Aviation House
125 Kingsway
London WC2B 6SE

T 0300 123 1231
enquiries@ofsted.gov.uk
www.ofsted.gov.uk

31 March 2017

Matt Dunkley
Executive Director of Children's Services
County Hall
Martineau Lane
Norwich
NR1 2DH

Dear Mr Dunkley

Monitoring visit of Norfolk County Council children's services

This letter summarises the findings of the monitoring visit to Norfolk County Council children's services on 1 and 2 March 2017. This was the third monitoring visit since the local authority was judged inadequate in October 2015. The inspectors were Nigel Parkes, Fiona Parker and Kath Townsley.

Overview

Since the last monitoring visit, the local authority has taken decisive action to speed up the pace of improvement.

A new, more confident and visible senior management team is providing a clear sense of purpose and direction. Performance management and quality assurance systems have been significantly strengthened. Managers and staff are responding well to increasing scrutiny, challenge and accountability. Morale is good. It is, however, too early to see a consistent impact of these changes on frontline services. Individually, social workers and personal assistants are doing some good direct work with children and young people, but the quality of assessments and plans remains very variable. The service that most children and young people receive, whether as care leavers, children looked after or children in need of help and protection, is not yet good enough. However, more effective oversight and quality assurance mean that the authority is better placed than before to identify and address problem areas.

Areas covered by the visit

During the course of this visit, which, by agreement with the local authority, was centred on Great Yarmouth, inspectors reviewed the progress made in addressing the weaknesses identified at the 2015 inspection in the areas of:

- Leadership and management, with a particular focus on the quality and effectiveness of strategic leadership and the use of performance management information to drive improvement.
- Care leavers, with a particular focus on the quality and effectiveness of work to prepare young people for independence and enhance their life chances by making sure that they are engaged in meaningful education, employment or training.
- Children looked after, with a particular focus on assessment, including initial health assessments, care planning and planning for permanence.
- Help and protection, with a particular focus on the identification, management and reduction of risks, and arrangements for stepping cases up or down between early help and children's social care services.

On this occasion, and at the request of the local authority, inspectors also reviewed the effectiveness of the local authority's quality assurance arrangements.

During the monitoring visit, inspectors tracked and sampled a number of children's and young people's cases, all from the Great Yarmouth area. As well as speaking to social workers and managers, inspectors considered a range of evidence from across the county, including electronic case records, minutes of meetings, management reports, tracking tools, case audits and improvement plans.

Findings and evaluation of progress

1. Leadership and management

The local authority has wasted no time in acting on the key messages from the last monitoring visit. It has invested additional resources in improvement and business intelligence. Chaired by the managing director, an improvement board has been re-established. Key strategic priorities are now clearly defined and local service plans, which are outcome focused, specific and measurable, are directly linked to an overarching improvement action plan. As a result, there is a greater sense of urgency and a much clearer sense of purpose and direction.

The quality of performance management information is greatly improved and means that managers, at all levels, are better able to monitor and interrogate frontline practice. Together with the recent introduction of regular, six-weekly performance and challenge surgeries, this means that strategic and operational activity is now more closely aligned. Local managers talked about feeling motivated and empowered by the increased visibility of senior managers and the greater emphasis on accountability and critical challenge.

The performance management framework, which has been comprehensively refreshed, was relaunched in November 2016. It sends out a clear signal about the importance of having a joined-up approach to business and service planning, performance management and quality assurance in order to speed up the pace of

improvement and achieve maximum impact for, and on behalf of, children and young people. Although it is too soon to evaluate the impact of these new structures and frameworks, there is a discernible change in both tone and mood since Ofsted's last monitoring visit in October. As well as being more business-like, senior managers and leaders are demonstrating a renewed sense of drive and determination.

The local authority has consistently used thematic audits to shape and inform improvements in practice and performance, though not always to best effect. An increased focus on quality means that greater use is being made of local case management audits. Team managers are being actively encouraged not to sign off assessments which are not up to standard simply to meet targets on timeliness. The majority of audits seen by inspectors, including those completed by local managers as well as centrally located audit officers, are robust. Case audits correctly identify strengths and weaknesses, are appropriately self-critical and make clear what, if any, remedial action is required, although not consistently in the form of specific or measurable action plans. The way in which audit activity is being rolled out means that managers and staff are becoming increasingly confident in identifying what good looks like. Previously depressed expectations are being raised.

Having recently audited the use by social workers of the child sexual exploitation screening and full risk assessment tools, the local authority is in the process of implementing a simple action plan designed to strengthen its response to children who are considered to be at medium or high risk. Since October 2016, children and young people who are considered to be at high risk are being reviewed by the multi-agency sexual exploitation group at regular weekly intervals to ensure that they are appropriately safeguarded and protected. This is a significant improvement.

In the short time that you have been in post, you have clearly invested time and energy in building bridges with key partners, including the police, the foster carers' partnership and the chair of the Local Safeguarding Children Board. You have agreed in principle with the chief constable to jointly commission services for children who go missing and/or who are at risk of being sexually exploited. You are also taking action to ensure that foster carers feel valued, and that they and the children whom they care for are properly supported.

2. Care leavers

At the time of the last inspection in 2015, the local authority had lost contact with 25% of its care leavers, including 26 of its most vulnerable children aged 16 and 17. This is no longer the case. Having established a dedicated care leavers' service, the local authority is now in touch with 96% of its care leavers. The quality of support that care leavers receive continues to improve. The local authority is about to introduce a new independence skills audit tool for use by personal assistants to ensure that young people are properly prepared for the transition to adult life.

