-up and timeliness of return interviews for children missing from home and ensure that data and information relating to all children who go missing from home, care and school are collated more effectively and analysed to better inform strategic understanding and planning.

4. Increase the capacity for meeting the needs of teenagers entering care. This includes out of hours provision to accommodate them closer to their home area in regulated placements, minimising disruption and preventing early changes of placement. Reduce the use of semi-independent accommodation before the young person is ready.

5. Improve the provision for educational achievement, particularly at Key Stage 4, through the pupil premium grant.

6. Extend the in-county capacity of the services to provide for children looked after with the most complex needs, through effective agency partnership working.

7. Continue to improve the range of suitable accommodation for care leavers, including Staying Put and supported lodgings, and undertake risk assessments to ensure that the accommodation meets their support needs.

8. Increase the awareness of rights and entitlements for care leavers, including the provision of full health histories.

9. Increase the pace of change in implementing improved IT and recording systems to support practitioners in recording and evidencing work and outcomes.

10. Develop a multi-agency strategy to tackle neglect, to identify prevalence and enable an evaluation of effectiveness.

Summary for children and young people

- Councillors and senior managers have worked hard to improve services for children and young people. They have made good progress in all areas, particularly for children who are looked after by the local authority, although educational outcomes at secondary school level still need to improve.
- Children and their families receive the appropriate help when they need it. Parents have said that they value this support and that it has helped them.
- Social workers act quickly to ensure that children are safe. They know children well, visit them often and listen to what they tell them.
- Social workers are good at helping children to return to live with their own family, or with another family if their own family is not able to keep them safe.
- Social workers try hard to find the right foster carers and adopters for children and they prepare and support them properly. Some children have lived with a number of different foster carers and have had to move schools before they are settled.
- Social workers know when children go missing or when they are at risk of being sexually exploited. Some children are not offered the opportunity to talk to someone when they return from going missing, which makes it harder to keep them safe.
- Social workers' records are not always clear enough about what happened and why, and this needs to improve.
- Care leavers do not always receive a good service; some do not live in the best accommodation to meet their needs, and some do not know what rights they have as care leavers. Managers know that the service is not good enough and are working hard to make improvements. Care leavers told us that they feel safe where they live and that they value the support of the staff who work with them.
- Councillors and senior managers take their role as corporate parents very seriously. They are really good at listening to children and value their views on how to develop and improve services. The children in care council (C2C) and Brighter Futures for younger children are making a real difference to services for children; two care leaver apprentice commissioners are helping to make sure that the views of children and young people are taken into account.

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

Services for children and their families who need help and protection require improvement to be good. Although there are considerable strengths and evidence of sustained progress, demonstrating ongoing improvement, some areas are not sufficiently or consistently embedded to have yet reached a good standard.

Early help services for children and their families are good. There are early signs of increased impact through the new integrated early help teams and the Signs of Safety and Well-being casework model. Some aspects of this work have been particularly effective, including Suffolk Family Focus (work undertaken with 'troubled families') and joint work with the police and other specialist services regarding child sexual exploitation, gangs and groups, and female genital mutilation.

Partner agencies are developing a clearer understanding of thresholds when specific services need to be involved. This is resulting in more appropriate contacts and referrals. Partner agencies are positive about the prompt support and advice available to them through the MASH (multi-agency safeguarding hub) professional telephone contact line and the referral process.

Customer First offers an efficient and effective access to services. The relatively new MASH provides a sound multi-agency response, with appropriate decision-making seen in relation to the need for assessments and strategy discussions. The service has only recently started ensuring that input from education has been sought for all school-age children.

Children in need and children in need of protection are receiving help at the right level. In most cases seen by inspectors, risk of harm and its significance were understood and responded to appropriately.

While children are seen within reasonable timescales in the majority of cases, case recording does not always note whether the child is seen alone or evidence how direct work with the child, and their wishes and feelings, influence case practice and care planning. The quality of assessments is inconsistent, with some not being informed by the voice of the child, historical factors or a clear rationale for decision-making. Child in need and child protection plans vary in quality, with some not showing clear actions, timescales or outcomes.

The offer and take-up of return interviews for children missing from home are low, meaning that planning at both an individual and strategic level is not sufficiently robust. This is steadily improving and the local authority has taken action to sustain improvements further.

Inspection findings

11. Children and families benefit from early help services that are well established and well developed. Thirteen locality teams, co-located in almost every case with children's social care, are helping to ensure that needs are identified and responded to at the earliest opportunity. All early help staff have had training on the new case work model 'Signs of Safety and Well-being'. High-quality assessments, using the common assessment framework (CAF), are timely and child-centred. CAF and team-around-the-child plans are regularly reviewed and, with weekly transfer meetings, step-up and step-down arrangements are dynamic and well managed. Eighty-five per cent of the families who responded to the latest monthly survey reported that their situations had improved as a result of the early help they had received.

12. The potential reach of children's centres has increased following their integration with health visiting and school nursing services in April 2015. Registrations have increased to 67.6% and are likely to increase still further now that registration consent forms incorporate a new data sharing agreement, and those responsible for maintaining and updating the NHS's SystmOne are based in the local authority's intelligence hub. As well as offering a range of evidence-based parenting programmes, children's centre staff are using video interaction guidance to help improve communication and change parenting behaviour. Good take-up of early years' entitlement is having a positive impact on children's development.

13. By reducing involvement in criminal activity and anti-social behaviour and increasing educational attainment and employment, Suffolk Family Focus has improved outcomes for 1,150 'troubled families'. The aim is to achieve similar results with 950 families a year over the next five years. There is an impressive range of voluntary sector services, including, for example, intensive time-limited support for families where the primary carer has drug and/or alcohol issues, and an extensive outreach service for victims of domestic abuse. This means that more families are getting the right service at the right time.

14. The range of early help services includes a proactive family nurse partnership programme and a successful Activities Unlimited service. Up to 2,000 disabled children are enrolled as members of Activities Unlimited, which enables them to access a range of short break and leisure activities.

15. Robust management oversight and rigorous quality assurance systems ensure that the service provided by the contact centre is safe, efficient and effective. Customer service advisers identify risks and needs, and referrals are passed to social workers in a timely way for assessment.

16. Service user feedback, including from children and young people receiving early help services (CAFs), assessment or child in need services, is collated and monitored effectively. The majority of feedback shows a positive response to services, with high levels of satisfaction. Partners' understanding of, and confidence in, the thresholds for access to children's social care are increasing. They are making good use of, and are positive about, the professional telephone contact line in the MASH, where they can receive timely advice and guidance.

17. The establishment of the MASH has improved the quality and timeliness of information-sharing. Staff working in the MASH have a good understanding of the threshold criteria. Risks and needs are identified, assessed and prioritised appropriately, leading, in the vast majority of cases, to a suitably swift response. In all cases seen, consent was recorded appropriately. However, staff in the MASH are not always sufficiently rigorous in gathering information from other agencies and professionals. For example, schools are not routinely consulted about the information they have about children and families. The rate of child protection enquiries is higher than in similar authorities, although inspectors did not find any evidence of children and families being subjected to investigations unnecessarily. In a small number of cases, inspectors found that the method for recording section 47 investigations was resulting in inaccurate data. Managers took action to correct this practice during the inspection.

18. Partnership working with the police, at both a strategic and an operational level, is good and strategy discussions are timely. However, while strategy meetings organised by the MASH ensure that information is shared effectively between agencies, leading to clear and specific identification of risks, practice elsewhere is more variable. Participation in strategy discussions outside of the MASH is more limited and often only involves the police and children's social care. Inspectors saw evidence of email exchanges between consultant social workers and safeguarding managers to confirm the need for an initial child protection conference being classed as strategy discussions, which is inaccurate and has the potential to distort performance management information.

