Annual Report

1 July 2022 – 30 June 2023

Norfolk Safeguarding Children Partnership

www.norfolklscp.org

Table of Contents

Foreword by the Three Statutory Partners

It is with great pleasure that we introduce to you our fourth Annual Report of the Norfolk Safeguarding Children Partnership. The Report represents an important opportunity for us to jointly reflect on our responsibilities and the effectiveness of our partnership. It allows us to consider how we continue to strengthen our approach to keeping our children and young people safe and enabling them to Flourish.

The past year has continued to present significant challenges for Norfolk's children, young people and families, and also for all those working to support them. The long-term implications of the Covid pandemic and the ongoing cost of living crisis continue to shape the lives of our communities, and this makes working together to provide a network of support ever more important. As strategic partners, we remain committed to supporting families and protecting children and young people through the work of our people.

We hope the Report demonstrates our focus on learning and development, listening to the voice of children, and challenging ourselves to understand where we can do more to improve our collective response. We have strengthened and developed our use of evidence, data and insight to enable us to prioritise our resource and consider the impact of our actions. Our continued commitment to independent scrutiny enables us to consider our effectiveness as a partnership, and to measure ourselves against both best and poor practice nationally, with an emphasis on improvement through learning. Our Section 11 process continues to develop and provides further valuable insight into the wider safeguarding partnership.

Throughout 2022-23 our priorities of Neglect, Vulnerable Adolescents and Protecting Babies remained at the heart of our safeguarding partnership, with jointly produced strategies guiding our collective response. We continue to develop our approach to building trauma informed practice and leadership through training and policy development.

Our workforce is the partnerships greatest asset, and we continue to prioritise joint learning, training and development to support them to be as effective in their practice as possible. Learning together is essential to enable us to further improve our joint approach to working with and for our children, young people and families and we hope the Report reflects the partnerships commitment to this.

Our partnership commitment for the coming year is to remain focussed on listening, learning and understanding, to continue to develop and mobilise our collective resource, working together to keep Norfolk's children and young people safe and support them to flourish

Sara Tough
Executive Director
Children's Services

Tom McCabe
Chief Executive Officer

Nick Davison
Assistant Chief Constable

Paul Sanford
Chief Constable

Patricia D'Orsi
Executive Director of Nursing
Norfolk and Waveney Integrated Care Board

Tracey Bleakley
Chief Executive Officer,
Norfolk & Waveney Integrated Care Board

Foreword by the Norfolk Safeguarding Children Partnership (NSCP) Independent Chair

Thank you for taking the time to read NSCP Annual Report. This document should give you an open, honest view of how the Partnership works to safeguard our children and young people in Norfolk. As the Independent Chair and Scrutineer of the NSCP I have the responsibility for scrutinising this report and making sure it is accurate and provides the information you, the reader, requires. I hope that it meets your expectations, provides you with the information you need and above all gives you complete confidence in the way the Partnership strives to safeguard children in Norfolk.

I wanted to start my introduction by offering some reassurance regarding the strength of the Partnership in Norfolk. During the reporting period covered by this report I have observed some truly outstanding partnership work. The safeguarding culture in Norfolk affords everyone the opportunity to be confident that they will be supported as they strive to improve outcomes for our children and families. That culture permeates from the very top of the organisations through to the practitioners whom we rely so heavily on. I meet with those at executive level, and I am consistently impressed with their commitment to safeguarding, personal investment and leadership. Representation at Partnership meetings is excellent and there is a culture of support and challenge as we strive to reach our joint objectives. Perhaps of greatest importance is the fact that Norfolk is blessed with a professional, caring and incredibly hard-working community of individuals who work and volunteer in the safeguarding arena. Without these people we would not be able to provide the level of support to children and families. On behalf of the Partnership, I would like to offer each of them our sincere thanks for all they do.