Most care leavers now have a pathway plan, although the plans themselves are not always sufficiently challenging or aspirational. The plans tend to focus on practical

issues without routinely considering care leavers' emotional well-being. Inspectors also saw examples of pathway plans, which, while referring to risks and vulnerabilities, did not identify the action required, or being taken, to address those concerns. This means that care leavers, many of whom have low expectations of themselves and others, are not consistently receiving the help and support that they need and deserve.

There has been a significant increase since the 2015 inspection in the proportion of care leavers being supported to remain engaged in education, employment or training, with current levels above the most recently published national and statistical neighbour rates. However, while this is welcome, across the county too many young people are in low-skill jobs, sometimes without training opportunities. In Great Yarmouth, too few care leavers or children looked after have the opportunity to undertake some form of work-related activity with the county council. The fact that corporate apprenticeships are largely confined to those living in Norwich means that care leavers or children looked after in other localities appear to be at a disadvantage.

The number of older care leavers, aged 18 to 21, who are identified as not in education, employment or training (NEET) has increased, but this is largely a product of the more reliable and accurate data that is now available. The local authority has a strategy in place to address this issue. The local authority is also taking action to address the relatively high proportion of 16 to 17-year-old care leavers in Norwich who are NEET. Care leavers in higher education continue to be well supported.

3. Children looked after

A clearer focus on permanency planning, particularly for children who have recently become looked after, means that most children have a permanence plan by the time of their second looked-after review. Practice in this area has improved since the 2015 inspection, at which found planning for permanence to be very weak. The adoption team is making effective use of an early alert system to identify unborn babies and children who may need a plan of adoption at the point at which they become looked after. Viability assessments of extended family members are timely and thorough, and result in robust recommendations. More use is being made of foster-to-adopt arrangements.

With current practice being more sharply focused and the permanence monitoring group providing effective management oversight, there is less evidence of the drift and delay that children looked after commonly experienced two years ago. Independent reviewing officers are better at providing robust, critical challenge, although not yet consistently in every case. While the quality of care plans has improved, some are not sufficiently measurable or specific about, for example, support for children in school, contact arrangements or life-story work. This means that children looked after are still not receiving a consistently good service.

Social workers are making better use of a range of different tools to explore children's wishes and feelings, including scaling tools to assess, on a scale of one to 10, how strongly children feel about things. The quality of this direct work is making it easier for children to come to know and build meaningful relationships with their social workers. However, it is not always clear to what extent children's thoughts, wishes and feelings inform and influence the outcome of their assessments or their plans.

More work needs to be done to help foster carers to understand the benefits of special guardianship orders, particularly given foster carers' concerns about the level and quality of support that will be available for them and the children whom they are looking after if they relinquish their status as foster carers.

At the time of the last inspection, only 9% of children looked after had a health assessment within 20 working days of coming into care. The timeliness of initial health assessments has improved considerably, but there is room for further improvement. Thirty-two per cent of children still do not have an initial health assessment within 20 days of becoming looked after. This is not good enough.

4. Help and protection

For children in need of help and protection, the quality of practice is still too variable and ranges from effective to poor practice. In response to a number of serious incident notifications, senior managers have taken decisive action to strengthen escalation procedures, particularly in cases where there is disagreement between professionals about levels of risk and the most appropriate way of safeguarding and protecting children and young people. Work is continuing to ensure that thresholds for access to children's social care are applied consistently within the multi-agency safeguarding hub.

Risks involving children in need of help and protection are not always clearly articulated. In the majority of cases seen by inspectors, strategy discussions are timely, well attended, and used effectively to plan and coordinate protective responses. However, strategy discussions are not routinely used to review the outcome of child protection investigations or formally to record decisions on whether to proceed by way of an initial child protection conference. This means that there is not a robust audit trail of the decision-making process in every case. This has the potential to blur the distinction between a child protection investigation and a section 47 assessment.

Although inspectors saw improvements in the quality of direct work being done by social workers with children, the quality of assessments is still too variable. While most assessments include a summary of risks and protective factors as well as an impact statement, these are not always sufficiently clear or concise. The quality of analysis is variable. This has the potential to undermine the effectiveness of the help and protection that children receive.

In cases tracked or sampled by inspectors, most child protection conferences and core groups were well attended. However, in these cases the quality of child protection plans is not yet good. The quality of chronologies seen is poor. By focusing on identified needs rather than risks, the child protection planning template does not encourage social workers to focus on the right things.

Contingency planning, which was identified as a concern at the time of the last inspection, is largely tokenistic. Those plans seen lack clarity and/or specificity. This makes it difficult for parents and carers to understand what they need to do and what the consequences are likely to be if they fail to do it.

The recruitment and retention of frontline managers continue to be a challenge. In Great Yarmouth, for example, at the time of this monitoring visit, two of the three team managers in the assessment and family intervention teams had been in post for less than six weeks. Caseloads are still higher than ideal, particularly in assessment teams. Despite the local authority's determined efforts to ensure that all social workers receive regular monthly supervision, management case audits have highlighted gaps in supervision in some cases.

Early help was identified as an area of strength at the last inspection. In Great Yarmouth, well-developed partnerships, an effective early help hub and good working relationships between the early help family focus team and children's social care ensure that the help and support provided are responsive to the needs of children and families. Inspectors saw examples of cases being promptly stepped up from early help to children's social care when risks, for example of child sexual exploitation, increased. The local authority is currently in the process of reviewing its early help offer to ensure that thresholds continue to be applied appropriately and that help and support are targeted effectively.

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

Yours sincerely

Nigel Parkes
Her Majesty's Inspector