19. In the majority of cases, children are seen within timescales, but case recording does not consistently indicate whether they are seen alone or fully reflect their voices. Additionally, although most social workers know their children well, it is not always clear from case recording how effective social workers are in using direct work to ascertain children's needs, wishes and feelings and/or how children's needs, wishes and feelings inform and influence case planning and practice. (Recommendation)

20. The quality and timeliness of assessments are variable. Assessments are not routinely updated in every case. In good assessments, the influence of the new casework model is strongly evident; risks and protective factors are clearly identified and analysed; children's wishes and feelings are actively explored, inform the assessment and are reflected in the plan. However, as the local authority's own audits demonstrate, a minority of assessments are not yet good. In those cases, risks are not sufficiently explicit or clearly articulated, and analysis, particularly of the impact of the 'toxic trio', is not sufficiently well developed. Children's views are insufficiently represented. In a very small number of cases, this results in a lack of appropriate focus or leads to delay in children and families getting the right help and support. (Recommendation)

21. The majority of chronologies seen were up to date, although some were over-lengthy and read more like a running record rather than a summary of the key events in the child's life. This does not assist in providing a clear overall understanding of a child's life or the impact of any previous interventions by services. Genograms are used to provide a visual record of family relationships but need further work to ensure that they are of a consistently high standard and easy to understand. Social workers who spoke to inspectors were able to demonstrate that they are using research and theory to inform their practice, but this was not always evident in their written assessments. (Recommendation)

22. Pre-birth assessments are an area of significant strength. An effective multi-agency response, good use of historical information, robust analysis of risks and parenting capacity and timely decision-making ensure that unborn babies are effectively safeguarded.

23. While most children in need and children in need of protection have an up-to-date plan, the quality of plans varies. A significant minority of plans lack precision about areas of concern or outcomes required, and are not sufficiently specific or measurable. This makes them less effective as tools to monitor progress. Contingency planning is not consistently well developed. In these cases there was a lack of escalation and challenge in the review process. (Recommendation)

24. Mechanisms are in place to monitor closely any child or young person subject to a child protection plan for more than two years. This currently affects five children. Chairs of child protection conferences review cases to assure themselves that plans are effective and consider whether the threshold for a legal planning meeting is met. Appropriate action is taken if required.

25. The new casework model, which has been enthusiastically adopted by child protection conference chairs, is contributing to an improvement in the level and quality of engagement with children and families. It has also helped to enhance other agencies' contributions to the assessment of risks and their involvement in monitoring child protection and other plans. Effective multi-agency working was seen in the majority of child protection and child in need cases; this multi-agency involvement helped to minimise risk and improve outcomes for children.

26. The majority of core group meetings are held within timescales and attendance is generally good. Child in need plans are reviewed regularly and in the majority of cases the plans effectively impacted on service provision and achieving the desired outcomes.

27. Robust step-up and step-down arrangements ensure that there is an appropriate and proportionate response as risks and needs change. An audit carried out by the Local Safeguarding Children Board found that some cases were closed prematurely and subsequently re-referred because of the same concerns, although this was not evident during the inspection. Of the 1,746 referrals completed in the three months before the inspection, 23% (402) were re-referrals and those seen by inspectors were appropriate.

28. Management oversight is not consistently recorded, actions from plans are not always followed through in subsequent case management supervision and progress and children's outcomes are not always effectively captured in case notes. Actions were delayed in a small number of cases as a result of ineffective management oversight.

29. Risks relating to domestic abuse are identified and addressed, with appropriate referrals from the police leading to service provision and for consideration at the multi-agency risk assessment conferences (MARACs). However, social care case recording does not consistently evidence actions being undertaken as a result of discussions at the MARAC.

30. Children at risk of sexual exploitation are identified and appropriately considered at the tactical tasking and coordination group (TTCG). The child sexual exploitation risk assessment tool, which is used for referrals to the TTCG, showed appropriate evidence of risk analysis. However, return home interviews are not consistently offered and completed to identify factors that influence the young people that go missing, so this information is not available when assessing risk. The local authority is aware of this and is in the process of appointing a child exploitation coordinator and a missing children coordinator to further improve the response. Gang affiliation is appropriately considered and positive evidence was seen of complex strategy discussions and review at the TTCG, with direct work being undertaken with young people. (Recommendation)

31. Data and information regarding children missing education are routinely cross-checked against children and young people missing from home or care. The database for children missing education will move to a new system in January 2016, allowing a joined-up approach to children who are missing from home or school regardless of whether they are looked after or not. The missing education coordinator has effective links with the police and UK Visas and Immigration, and is also a member of the TTCG. The tracking of children missing from education is robust; schools have clear guidance to support them and monthly monitoring has led to better school attendance and a reduction in persistent absence.

32. Early identification of risk with regards to female genital mutilation, forced marriage and radicalisation leads to proactive and immediate safeguarding of young people, underpinned by comprehensive multi-agency support. A particular strength is the active partnership working between social care and early help family support practitioners, along with the specialist Make a Change child sexual exploitation team on cases of child sexual exploitation and female genital mutilation. This provides continuity of relationships and sensitive specialised support for children and families. Impressive protective work was demonstrated by workers in a case of female genital mutilation.

33. The emergency duty service (EDS) provides a generic, county-wide service for children and adults. It delivers an effective service to children and families in crisis outside of office hours. Access to the fostering out of hours service is reassuring for foster carers and helps to reduce unnecessary placement disruption. Communication between the EDS and day-time services is good.

34. Private fostering is well understood and arrangements for the safeguarding of privately fostered children are well managed and effective. There are a high number of notifications (93 during 2014–15, of which 19 did not meet the criteria) and a combined total of 133 notifications and active, open cases during the same period. Currently, 37 children and young people are in private fostering arrangements. There is a dedicated private fostering panel, ensuring a high level of monitoring and oversight. Additional temporary capacity has been added to further improve awareness-raising by an already successful service.

35. The local authority has taken effective action to reduce the risks to young people aged 16 or 17 at risk of homelessness. In 2014, the Corporate Parenting Board tasked the young person's suitable accommodation task and finish group with reviewing the supply of suitable accommodation for 16- and 17-year-old care leavers and young people potentially presenting as homeless. They have raised the profile of youth homelessness and children looked after through an active role in the Suffolk Strategic Housing Partnership and the development and adoption of the Health and Housing Charter for Suffolk. There have been significant improvements in the last two years on prevention of homelessness for families and young people due to the early help offer and effective partnership engagement.

36. The local authority recognised that the designated officer service required improvement and has invested in two full-time designated officer posts. Work seen by inspectors showed evidence of a timely and proportionate response to referrals and allegations with clear audit trails of events, actions and decisions. However, the designated officer service action plan is not outcome-focused or sufficiently specific and does not, for example, reflect the need or commitment to establish and further develop partnerships with education, health, independent fostering agencies or the voluntary sector. While data and information are being collected, they are not being analysed effectively to identify key issues or patterns in reporting or referral sources, for example identifying schools that have not reported any cases.

37. Children's attendance at child protection conferences is low, but improving. Between April to September 2015, attendance of children eligible to be invited was 33.3% at initial child protection conferences, and 21.1% at review child protection conferences, with low take-up of advocacy. The child protection conference chairs have an action plan to address this and are exploring alternative methods of obtaining feedback from children and timing reviews to be after school hours, alongside capacity issues in the advocacy service being closely monitored through contract monitoring.

38. The risk, impact and effect of elements of diversity are not consistently evidenced in assessments. Social workers can articulate how this has or will be considered as part of their thinking, but this was not sufficiently reflected or analysed in case recording of the cases tracked by inspectors. Stronger practice was evidenced for children with disabilities, with staff clearly eliciting and supporting the voice of the child using a range of techniques to meet the communication needs of individual children. Strong evidence was seen of the use of consistent translator services for young people, with child protection documents translated to ensure that parents understood the risks and the actions required of them.