This report sets out our achievements, concentrating in part, on the areas we have prioritised. Whilst it is right that we celebrate success it is also important that we recognise that we should always seek to improve. Norfolk's investment in independent scrutiny, data analysis and learning from reviews indicates a culture of continuous learning. This is something that the Partnership should be extremely proud of. At a time when there are developing threats and risks to children's safety it is imperative that we all remain vigilant and able to react, Norfolk has the systems and people to do this.

NSCP are committed to hearing the voice of the child and co-production wherever possible. Last year we produced a children's version of the Annual Report. This was done in conjunction with local children and young people. Part of my role involves presenting this report to local council members, a somewhat daunting prospect, even when you have done it on several occasions. In 2022 I was joined by one of the young people who had helped produce the children's version. As we sat in the council chamber looking out at a large number of smartly dressed political representatives, I started to nervously tap my pen. I introduced myself and my co-presenter and then watched a masterclass. The young person simply stole the show, he was honest, articulate and engaging. Those in the room were genuinely supportive and listened intently to what he had to say. This is why we do the work we do.

I would also like to take a moment to recognise the fantastic work of the NSCP Business Unit. The team works tirelessly behind the scenes to make sure that our business runs smoothly. I would like to thank them on behalf of all the partners,

It is important that this report is fair, informative and balanced, having read it I am completely satisfied this is the case. I want to thank everyone involved in the NSCP for their tireless work over the last twelve months for your continued support.

Introduction

The Norfolk Safeguarding Children Partnership is the body responsible for implementing and reviewing the local plan for Multi-Agency Safeguarding Arrangements, (MASA), published in September 2019. The MASA is owned by the three statutory partners, i.e. the Local Authority, the Police, and Health, who actively engage the wider partnership in fulfilling their safeguarding duties.

This annual report has been written in adherence to *Working Together 2018* requirements as set out in Chapter 3 (paragraph 42). The purpose is to be transparent with Norfolk children and families about the county's safeguarding system: the challenges we have faced as well as our achievements.

The scope of this annual report runs from 1 July 2022 to 30 June 2023. The report aims to provide:

- evidence of the impact of the work (including training) of the safeguarding partners and relevant agencies on outcomes for children and families from early help to looked-after children and care leavers
- an analysis of any areas where there has been little or no evidence of progress on agreed priorities
- a record of decisions and actions taken by the partners in the report's period (or planned to be taken) to implement the recommendations of any local and national child safeguarding practice reviews, including any resulting improvements
- ways in which the partners have sought and utilised feedback from children and families to inform their work and influence service provision
- response to learning from child Safeguarding Practice Reviews, Rapid Reviews and child death

As in previous annual reports, much of the contextual background has been stripped back to allow for more detailed analysis of the evidence of outcomes in our safeguarding system. Information on Norfolk's population and demographics can be found on Norfolk Insight.

This report, summarises the work of the NSCP, capturing our achievements as well as the ongoing challenges and areas for development.

A separate children and young people version of this report has been produced in consultation with them as key stakeholders and this serves as an Executive Summary.

1. Governance and Strategic Overview

The overarching governance arrangements adhered to Norfolk's plan for Multi-Agency Safeguarding Arrangements (MASA), which was refreshed in autumn 2021. The three statutory partners named in the MASA are:

- **Norfolk County Council**: represented by the Executive Director of Children's Services, Sara Tough and the Chief Executive, Tom McCabe
- **Norfolk Constabulary**: represented by the Assistant Chief Constable, Nick Davison, and the Chief Constable, Paul Sanford
- **Norfolk & Waveney Clinical Commissioning Group**: represented by the Joint Director - Children, Young People and Maternity, Rebecca Hulme, and the CEO of Norfolk and Waveney's Integrated Care Board (ICB), Tracey Bleakley

The three partners met quarterly with the Independent Chair of the NSCP to consider MASA milestones as well as to respond to emerging challenges and maintain a strategic overview on the system. In addition, the NSCP Chair and Business Manager provide quarterly written updates and hold bi-annual meetings for, and with, the Chief Officers of the respective organisations.