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

Substantial improvements in services to children and young people who need to be looked after have been achieved since the previous inspection in 2010. Active, early assessment takes place to gauge need and prevent children from becoming looked after where it is in their interests. Decisions then made to look after children and young people are clear and timely, with highly effective processes ensuring that realistic thresholds are applied, with no delay in action being taken. Children are cared for within their extended family where possible; these family members are given the same level of support as other approved carers.

Court orders to secure good outcomes are sought, focusing on safety, stability and permanence. Placement stability has also improved over recent years; it is now good, and particularly strong for younger children, where some elements are outstanding.

The individual needs of children are sensitively considered and their views are heard. There is careful consideration of whether they should live with their brothers and sisters. Where this is not possible, arrangements supporting continuing contact are in place, if appropriate.

While efforts are made to maintain a young person within their school placement, this is not always successful, particularly for older children. The majority of children looked after attend good or better schools.

Significant advances have been made in assessing and addressing the health needs of children and young people, although improvements are required in meeting their emotional needs.

Adoption as a permanency option is considered early for children where care proceedings are being initiated. The local authority has a small number of children waiting to be adopted, with 70 children adopted in the last year. Suffolk is rated well above the national average of local authorities in England for children being adopted. Once matched, children quickly move in with their adoptive families. Children and their families receive good-quality, post-adoption support. As a result, the disruption rate is very low.

Services for care leavers are improving, but the impact has yet to be seen in some aspects of care, for example in pathway planning. Ambitious commissioning is in progress, with improving partnership working, but there remains much that is yet to be achieved. While the arrangements are safe for independent living, young people are not always sufficiently prepared for this. Young people who are homeless and vulnerable benefit from being considered as looked after. Young people are positive about the accessibility, support and positive relationships they have with their workers.

Inspection findings

39. Substantial and significant improvements have been achieved for children in care in Suffolk in recent years. These improvements reflect a commitment that puts safe, stable lives for children at the heart of the work undertaken. The large majority of children are receiving good-quality, purposeful and well-coordinated services. The local authority acknowledges that further work is still needed to achieve consistency across some parts of the county, as well as to improve services for a small but important group of older children with more complex needs, who come into care in the later years of their childhood.

40. Services aimed at preventing children coming into care and assessing risk and need are being delivered across the county, particularly through the family assessment support (FAST) staff within social care teams. These provide intensive and flexible interventions, often within an extended family focus. Workers try to ensure that children and young people remain in their families wherever possible, as well as supporting those who return home after a period in care. These teams are successful and demonstrate positive impact by ensuring that many children are maintained within the family networks or remain there if they return home.

41. Decisions to look after children are appropriate and children are not taken into care unless it is necessary. This is a particular strength in relation to those who are very young and those yet to be born. The role and functions of the child resource panel and associated legal planning and tracking systems ensure and support determined action at an early stage. Robust decision-making is in place, ensuring that thresholds are applied appropriately and delay is avoided. Assessments of those most at risk or in need are clear, robust and well-focused on safety, stability and permanence for children at this stage.

42. The general assessment approach and wide use of extended family meetings has led to an increase in kinship care arrangements, child arrangement orders and special guardianship orders. More than one in eight children leaving care go to their extended family under a special guardianship order. This is similar to the number of children who leave care through adoption. The same level of support is offered to children who leave care either by adoption or by a special guardianship order.

43. Oversight by senior managers is active throughout the duration of children being in care, offering challenging and appropriate additional scrutiny, particularly on cases that pose a high risk or complex challenges. The arrangement for 'stop and review' by a senior manager if concerns persist is a particularly useful approach to ensure that protective, coordinated action is achieved when necessary.

44. The Public Law Outline is used to substantial effect to ensure that children are only taken into care when this is in their best interests. Where there is a need to intervene through the use of public law, the local authority, supported by effective legal advice and guidance, performs its duties to a consistently high standard. Suffolk is among the highest-performing authorities in the country; in the second quarter of 2015–16, public law proceedings were being completed within 22 weeks, and timeliness continues to improve.

45. There remains a need for greater consistency and well-focused assessments and plans for those young people becoming looked after for reasons other than abuse or neglect, particularly in taking account of their – sometimes – extensive history of involvement with targeted services. (Recommendation)

46. Before entering care, careful consideration is given to matching children and young people to appropriate places for them to live, with a very high proportion of children remaining both within the area as well as being provided through an efficient in-house service. For most children, arrangements are often well made, with appropriate consideration of extended family or connected others. Few children are placed outside of the area and, where this takes place, it is almost always because of the child's additional needs and the specialist services required for them.

47. The very large majority of children and young people live in accommodation that is meeting their needs and the majority of carers are highly positive about the support they receive from the local authority. Some children entering care as the result of a crisis out of hours are not always placed in a local or enduring placement. Many experience an early change of placement, with some being provided with very temporary provision through arrangements known as the 'crash pad'. While safety is paramount and is considered in such placements, immediate provision of potentially stable accommodation has not been such a priority. (Recommendation)

48. Placement decisions prioritise placement with or near brothers or sisters, maintaining schools and continuing other services, and then proximity to birth and extended family, particularly where rehabilitation is the plan for permanence for the child. The wishes and feelings of the child are also considered within this. Few children (34 of the 758) are looked after out of the area and beyond the immediately adjoining areas. Where this is the case, it is usually due to their highly complex needs or placement with extended family members. There are good or better levels of placement stability for most children, with fewer than 10% of primary school age or young children experiencing substantial placement disruption in the previous year.

49. Family-finding takes account of individual needs and identity. Almost all children are matched with carers able to meet these needs. Those caring for asylum-seeking young people are also sensitive to their cultural and other needs. The local authority is recruiting carers that can provide for more children with higher or more complex levels of need. The central resource team uses a wide range of provision to provide placements, including almost 100 places from independent providers.

50. The increase in the number of children in care over the past year (55 of the 758 children) is substantially accounted for by an appropriate increase in young people becoming looked after, including a significant increase in the number of unaccompanied asylum-seeking children from 17 in November 2014 to 33 in November 2015. The local authority recognises that some children and young people have not previously experienced sufficient help and protection. Assertive and positive decisions are now being made. For some children who have previously experienced periodic neglect and/or emotional harm, achieving safe and stable arrangements remains both a priority and a challenge for the local authority. For a small number of these young people in their mid-teens, this has led to a challenge in ensuring that there are enough well-supported placements. Also, some of these young people experience several placements, including being away from family, school and friends. Although, this involves additional disruption, it frequently results in achieving a better match of placement in the long term. Again, this is most likely to be the case with children at Key Stage 4 and beyond. (Recommendation)

51. Social workers and their managers know children well, and often very well. Social workers visit children frequently, spending time alone with them to help establish a trusting relationship and getting to know their hopes and wishes. Children and young people are helped to understand what is happening to them through innovative and effective life story work. Almost all children say they have trust and confidence in their social worker. In the current year, this has proved difficult for some, due to organisational restructuring in social care, resulting in some children being assigned a different social worker as a consequence of these changes, although managers made efforts to reduce disruption for individual children. The impact of this on some children has also been mitigated by active relationships and consistent involvement of the child's independent reviewing officer (IRO).

52. Social workers are well versed with the needs of the child they are responsible for. They are able to tell the child's story, outline their plan and their own actions, as well as those of other professionals and carers. This clarity is not always reflected in the written records; full, clear and up-to-date chronologies, assessments and plans are not always well documented. The arrangements for recording key documents are improving, but managers acknowledge that more work is needed to achieve consistently high-quality outcome-focused plans. This is not helped by the multitude of databases and document storage arrangements.

53. In cases tracked and sampled by inspectors, some improvements can be seen clearly in recent months. The change in the whole service approach, using the new casework model, is positive and has resulted in a rapidly improving focus in recorded planning. Similarly, while management guidance and direction had also not been consistently recorded, practitioners were able to clearly describe routine and positive casework supervision, challenge and oversight by their managers.

54. Assessing new or emerging risks for children in care is a high priority, with practitioners and placement providers appropriately using tools such as the child sexual exploitation risk assessment matrix to assess, monitor and adapt plans. Return interviews are timely, where agreed by the young person, taking place in line with levels of risk and complexity. Routine aggregated analysis of return interviews does not fully inform intelligence of patterns of possible risk, although examples were seen where broader intelligence has driven and supported targeted activity to prevent or disrupt potential harm.

55. Foster carers report that they are a part of the professional team supporting the child. They talk positively about the training they receive and the care taken in planning for the child, meeting their needs and the contact arrangements. Those looking after children with complex and challenging behaviours are also being strongly supported through Zipwire, an in-house intensive support service for carers.

56. IROs meet children between reviews, often in their homes, and know them very well. There is a continuous flow of communication and testing of the impact of changes, progress or unplanned events; this is a strength. Reviews are timely and caseloads are now manageable, showing improvement from the last inspection in 2010. Some examples seen have shown appropriate challenge, although this is still not fully consistent. Escalation of concerns or challenge is part of the relationship between the IRO and the local authority and routine communication is in place. IROs have also supported the transfer of case management between workers, ensuring continuity and essential levels of consistency and trust with children.

57. Advocacy and independent visiting arrangements are routinely available through a commissioned service. While there is not a high level of take-up, many previously receiving support return later when new issues arise for them. Similar support is also in place for parents less able to understand or communicate their views. Few complaints are made by both children and parents in relation to children in care. When these are made the customer care service is actively engaged at an early stage in considering the merits of the complaint, with almost all complaints being resolved at the earliest possible stage.

58. When the plan is for a child to return home, assessments are robust. These consider the needs of the child and the potential risks, and appropriate support is offered. Very few children return to care for a second or subsequent time (less than 1% of those looked after at the time of the inspection). This is impressive and is a particular strength in the area. Those who do return to care tend to be older children or those who had become looked after through a voluntary agreement with the parent. Of those children and young people becoming looked after in the year prior to inspection, almost a quarter were 15-years-old or older, but fewer than half were living within a family setting. Many were placed in residential or semi-independent accommodation. The use of the latter provision for some young people in care at this young age, when they remain emotionally and practically unprepared for this level of self-management, is unlikely to support them sufficiently into a stable adulthood.

59. Health needs assessments are improving in both timeliness and quality and indicate a strong current performance. Appropriate responses are provided when a need for sexual health services, substance misuse services or therapeutic assistance is identified. There has been some detailed analysis of the overall health needs of children looked after, which is assisting with commissioning arrangements. It is recognised that the provision of emotional and psychological support services through child and adolescent mental health services (CAMHS), and a specific service for children looked after (Connect), continue to need improvement; a clear, active joint plan is in place to achieve this.

60. The council and its partners have worked closely together to ensure that young people on the edge of care, children looked after, and the families with whom they live, have access to a range of social and leisure activities. An activities scheme in the south and west of the area provides bespoke individual and group work approaches with young people. This is a popular scheme and currently has a waiting list, indicating that this service is of value to children and their carers.

61. Strong partnerships with schools, the strengthening virtual school and school improvement services are leading to improvements in the attendance and attainment of primary-aged children looked after in the area. The provisional results for 2015 indicate significant improvement at Key Stage 2. In reading and writing, results have improved over the past three years. In 2015, provisional results indicate that attainment at Key Stage 4 dipped and they were well below the national average for all pupils. An analysis of the factors that contributed to these poor results identified that over a third of the young people entered care during Key Stage 4. The Year 11 young people doing well at Key Stage 4 had been in care for an average of over five years before taking their exams. Additionally, a quarter of this group of children changed placements or schools during Key Stage 4. Nonetheless, results are poor at age 16. Only 7.5% of young people achieved good GCSEs and the gap with all 16-year-olds in Suffolk is widening. (Recommendation)

62. More than 80% of children looked after have a personal education plan, the quality of which is checked by the Looked After Children Education Support Service (LACESS). Schools welcome the very good support from the LACESS professionals. They report that they are challenged to explain how they spend the pupil premium grant. However, the quality of personal education plans is not consistently good, and the pupil premium grant is not being used as effectively as it could be in all cases to improve outcomes. While absence rates have dropped slightly, they remain above the average for children looked after in England. Persistent absence was slightly lower than average in 2013–14, compared with other local authorities, but the most recent data show that it was high in Years 10 and 11, impacting on GCSE outcomes.

63. The children in care and care leavers council, through its two groups – C2C (for older children looked after and care leavers) and Brighter Futures (an activity group for children looked after aged 12 and under) – is highly active and is supported well by the local authority. These groups are dynamic and purposeful, and have a strong social activity base. C2C and Brighter Futures have influenced a range of practice initiatives; they routinely attend the now well-focused Corporate Parenting Board, and they have been involved in developing the revised Promise and associated consultation booklets for children in care. They have also ensured a 'no more black bags' provision of appropriate luggage and the allocation of personal laptops for those at Key Stage 4 and beyond. Looked after young people's achievements are celebrated at annual events, with awards tailored to the individual's interests.

The graded judgement for adoption performance is that it is good

64. The adoption service in Suffolk is well run, well managed and appropriately resourced. Adoption is considered for all children who are unable to return home or live with their birth family and this happens in a timely way. Adoption is the plan for a wide range of children including older children, children with complex needs or disability and for brothers and sisters together.

65. The service reorganised recently and offers equity of service and support for a range of different types of permanence for children alongside adoption. There is a clear, up-to-date statement of purpose and recruitment priorities are regularly reviewed to ensure that the service is recruiting for the children who are waiting. The local authority has invested significantly in rebranding its adoption service and has an effective recruitment strategy with a target to recruit 50 adopters in 2015–16. Between April and October 2015, 26 adopters were approved, demonstrating a considerable strength in recruitment. The local authority has worked hard to improve the conversion rate from enquiry to approval and monitors this carefully (currently at 20%, compared with 14% the previous year). Current priorities are specific geographical areas, those who are able to offer placements to brothers and sisters, children with disabilities, complex needs and older children (four years and upwards). The most recently approved adopters showed positive recruitment in relation to diversity and offer placement options for a wide range of ages of children.

66. Children receive a comprehensive family-finding service, including early consideration of in-house approved adopters, the local adoption consortium, referral to the adoption register and a wide range of external family-finding services. Suffolk has been particularly successful in implementing a foster to adopt programme. In 2014–15, 10 children benefited from early placements (six foster to adopt and four in concurrent placements) with seven children being placed in foster to adopt placements between April and October 2015, enabling early attachment to their primary carer. Foster to adopt is currently being considered for an older child, demonstrating a continued pro-active approach and impressive performance for children in this area.

67. Progress for children is monitored effectively through weekly permanence panel meetings using a tracking system for children with a placement order and children in proceedings. In the vast majority of cases, child profiles were in place and were of a good quality. Active family-finding was underway for each of the nine children currently waiting for adoption.

68. Recent local performance data indicate that the local authority is likely to better the DfE target for 2013 to 2016 for the average time between a child entering care and moving in with his or her adoptive family. This demonstrates good performance. The time between date of matching and being placed for adoption is particularly good, currently an average of 13 days, meaning children move quickly into their adoptive families. The local authority will not, however, meet the DfE target for 2013 to 2016 for the average time between receiving court authority to place a child and deciding on a match to an adoptive family. The authority recognises that it needs to improve the timeframe between placement order and matching as it does not yet meet the government threshold of 121 days. There are some longer term issues, which impact on the figures, for example three children with significant complex needs and two children whose first adoptive placement disrupted. The local authority is persistent in finding the right places for these children. Overall, the picture is an improving one. For matches between April and October 2015, the average timescale is currently 108 days, with 77% of children being matched within timescale.

69. The local authority understands the assessed needs of children requiring adoption extremely well. Child permanence reports seen were of consistently high quality, being comprehensive and analytical with an appropriate balance of history and the child's individual needs. There was a sensitive understanding of the impact on birth parents and wider family. Viability assessments of the extended family were of a consistently high quality, with appropriate consideration given to a range of extended family members.