Independent Scrutiny Team

Norfolk Safeguarding Children Partnership continues to invest in high levels of independent scrutiny. This reflects the value they place on their independent scrutiny team. The MASA has three clearly defined roles for independent scrutiny. The Independent NSCP Chair, Chris Robson, continues with the duties from the previously statutory LSCB Independent Chair role. As well as undertaking discrete pieces of scrutiny alongside the other team members, he also chairs the Partnership Group meetings and keeps the three named statutory partners and their Chief Officers apprised of strengths and areas for improvement detected in the safeguarding system.

The NSCP Independent Chair is supported by two other independent scrutiny roles: the Independent Chair of the Safeguarding Practice Review Group, Sian Griffiths, and the Independent Chair of the Workforce Development Group, Bridget Griffin. Bridget joined the team in January 2023.

The three members of the Independent Scrutiny Team meet regularly to triangulate their findings and report back to the statutory safeguarding partners.

Partnership Group

The purpose of the Partnership Group is to support the statutory partners in the co-ordination of local arrangements and to provide challenge and feedback on the safeguarding system. In addition to the three statutory partners, membership of the Partnership Group includes representatives from key partners, including education, early years and the voluntary sector. Chairs of the priority working groups also attend and provide regular progress reports on their areas of work. Other partners are invited to present on specific agenda items as required.

Partnership Group play a crucial role in sense checking the safeguarding system and providing an opportunity for all partners to share concerns and find solutions collaboratively. Between July 2022 and June 2023, Partnership Group met eight times, including a priority review/priority setting workshop in June 2023.

Partnership Group agendas include priority updates as well as safeguarding issues and systemic solutions. Data and performance intelligence are also reported regularly as well as a bi-annual report from the Multi-Agency Safeguarding Hub (MASH) Oversight Group. Father inclusive practice: project updates are reported quarterly. They also sign off any annual reports including this report, the work of the Local Safeguarding Children Groups, Child Death Overview Panel and Independent Services. Other agenda items have included:

- Reflective Practice update and development of our Joint Agency Group Supervision
- National research on independent scrutiny (see below)
- Integrated Care System overview in Norfolk
- Sign off on two Child Safeguarding Practice Reviews (CSPRs): Cases AK and AL
- Sign off on Section 11 report (safeguarding self assessment)
- Policy sign off: concealed/denied pregnancy; Practice Guidance for Safeguarding Diverse Ethnic Minority CYP & Families; and Fabricated and Induced Illness
- Child Protection Conferences: changes to procedures
- Outcomes of the Ofsted Inspection of Local Authority Children's Services (ILACS)
- Interim sign off on revised Threshold Guide – renamed as Continuum of Need Guidance
- Update on School Attendance Strategy
- Working with Ukrainian families
- Sign off on multi-agency audit on children on second or subsequent Child Protection Plans
- An overview of Norfolk County Council's project in partnership with Anna Freud Centre
- Family Hub developments

Partnership Group also provides support and direction in the development and delivery of Leadership Exchange & Learning Events, where the wider partnership is invited to reflect on the system. This year the event focused on learning about neglect, linked to the two CSPRs published (see Chapter 6).

Other Partnership Boards

The Children and Young People Strategic Alliance (CYPSA) is chaired by the Executive Director of Children's Services, providing system leadership to deliver the NHS Long Term Plan and the Health and Wellbeing Strategy for children and young people. The core functions of the CYPSA are to:

- Develop and agree strategic priorities and ensure delivery of a CYP Partnership Plan. Their priorities are:
    - Prevention & early help
    - Mental health & wellbeing
    - Special Educational Needs & Disability(SEND)
    - Addressing gaps in learning post pandemic
- Monitor performance in relation to securing impact and outcomes
- Develop and agree strategic commissioning and transformation priorities and processes to ensure best use of resources
- Ensure and promote co-production with service users and stakeholders
- Advocate on behalf of children and young people within wider partnerships and boards

As the NSCP's 'sister' board, the CYPSA is responsible for implementing the Flourish Strategy.[1] The NSCP is actively signed up to promoting Flourish, for example, looking at the strategic outcomes against our priorities through a Flourish lens and writing this into the revised Threshold Guide, which will be branded as the Continuum of Needs Guidance (see Chapter 5 NSCP Projects, Priorities and Developments).