70. Good use has been made of the adoption reform grant to fund additional posts within the recruitment, assessment and matching team and also within the new permanence support team. This capacity increases the ability to respond to new referrals in a timely manner, prioritising any urgent need, matching children and supporting families to minimise the risk of disrupted placements.

71. All prospective adopters reports seen were of good quality, analytical and demonstrated an understanding of diversity issues. Adopters spoken to were positive about their initial enquiry to the service, had received a timely and realistic response and thought highly of their social workers. The majority of adopters have timely progression through the different stages. At October 2015, 76% met the target for stage one and 96% met the target for stage two. Delays in the assessments seen during the inspection were appropriate. The local authority currently has 15 adopter households waiting to be matched with children.

72. There has been less urgency to secure adoption when this is with the current foster carer and, although the impact is lessened for children, this is an area that should be given a higher priority. There are low numbers of cases where plans change away from adoption, at 5.6%, but delays were seen in a very small number of cases when securing a different form of permanency, following a change of plan.

73. The local authority ensures that sufficient adoption and permanence panels are held to consider work in a timely way and avoid delay. The panel is appropriately constituted, well supported and well chaired. It includes panel members who have personal experience of being adopted or fostered, adopters and elected members who consistently attend. The panel provides feedback on the quality of each report and on the presentation by social workers. This has contributed to improving practice, with reports being of a consistently high standard. Decisions by the agency decision-maker are timely and there is appropriate challenge.

74. The adoption service demonstrates an impressive commitment to adoption and post-permanence support, with 76 families currently receiving adoption support. One adopter spoke about the range of support her family received, which enabled them to cope; this included different services for each child appropriate to their needs and counselling for the parents. Adoptive parents spoken to were aware of their entitlement to support and how to access it. They were impressed at the speed at which the support was available following their assessment and at the quality of support received. In particular, adopters spoke highly of the Theraplay support they and their children had received.

75. The permanence team comprises experienced and skilled workers who spoke of the high-quality training they had received. The local authority has invested in training three staff in video interactive guidance, for example. There is a good range of in-house and commissioned services.

76. The local authority has good-quality medical advice available. Agency decision-makers spoke of the quality of this, both within reports and at panel; summaries for individual children seen by inspectors also evidenced this. Adopters spoke of receiving concrete information during their preparation days, which helped them to understand the potential impact of specific complex health needs on the child and the family.

77. The local authority has a very low rate of disruptions (one placement in the last year) and, appropriately, considers any learning through a formal disruption meeting. In addition, the permanence panel chair and the agency adviser produced a report on disruptions, which has been used by the panel and frontline social workers.

78. Senior managers are visible within the service and all social workers spoke about the positive learning and development culture. The local authority will be undertaking a review of its new structure within the service following reorganisation in April 2015 to consider its effectiveness, and plans to include adopters in development of service review and service delivery.

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

79. Services for care leavers are now receiving a higher priority, but current outcomes are variable and inconsistent. The local authority has recognised the need to improve services and outcomes. It has given this a concerted focus, including a task and finish group looking specifically at accommodation. At the time of the inspection, 29 (10%) care leavers were living in unsuitable accommodation; twelve young people were in custody. For care leavers aged 19–21, 19 (10%) were living in unsuitable accommodation; five young people were in custody; this is an improving picture from 20% in 2013–14. The Corporate Parenting Board's priority to ensure a wider choice of more appropriate and suitable accommodation for young people has resulted in a clear vision with robust commissioning plans in place to improve outcomes; new contracts are due to begin in April 2016.

80. Bed and breakfast arrangements have been used for young people who need accommodation. The local authority continues to reduce the use of this type of accommodation, from 22 young people 12 months ago to two, including two young people who were moved to suitable placements from bed and breakfast accommodation during the inspection. Some care leavers, particularly those aged 16 and 17 years, have had three or more changes in accommodation until they experienced stability. This indicates that young people are not ready to live independently and have been moved too early into this type of accommodation, or have not been offered accommodation that fully meets their support and preparation needs. For some young people, risk assessments have not routinely been undertaken or updated in relation to specific accommodation when they move. (Recommendation)

81. Young people spoken to by inspectors value the quality of their relationship with their worker. They feel supported and listened to and receive practical and financial help. One young person receiving support said of his personal adviser 'He is fantastic' and that he was 'Glad they are here'. The local authority commissions 16+ services from a national charitable organisation and keeps in touch with 98% of its care leavers.

82. Risk assessments are not routinely completed for those care leavers over 18 years old to ensure that their accommodation meets their support needs. Responses to care leavers missing or at risk of child sexual exploitation are variable. However, one case seen by inspectors demonstrated a proactive response to protect a young person, with risk assessments updated to reflect changing needs.

83. Care leavers spoken to feel safe where they live and know where to go to for help and support. Positive examples seen during the inspection included a worker attending a health appointment with one care leaver and a housing assessment for another pregnant young person who required alternative accommodation with increased support. Staff identify and respond well to young people's diversity and identity needs.

84. Young people in 'Staying Put' arrangements continue to have stability and maintain relationships with their carers. At the time of the inspection, the local authority had 21 young people in these arrangements. Promotion of Staying Put arrangements is inconsistent. Opportunities to stay put for those young people in supported lodgings require further development. (Recommendation)

85. At the time of the inspection, 118 (39%) care leavers were not in education, employment or training (NEET). Of these, 91 (46%) were 19- to 21-year-olds. Several projects are in place to increase participation in education, employment or training. One specific project is a joint venture with British Exploring, which provides experiences in remote locations. When young people are in stable placements they sustain their participation in learning and do well, with currently about 100 in colleges or school sixth forms and over 20 at university. The transition from Year 11 to Year 12 was planned effectively this year with all young people, who took their GCSEs in July 2015, being offered a place of learning or training in September 2015.

86. Care leavers who have gaps in their basic literacy and numeracy skills lack confidence or resilience to sustain their engagement in education, employment or training. Those spoken to were not able to talk about the help they had received to encourage them to further their learning or training, although there are many opportunities available, such as through the Pathway Into Learning And Work (PILAW) project or the MyGo provision, a youth employment centre. Participation is improving, with currently 59 young people registered with MyGo in Ipswich.

87. At the time of this inspection, a small number of young people (seven) were on apprenticeships. The local authority has created an apprentice commissioner scheme, ring-fenced for two care leavers, which provides opportunities to develop skills and gain work experience and training to secure future employment. The apprenticeship commissioners are working with children looked after and care leavers on the design and shaping of service provision and this is a strength of the service.

88. There are insufficient links between the virtual school and post-16 provision. The post-16 personal education plans are new and most pathway plans lack clear and aspirational learning or training targets for care leavers.

89. Pathway plans and reviews are routinely and consistently completed on time with sufficient management oversight. The detail of the plans is not specific or outcome-focused and the quality varies, with the majority not having clear timescales for actions. Risk assessments are not always updated, and lack evidence of how risks will be mitigated and reduced. (Recommendation)

90. Pathway plans do not consistently evidence the young people's voice being central throughout the plan and not all young people receive a copy. The local authority is piloting redesigned pathway plans to incorporate the new casework model and the Promise charter. (Recommendation)

91. Care leavers are supported to take responsibility for their own actions and to make choices, and are provided with information on their health needs, including sexual health. The majority of care leavers are registered with a GP and a dentist. Health passports are in development. However, at the moment, some young people do not have all the information they require on their health to support them into adulthood. (Recommendation)

92. The local authority promotes a range of positive activities for care leavers that aim to build a strong sense of identity and achievement, while helping young people to develop skills and opportunities for training and employment. These include preparing and cooking a collective Christmas dinner for care leavers, staff and managers to enjoy together. Other activities include volunteer opportunities on school holiday schemes, the Princes Trust and celebration of achievement awards, with recent examples including 10 young people participating in a camping trip and eight young people on target for a trip to trek around Iceland.

93. Managers and workers work extremely hard to try to keep in contact with the very small number of young people who disengage with services. Case recording does not fully reflect this and the multiple recording systems do not support consistency in recording or information sharing within the team, with some information being difficult to find.

94. The co-location of the Youth Offending Service with the leaving care teams is well received by staff and communication is improving for care leavers in receipt of both services. The two services are not yet fully coordinated in their systems for care leavers to support information sharing, particularly in risk assessments and pathway plans.

95. Young people spoken to by inspectors said that they were supported when living independently and received help with budgeting and attending appointments. Knowledge of entitlements and rights information and the work of C2C, the local authority's children in care council, are not fully embedded and known to all care leavers. The local authority is aware of the need to promote this further and is developing an app, funded by the virtual school, to support the promotion of rights and entitlements. There is also a dedicated website for young people, 'The Source', which young people helped to design. This has a dedicated section for care leavers, including an entitlement guide for young people leaving care.

Leadership, management and governance	**Good**

A strong and energetic senior management team with a clear sense of purpose and direction, robust governance arrangements and clear lines of accountability is transforming the way in which services are designed, developed and delivered. Outcomes for children are improving.

The local authority knows itself well. Senior leaders have a clear understanding of strengths and areas for development and are making intelligent and effective use of qualitative and quantitative data to address shortfalls and raise practice standards. Lessons learned from audits are acted on and the quality of practice is improving strongly.

The local authority is continually looking for ways to deliver best value, while at the same time improving outcomes for children, young people and families. A more coherent approach to procurement and commissioning is being developed, one that is more responsive to the experiences of children and families. Further integration of the already well-established early help services is starting to have a real impact.

The local authority takes its responsibilities as a corporate parent very seriously. The children in care and care leavers council is lively, dynamic and influential.

Partnership working, particularly with the police and with health services, is strong. Inspectors saw evidence of good practice and effective interventions involving child sexual exploitation, gangs, unaccompanied asylum-seekers, female genital mutilation and radicalisation.

Positive Choices, which supports women who have previously had a child taken into care, is a particular example of good practice.

The strength of the local authority's approach to permanency means that children looked after are being well served, with some outstanding features of practice.

A simple and uncomplicated approach to recruitment, retention and development is contributing to a more settled and stable workforce. Staff morale is good.

While there is a strong trajectory of improvement, the local authority recognises that there is much still to do. The quality of strategic action plans varies. The impact and effectiveness of frontline management are not sufficiently robust. The planned transformation of services to meet the mental and emotional health and well-being needs of children and young people cannot happen soon enough. Accommodation services for young people aged 16 to 18 are being recommissioned. Educational attainment, particularly for children looked after, continues to be a cause for concern.

Inspection findings

96. Strong leadership, an ambitious and well-articulated vision and robust governance arrangements are leading to improved outcomes for children, young people and families. Senior leaders are energetic, active and visible. They understand the scale of the challenges they and their staff face and are realistic about strengths and areas for development. Rigorous implementation of Making Every Intervention Count (MEIC), a five-year transformation programme, is changing the way services are designed, developed and delivered. The Director and Deputy Director of Children's Services routinely consider and observe frontline practice and, as part of their commitment to openness and transparency, members of staff are able to sit in on meetings of the departmental management team and provide feedback.

97. Clear links between the Children's Services Accountability Board, the Children's Trust Board, the Health and Wellbeing Board and the Local Safeguarding Children Board (LSCB), and good engagement with elected members, enable effective scrutiny and critical challenge. For example, the Education and Children's Services Scrutiny Committee has provided appropriate critical challenge on issues such as the recruitment, retention and turnover of social workers and the quality of mental health services for children and young people. As well as reviewing performance management information, the Children's Services Accountability Board closely monitors the progress of MEIC.

98. Informed by a rolling programme of joint strategic needs assessments, the local authority and its partners have a good understanding of the shape and scale of existing provision, appreciate the likely demand for services in the future and are aware of gaps that need to be addressed. Chief among these are the limited availability and capacity of services to meet the mental and emotional health and well-being needs of children and young people and the sufficiency of placement and accommodation options for young people aged 16–18. Urgent action is already being taken to improve these services. The Health and Wellbeing Board has successfully accessed additional funding of £6 million over five years to support the transformation of CAMHS, and accommodation services are in the process of being recommissioned.

99. Senior managers ensure that they have appropriate plans in place to strategically plan and monitor progress and impact. However, the quality of strategic action plans is variable. In some cases, such as the CAMHS transformation plan, these are ambitious and clear. In others, such as the high-level strategic action plan on child exploitation, children who are missing and gangs, and the hidden harm action plan, plans are not sufficiently outcome-focused, specific or measurable. This makes them less effective as tools with which to monitor progress and hold others to account. Moreover, although the local authority and its partners have recently completed a strategic needs assessment of hidden harm, they have yet to agree a formal multi-agency strategy on neglect. This is a significant omission and has the potential to undermine the effectiveness of the collective response to the corrosive impact of domestic abuse, parental mental ill-health and substance misuse on the lives of children and young people. (Recommendation)

100. A responsive and well-managed approach to commissioning, combined with robust procurement arrangements, is helping to build capacity and shape the market. As well as making public their commissioning intentions for 2015–16, commissioners have worked hard to ensure that providers understand the strategic direction of travel.

101. Contract monitoring is being strengthened in order to focus more on outcomes, and children, young people and families are being brought into the centre of commissioning activity. For example, young people have delivered presentations to providers at stakeholder engagement events and are involved in evaluating tenders. Additionally, commissioning and decommissioning decisions about short break services are influenced by feedback via social networking sites from children and young people with disabilities, and two care leavers, who have been appointed as apprentice commissioners. This gives children, young people and families greater influence over the way in which services are designed and developed.

102. Corporate parenting is given a high profile. Elected members are serious about their responsibilities as corporate parents. The Corporate Parenting Board, which meets bi-monthly and includes representatives from C2C, is able to demonstrate that it is having an impact. For example, it has been influential in helping to virtually eliminate the use of bed and breakfast accommodation for care leavers, eradicating the use of black bin bags by children looked after for their belongings when they change placements and producing, in collaboration with C2C, a revised Promise in three easy-to-understand and age-specific leaflets. The board has also developed a more flexible and responsive approach to the provision of laptops for children looked after and care leavers who are pupils/students. It is also improving career pathways for care leavers through the introduction of more apprenticeships in both the county and district councils.

103. Regular face-to-face contact between the Chief Executive, the Director of Children's Services, the lead member and the LSCB chair ensures that there is good four-way communication. The Director of Children's Services meets monthly with the Chief Executive and separately with the LSCB chair. The Chief Executive meets with the LSCB chair once every quarter. As well as providing the Chair of the LSCB with the opportunity to exert influence, this means that the LSCB is being held to account effectively.

104. Some progress has been made to provide suitable technology to support the workforce, and the recent roll-out of equipment to support mobile working has been welcomed. The complex range of IT systems currently used is a challenge for practitioners and does not provide a coherent or easily accessible structure for record-keeping. The senior management's understanding of this is clear, including about action required on what needs to be achieved. The local authority accepts that the pace of this change needs to quicken. Against this background of challenging IT systems, an intelligent and purposeful approach to the development and use of performance management information is helping to create a culture in which performance is seen as everybody's business. (Recommendation)

105. The current dataset enables middle and senior managers to drill down to individual, team and area performance and provides a direct line of sight to what is happening at the frontline. Performance monitoring reports are routinely scrutinised. Information is being used to identify and explore issues and concerns, although these do not routinely have a written commentary, and accompanying analysis to highlight causal and mitigating factors. For example, in one case, interrogation of referral data raised concerns that, following further enquiries, culminated in a major investigation into young people being groomed as drug-runners by adult gang members. However, the current dataset does not include any information about the offer or completion of return home interviews or the use, outside of the MASH, of the child sexual exploitation toolkit. This means that middle and senior managers rely on manually-generated information and/or repeat audits to know what is happening in those areas.