The CYPSA relies on the NSCP to act as a critical friend in terms of developing and delivering operational and transformation plans and commissioning specific services that will protect children. The interface between the NSCP and the CYPSA is critical to the ongoing drive for improving safeguarding arrangements.

To enhance governance arrangements the NSCP and CYPSA have streamlined functions to minimise duplications. Workforce development and strategic analysis, including data interrogation and performance intelligence, are shared. This year engagement and participation has also been strengthened by the alignment.

In addition to the strong links with the CYPSA, the NSCP has continued to build on partnership networking through other fora, notably the Norfolk Safeguarding Adults Board. The annual report is shared with the Health and Wellbeing Board, and the Head of NSCP Business Delivery sits on Norfolk's Domestic Abuse Partnership Board. The NSCP has also links with Norfolk's seven Youth Advisory Boards (YABs) through the Local Safeguarding Children Groups.

Subgroups relating to Statutory Duties

The NSCP is committed to learning and has subgroups focusing on Child Safeguarding Practice Reviews and Child Death. Both groups fulfil the statutory duties set out in *Working Together 2018*. In addition, there is a dedicated Workforce Development Group which looks at multi-agency training and understanding the safeguarding system from the perspective of the entire workforce, from frontline to strategic leadership. The Safeguarding Practice Review Group and Workforce Development Group are chaired independently.

Local Safeguarding Children Groups

The NSCP is represented at locality level by six Local Safeguarding Children Groups (LSCGs), made up of representatives from the multi-agency partnership in each area. An LSCG annual report on their achievements is published separately on the NSCP website. The LSCGs are an ongoing strength of the NSCP with effective co-chairing arrangements, excellent communication channels, committed and engaged members benefitting from dedicated support from the NSCP Business Unit.

The chairing arrangements continue to be multi-agency, with strong leadership from senior officers in Children's Services Partnership, Inclusion and Practice Directorate, the voluntary sector, Cambridgeshire Community Services and education.

Advisory Groups

The Health Advisory Group has been reconvened with a primary focus on evidencing impact of learning from Safeguarding Practice Reviews.

[1] Flourish is an acronym for: Friends and Family; Learning; Opportunity; Understanding; Resilience; Individual; Safe and Secure; Healthy.

The NSCP is also supported by other sector-specific advisory groups: Early Years and District Councils. These groups are made up of representatives from the relevant sectors and focus on safeguarding issues at sector level. The advisory groups have an important role in highlighting to the Board key issues they are facing and how these impact on safeguarding children as well as disseminating effective safeguarding practice across their sectors. Where relevant, they are also charged with responding to sector specific recommendations from SCRs/SPRs. They are active and supportive with the Section 11 safeguarding self-assessment process, including responding to Section11 recommendations.

These groups ensure that we have reach into areas where professionals may feel isolated (such as childminders) and/or do not have safeguarding children as the main focus of their professional life, e.g. the District Council Advisory Group.

The NSCP also works with the Safeguarding Adults Board to deliver bi-annual safeguarding sessions with housing providers.

Regional and National LSCP Networks

Norfolk is a regular participant in the Eastern Region Networking Meeting for Local Safeguarding Children Partnerships. The Head of NSCP Business Delivery was involved in the report on Independent Scrutiny and LSCPs from across England (published July 2022). Norfolk's contributions to the process were recognised in the acknowledgements. The findings show that the NSCP's arrangements are robust and compare well to other areas.

The NSCP Business Unit

The governance structure is supported by an efficient and experienced team, including the Head of NSCP Business Delivery, a Safeguarding Intelligence & Performance Co-ordinator, a Workforce Development Officer, Safer Programme Co-ordinator and 3.5 FTE administrators. The Business Unit is responsible for supporting on a range of activities from strategic leadership, monitoring/audit, budget oversight and training provision through to setting agendas, administering meetings, communications, website development and event co-ordination.

The team includes a 0.5 FTE dedicated senior analyst officer, shared with the Children and Young People's Strategic Alliance.

2. Voice of the Child

The NSCP is working with the Children and Young People's Strategic Alliance (CYPSA) to further develop mechanisms for hearing the voice of the child. CYPSA and Norfolk County Council have done some impressive work in this arena as recognised in the Ofsted Inspection of Local Authority Children's Services:

> *Children's participation is encouraged and is a strength of this authority. The Young Adult Forum care leavers' group is an influential and well-coordinated group. The group has been involved in several initiatives that have influenced practice and service delivery through the corporate parenting board. A number of other young people shared their views on services with inspectors and were mostly positive about the support they receive and rightly proud of their involvement in the planning and development of services.*

The CYPSA was responsible for leading on the My Norfolk, My Voice survey looking at how to build an interactive and productive relationship with children and young people in Norfolk. The survey was open to everyone aged 5-25, running from November to December 2022. With over 1,600 responses, our service users helped us to respond to three key questions:

1. What are the most effective methods or platforms to use to engage with children and young people?
2. What are the most effective times and places for engagement?
3. What issues and topics interest children and young people?

The report provides valuable insights and recommendations and will help make engagement more relevant, appealing, and effective. This is being shared with the NSCP's Local Safeguarding Children Groups in July 2023.

Another lovely example from CYPSA was commissioning the Flourish Anthem, "We are Norfolk", completely written, composed, performed, and sung by children and young people from across Norfolk.

The NSCP's Safeguarding Intelligence and Performance Co-ordinator sits on the CYPSA's Stakeholders Engagement Insight Group and can readily access young people for consultation and feedback.

There is always more we can learn from children, young people and families when we speak to them directly and opportunities to do this are followed up directly in any project plans or indirectly through speaking to the professionals who have established relationships with the children and young people.

We were really proud of the children and young people's version of the 2021 - 22 NSCP annual report and so grateful to the children who helped us with that. This year we are pleased to say that our key stakeholders have agreed to come back and help us with the second CYP version of the annual report. We hope you enjoy it as much as we do!

3. Data and Performance Intelligence

Using data and evidence to inform NSCP's work

NSCP has committed to improving the way in which it uses data, evidence and analysis to inform its work.

In 2020 the partnership created a 'Joint Strategic Analysis Group' (JSAG) to coordinate and improve its use of data, and in 2021 a dedicated analyst was recruited to deliver key analytical products and outputs. A number of products have been delivered, and pieces of work undertaken, including:

An online, partnership wide dashboard and data collection system that allows monthly data to be submitted and reviewed in agreed areas.

Linked to the dashboard, a narrative report that uses agreed escalation principles to highlight key and emerging issues to NSCP's Partnership Group.

Data Reviews on its priorities – reviewing what data tells us about the context to, and delivery of, NSCP's three priorities.

Specific analyses in support of the partnership's work. This includes supporting Independent Scrutiny activity around the partnership's response to mental health and to its 'front door'.

This progress has enabled a more data-focused culture within the partnership, evidenced by:

- Reviewing our data has been a key element of the prioritisation process for the coming years' strategy.
- Findings from Data Reviews have informed the delivery plans for each priority.
- "What does the data tell us?" is one of the first questions asked when new issues emerge, and data is used to scope our response.
- NSCP's data is included within the county-wide Flourish monitoring framework, linking its work with broader outcomes and activity.