106. Audits are used effectively to quality assure social work practice and gain an insight into the progress and experience of children, young people and families. Lessons learned from audits are used well to identify and address areas for improvement. Members of the quality assurance and professional development team, led by the principal social worker, have regular quarterly meetings with area teams to review key messages. As a result, the proportion of assessments judged to be good or better has improved significantly, as has the quality of child-centred practice. However, senior managers acknowledge that further work is required to ensure that plans are of a consistently high standard.

107. Frontline managers are committed and capable and support staff well. However, the impact and effectiveness of frontline management are not sufficiently strong in relation to the quality of supervision and management oversight. The recent introduction of the new, but critically important, role of consultant social workers is intended to address this through the additional supervisory support this role will provide to team practice managers; a programme for the development of these staff is underway. Supervision takes place regularly for most staff. Management oversight was seen in the majority of case files, but in a small number it was unclear how much this had directed or influenced practice. Management compliance with the expectation that they audit at least one case per month currently stands at 57%, which is below the acceptable standard.

108. As a learning organisation, the local authority is able to demonstrate an openness to different ways of thinking and working and a willingness to innovate. Bringing together health visitors, children's centres, school nurses, youth support services, education welfare officers and family support practitioners, the integration of early help services has increased capacity and is already starting to increase the proportion of families who access the services. The adoption of the new casework model and well-being practice framework is changing the way in which social workers, and others, relate to and communicate with children and families. Positive Choices, which supports women who have previously had a child taken into care, is helping to break the cycle of serial pregnancies and children being removed, and is an example of good practice.

109. A strong focus on the needs of children and young people who are unable to live with their birth families ensures that children achieve permanency quickly. Good relationships with the Children and Family Court Advisory and Support Service (Cafcass), the local family courts and the local Family Justice Board, supported by robust and vigorous early assessment and decision-making and high-quality applications, are helping to minimise delay and uncertainty.

110. A joined-up approach to recruitment, retention and development is making Suffolk a more attractive place to work. Job applications from experienced social workers have increased and turnover rates have fallen. Local authority reported data show this is down for social workers from 13.5% to 12.6% between September 2014 and September 2015 and for all social care staff from 10.5% to 8%. The number of locum social workers employed has also reduced to 24. With more manageable caseloads, and a more settled and stable workforce, outcomes for children, young people and families are improving.

111. In the absence of a formal competency framework, a flexible response to training and development needs is helping to ensure that staff have the right knowledge and skills. Staff employed in early help and social care have access to extensive and well-targeted training menus. The learning management system is used to closely monitor the take-up and delivery of training. The impact of training is being evaluated through the use of follow-up telephone calls to practice managers three months after their staff have completed training courses. Performance appraisals are also being used effectively to motivate staff and raise performance standards. In the last 12 months, 89% of staff have had a performance appraisal and, according to the results of the latest staff survey, most described their performance discussions as helpful.

112. There is good oversight of the commissioned provider that provides the leaving care service. The head of corporate parenting has direct management oversight of the service and uses a tracker tool to monitor, on a weekly basis, the progress of cases, particularly those that are high profile. The provider's activities are included in the monthly performance monitoring reports, which are scrutinised by the departmental management team, the Children's Services Accountability Board, the Corporate Parenting Board and the Quality Engagement and Improvement Board. The Corporate Parenting Board receives regular updates on care leavers, including NEET and EET figures, and the manager of the Corporate Parenting Board is also involved in the quarterly contract monitoring meetings.

The Local Safeguarding Children Board

The Local Safeguarding Children Board is good

Executive summary

Suffolk's Local Safeguarding Children Board (LSCB) is comprehensively addressing its statutory duties and has evolved into a body that is rigorously holding agencies to account and strongly influencing improvements across the safeguarding system in Suffolk. The Board has achieved substantial progress in the last 12 months following the appointment of a new independent chair, who has galvanised the Board towards a model featuring greater scrutiny, evaluation and support for partner agencies. Partners have demonstrably become more engaged within all the Board structures, appreciating a climate of open evaluative discussion and debate concerning the effectiveness of safeguarding activities undertaken within their agencies.

The Board holds agencies to account for safeguarding performance through a variety of quality assurance mechanisms. The Board requires that the quality and relevance of data and commentary provided demonstrates a sharper focus on safeguarding outcomes, with indicators that clearly measure performance. The new casework model is being increasingly adopted to good effect, as a method of partner reporting to the Board.

The Board's engagement with other strategic bodies has developed quickly, with examples where this has resulted in constructive challenge and clarification of priorities across agencies, avoiding duplication and confused accountability. Board priorities are well informed from diverse sources of intelligence and its field of vision, across the spectrum of multi-agency safeguarding, is broad. This panoramic scope does not reduce the Board's focus on key statutory safeguarding responsibilities including thresholds, the quality of decision-making for referrals and child protection conferences and plans.

The Board has started to secure feedback and views from children and young people and recognises that it needs to expand the scope and extent of the information it receives to introduce a stronger vein of participation and involvement in its evaluation and influencing of safeguarding services.

The Board's learning and improvement group is the fulcrum of its evaluation function, featuring a well-targeted multi-agency audit programme and persistent tracking of recommendations. Demonstrable evidence is sought of more informed practice emerging and embedding in assessments, plans and interventions across partner agencies.

Through monitoring, evaluation and challenge, the Board has actively helped the local authority to achieve the improvements that have been seen.

Recommendations

113. Ensure that the Board continues to improve its understanding of the scale and prevalence of child sexual exploitation across the county, particularly improving its use of the amalgamated intelligence from children and young people's return interviews and activities to disrupt exploitation.

114. Ensure that the Board clearly demonstrates how the views and concerns of children and young people influence its priorities and plans.

115. Ensure that the Board develops the evaluative analysis of performance data to heighten partner agencies' understanding and reporting of the impact and quality of safeguarding practice in their services.

Inspection findings – the Local Safeguarding Children Board

116. The LSCB's priorities are well targeted. They derive from a wide range of intelligence sources, including audit recommendations, performance data, section 11 audit returns, board discussions and serious case reviews (SCRs). Joint, cross-cutting priorities are agreed with other strategic boards concerning, for example, hidden harm, domestic abuse and child exploitation. A pan-county Safer Stronger Communities Group was formed as an outcome of the LSCB's influence with other boards, determining which strategic body leads on cross-cutting safeguarding programmes to avoid duplication and fragmented accountability. The LSCB chair meets regularly with the chairs of the Health and Wellbeing, Safeguarding Adults' and Corporate Parenting Boards. The Chair also frequently meets with the Director of Children's Services, the Lead Member for children and families and quarterly with the council Chief Executive. The Board is well supported by a full-time manager and professional adviser.

117. The LSCB effectively challenges the priorities and safeguarding scrutiny arrangements of other boards. Two recent examples of the Board's influential oversight are the implementation of a multi-agency risk assessment conference (MARAC) strategic steering group to improve coordination and threshold management for adults and children affected by high-risk domestic abuse, and the appropriate strategic positioning of responses to female genital mutilation. Cross-board representation has progressed purposefully, although the Board recognises that the next evolutionary stage is to continue the construction of sharper strategic collaborations. It intends to build more integrated approaches and responses to cross-cutting safeguarding initiatives, including, for example, a recent increase in self-harm presentations at accident and emergency units. This has led to the Board's health executive group identifying young people with repeat attendances, and active consideration of what interventions could be attempted to address the emotional and mental distress underlying these behaviours.

118. An LSCB pact and constitution clearly explains governance arrangements and cross-board accountabilities. A well-crafted protocol clearly describes the respective responsibilities of the mental health trust, adults' services and the LSCB, where parents' specific vulnerabilities trigger safeguarding concerns including mental illness, learning difficulties and substance misuse. The number of referrals made to adults' services and monitoring the effectiveness of responses to them, pursuant to the council's 'Hidden Harm' strategy, is one example where the protocol has a purposeful impact.