This section reviews some key outputs and findings from our analytical work. The next page looks at a 'Week in the life of the NSCP' from the perspective of our data, showing the breadth and scale of the activity undertaken within the partnership to safeguarding children. The following pages then look at overall trends, review what we've found out about our NSCP priorities, and sets out some emerging issues that will inform our work in the future.

A week in the life of the Norfolk Safeguarding Children Partnership

This section looks at the scale and nature of children's safeguarding in Norfolk and presents an average week expressed through partners' data.

- Around **150** babies are born.

At any time there are around:

- **186,600** children and young people (CYP) aged 0-19 living in Norfolk.
- **125,000** CYP attending school in Norfolk

Partners in the NSCP have responsibilities for safeguarding Norfolk's children. Within this context, each week there are around:

- **960** A&E attendances for Under-18s and **350** for under-4s.
- **21** acute hospital admissions caused by injuries for under-15s.
- **4** acute admissions for mental health problems and **3** for alcohol specific conditions for under-19s.

- **6** children are screened for exploitation by the Police
- **120** Police domestic abuse investigations are started where a child is present.
- **22** children and young people are stopped and searched, and around **22** arrested.

- **840** contacts are made to the Children's Advice and Duty Services (CADS)
- These include around **200** contacts from schools and education, **200** from the Police, **130** from members of the public, and **95** from health services

Where contacts suggest there may be an ongoing risk to the safety and/or wellbeing of a child or young person the Multi-Agency Safeguarding Hub brings partners together to agree the best course of action – which can lead to a referral for a formal assessment. Within this context each week:

- Around **114** referrals are made to prompt a formal social care assessment.
- These include **33** originating from the Police, **19** from schools, and **13** from health services.

Where an assessment identifies specific risks to a child's safety, additional assessments and interventions are urgently put in place. Each week around:

- **47** Section 47 enquiries take place, where action is needed to ensure a child is safe
- **16** Initial Child Protection Conferences take place where investigations conclude that a child has suffered, or is likely to suffer, significant harm.
- **14** CYP start a Child Protection Plan (CPP), **4** of whom will have had a previous CPP.
- **9** CYP become looked after
- **3** CYP enter the Youth Justice system for the first time

All of this means that at any time in Norfolk there are around:

540 CYP with a Child Protection Plan

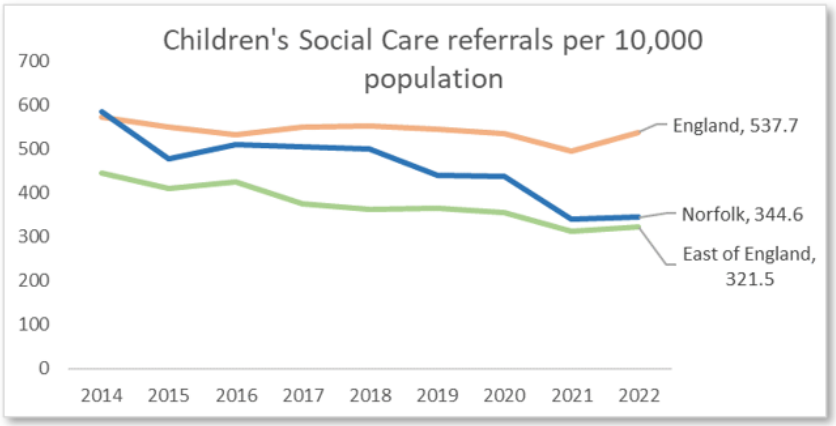
1,140 Looked-After Children

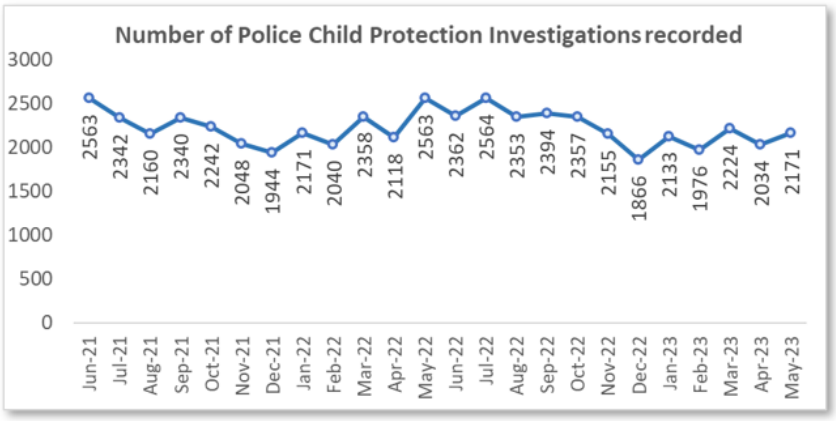
188 CYP receiving Youth Justice Service interventions

Overall trends in child safeguarding and child protection

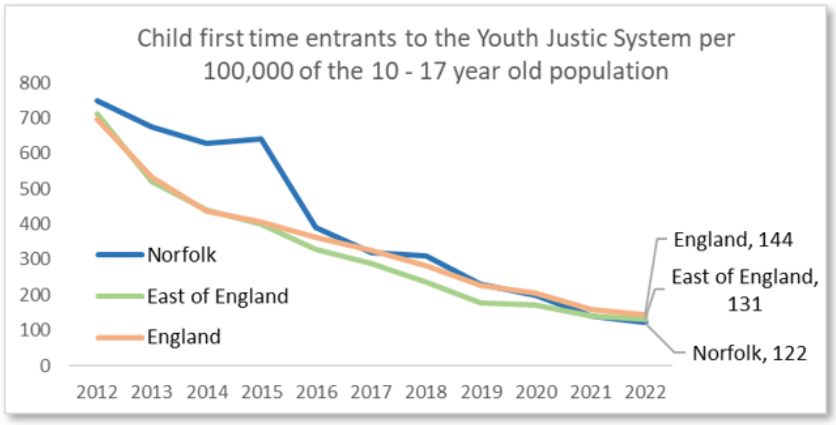
For most indicators of activity within formal safeguarding and child protection pathways, Norfolk's rates and trends broadly reflect those regionally and nationally. Referrals (see graph), Child Protection Plans (CPPs) and Initial Child Protection Conferences all show slight overall reductions in the longer term. Conversely, levels of Section 47 enquiries and numbers of Looked After Children have increased slightly in recent years.

The reasons behind these trends are complex, but may reflect changes in demand for, and organisation of, children's safeguarding activity over time. Increases in demand for intensive Interventions (e.g. rates of looked after children) and activity to ensure risks are considered widely (S47 enquiries) are likely to reflect understood pressures on social care services. Reductions in CPPs and formal referrals, along with increases in Family Support activity, may indicate the increase in Early Help and Prevention activity – trying to support children and families.





Similarly, reductions in first time entrants to the Youth Justice System nationally and locally reflect specific efforts to put diversionary and 'upstream' interventions in place to avoid criminalising children and young people.

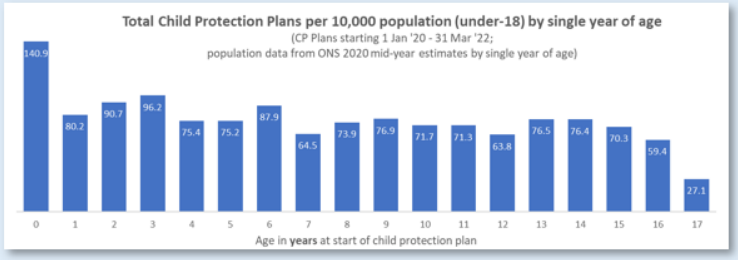


As our understanding of the drivers of these trends improves through increased analytical activity, we will be more confident in telling Norfolk's story through data.