119. The Early Help Strategy is a joint priority with the Health and Well-being Board. The quality and take-up of early help provision in Suffolk has increased markedly, but the LSCB retains its concerns that access to the early help system is not entirely understood by all agencies. Thresholds are not consistently applied, leading to a continuing, although reducing, pattern of inappropriate referrals to the multi-agency safeguarding hub (MASH). The Board is addressing this by revisiting the threshold guidance and service pathways to ensure that greater clarity and confidence develop across the children's workforce. The Board routinely commissions audits of thresholds in early help, re-referrals, decision-making in child protection enquiries, child protection conferences and core group planning to identify sources of weaker practice, designing well-formulated recommendations for improvement.

120. LSCB partners described a reformed climate in which challenge, analysis, accountability and support have increased since the appointment of the current independent chair. This approach is also apparent in the minutes of full Board, executive group and sub-group meetings. Lay members attested to meetings that are reflective, questioning and welcoming of their scrutiny as representatives of the Suffolk public. The Board has a wide field of vision and a strong understanding of where improvements are required in the safeguarding system, including, for example, overdue health assessments for children looked after and the effectiveness of services provided to children who are looked after outside the county. The Board has purposefully engaged with a significant number of independent schools in the county and with health partners regarding young people placed in mental health settings. The LSCB features a health executive group, providing a single, coherent voice from a diverse network of health trusts, providers and clinical commissioning groups. An example of the group's impact is its work with substance misuse services, collecting data by assisting in identifying young people who may be at risk of child sexual abuse.

121. LSCB risk and challenge registers demonstrate persistent tracking of recommendations until sustained evidence of improved practice occurs. The Board had been concerned, for example, that children and young people's services and housing departments did not consistently offer efficient joint assessments of homeless 16- and 17-year-old young people, potentially leaving some at risk. The Board has persistently sought improved, accountable and legally compliant joint responses. Poor attendance, or lack of senior representation at the Board and its groups, has been purposefully addressed, leading, for example, to increased engagement of school leaders.

122. The Board has introduced three area safeguarding groups across the county, serving as an effective platform to impart key messages and learning priorities directly to multi-agency frontline practitioners and managers. Importantly, the Board is also able to receive local intelligence and feedback, extending its influence to all parts of a large rural county. Senior representation at Board level from the county's district and borough councils ensures that pertinent safeguarding recommendations are promptly addressed at that level of governance. These have recently included licensing work with taxi drivers, in connection with the child sexual exploitation action plan, and basic safeguarding training and awareness-raising for local authority housing and housing association staff.

123. The Board identifies relative strengths and shortcomings in the safeguarding system, primarily through themed multi-agency audits, completed to high standards, with recommendations rigorously monitored through the learning and improvement group. This group, led by the LSCB chair, is at the centre of the Board's ambition to achieve consistently reliable, robust safeguarding services. The Learning and Improvement Framework and audit programmes are aligned with Board priorities and SCR action plans. Recent auditing programmes have prioritised core statutory safeguarding services, as the Board recognises that, although improving, some practice is insufficiently robust, such as the quality of core groups and child protection conferences and plans. This Board sub-group carefully evaluates all audits undertaken, forming considered recommendations to the Board on risks, impact and actions.

124. The section 11 audit process is rigorous, with 100% of agencies completing the exercise. Significantly, partners report that the process provides important learning about the quality of their safeguarding services, enhanced by constructive peer challenge and support. Action plans are stringently reviewed, annually, led by the LSCB's professional development adviser. This enabling approach has generated interest from other agencies, including the Diocese of St. Edmundsbury and Ipswich, which has chosen to undertake the audit programme. Over the forthcoming year, agencies will be required to demonstrate, congruent with Board priorities, how they involve children and young people in reviewing and influencing their service provision. Partners will also be asked to illustrate how they are improving awareness and the application of thresholds in their staff groups.

125. The LSCB makes timely and appropriate recommendations to initiate SCRs through the Board's sub-group. One serious incident notification to Ofsted by Suffolk County Council was significantly delayed, regarding a serious case review which was in progress at the point of the inspection. The Board undertook a thorough review of its reporting arrangements, providing assurance that the single omission did not signal systemic weaknesses in reporting and making decisions on SCR thresholds. Two recently completed SCRs have produced significant learning that the Board persistently evaluated until evidence of improved practice was developed and sustained. The Board continues to monitor longer-term outcome measures, particularly better consideration of parents' childhood histories in statutory assessments and more effective interventions with families who resist and avoid interventions. Board activities are consistently targeted at improving safeguarding services and the experiences of children.

126. The Child Death Overview Panel (CDOP) features a wide range of expertise allowing rapid, evidence-based reviews of each reported death. Modifiable factors are appropriately identified and regularly reviewed through a learning and action log. The Panel contains strong public health expertise, facilitating a research-informed approach and effectively targeted public health campaigns.

127. A wide range of quality-assured multi-agency LSCB courses is provided by the children and young people's services' workforce development service. The content of courses is closely informed by the priorities of the learning and improvement group. Multi- and single-agency courses are evaluated and accredited through the Board's professional development adviser, ensuring consistently high levels of content and trainer proficiency. The majority of courses are currently evaluated by participants, but the Board is introducing further rigour, including evaluation of training by frontline line managers, demonstrating improved practice by frontline staff. The Board is ensuring that training and learning attendance rates are not viewed as the sole measure of partner engagement. It is introducing mechanisms that will identify whether relevant training is reaching all parts of the workforce, through the establishment of a training sufficiency group.

128. An 'exploited children's sub-group' incorporates children and young people with a spectrum of interlocking vulnerabilities encompassing child sexual exploitation, trafficked children, female genital mutilation, forced marriage and gangs and groups. The Board has influenced the implementation of robust operational responses to identified risk and harm, identifying and addressing weaknesses in the consistent completion of child sexual exploitation screening and assessment toolkits and missing from home return interviews. The Board provided recent multi-agency training on conducting more effective return interviews to improve the skills of practitioners in acquiring better intelligence and reducing further missing episodes.

129. Acceleration of improved strategic and analytical capability to demonstrate the scale and profile of child sexual exploitation in Suffolk is an important Board priority. Combining intelligence from return interviews of children who have gone missing and capturing the coordinated impact of disruption activities are key elements to this work. The Board has recently added additional analytical and administrative resources to purposefully progress this objective. (Recommendation)

130. The LSCB performance data set has been reformulated, requiring partners to better demonstrate how the impact of their interventions are improving children's experiences and safety. The quality of data has developed, but the level of evaluative commentary on performance indicators is either absent or too rudimentary to explain data trends and their impact on producing better safeguarding services for children and young people. The performance framework does not consistently include feedback from frontline practitioners and children and young people. Cross-agency data is not yet systematically used to inform service and demand planning. (Recommendations)

131. The LSCB has revised and updated all safeguarding policies and procedures, which are clearly signposted and navigable on an informative and accessible Board website. While the LSCB has published guidance on neglect, this is not sufficiently rigorous to assist in monitoring and evaluating impact. Periodic reviews are undertaken and interim updates completed promptly in response to new legislative, regulatory and procedural requirements. Expert guidance is available on the sub-group for specialist areas such as concealed pregnancies and fabricated or induced illness. A Board priority is to both enhance awareness of policies and procedures and test the level of compliance with them across the multi-agency partnership.

132. LSCB threshold guidance is comprehensive and detailed but it is complex and does not yet refer to the most recent *Working together to safeguard children* (2015) guidance.

133. The LSCB annual report is a comprehensive and evaluative assessment of the performance of Suffolk's multi-agency safeguarding services. The report clearly identifies learning, and provides documented examples of effective, constructive challenges to other partnership boards.

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 eight of Her Majesty's Inspectors from Ofsted.

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