Informing NSCP's priorities with data and evidence

Two of NSCP's three priorities have undertaken Data Reviews, with the third review (for Vulnerable Adolescents – due for completion in October) underway. Some key findings from the first two reviews are below.

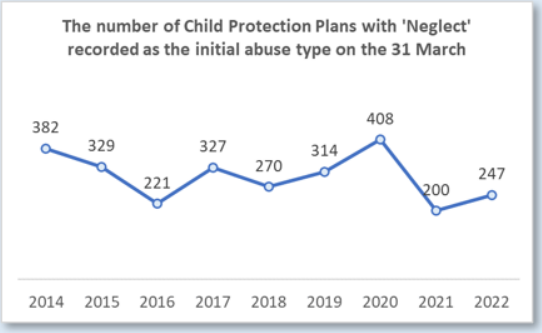
Protecting Babies



Key findings:

- There is clear evidence that communities and services in Norfolk recognise safeguarding risks to babies.
- All statutory services are more likely to see and support children around birth, and the highest rates of Child Protection Plans are for children who are unborn or under 1.
- Neglect is the most ascribed risk for unborn and young babies within formal child safeguarding pathways. Where the Police attend incidents involving babies and very young children this is most often because of domestic abuse and assault.
- Overall health and safeguarding outcomes for babies are similar in Norfolk to other areas, though rates of infant mortality have risen slightly in recent years, and rates of hospital admissions for babies under 14 days old are higher than other areas. Investigation into the latter suggests that issues that were previously picked up by midwives in the community were being referred to hospital. Neither presented specific safeguarding risks.

Neglect



Key findings:

- The rates of recorded child neglect in Norfolk is similar to that regionally. Neglect is the most recorded form of abuse in Norfolk and nationally. In Norfolk, recording around neglect has improved and is more precise – as a result recorded rates of neglect have fallen slightly, with other forms of recorded abuse increasing.
- Local data evidences the correlation between neglect with parental circumstances – particularly parental mental health problems, parent drug and alcohol use, and domestic abuse.
- It also showed a small but significant number of cases where neglect associates with a parental disability.
- Findings are driving an action plan focused on multi-agency practice where key indicators of neglect are evident, ensuring the right support is available for children, families and staff.

Other emerging themes

Through our analysis of Norfolk's data in support of reporting and data reviews, a number of additional and important themes have been identified that will shape our planning. Some of the most notable are as below.

Mental Health

- In last year's report we highlighted Norfolk's higher rates of identified mental health problems in some indicators (e.g. through hospital admissions or primary support needs for children with Special Educational Needs or Disability).
- Activity in the past year has reinforced the importance of the mental health of both children and parents as we seek to understand child safeguarding risks.
- The Neglect Data Review identified parental mental health as the factor that most often associated with neglect within social care assessments (64% of assessments that identified neglect also identified parental mental health concerns).
- As a Flourish priority, data around this has been reviewed and is monitored.
- Mental health outcomes are also closely associate with another identified theme: families' socio-economic circumstances and deprivation.

Deprivation

- All of the NSCP data reviews, and Flourish priority reviews, evidences that poor outcomes for children and young people – including some safeguarding and child protection outcomes – are to some extent linked to the level of deprivation in an area.
- Current economic pressures are well understood, with evidence showing the impact on children and families, for example through rates of homelessness impacting children.
- The relationship between socio-economic circumstances, other outcomes, and child protection and safeguarding risks is complicated and improving our understanding on this will improve our multi-agency planning and in particular how we support communities (for example through hubs).

Using data to inform planning and practice

- As our use of data improves, we will be able to be more precise and effective in commissioning services and in our practice.
- Applied across partnerships, this provides significant opportunities to improve outcomes – accounting for people's broad circumstances, and improving the causes of poor outcomes, rather than the symptoms.
- A number of initiatives – notably the Supporting Families Data Transformation Project – should mean that activities can increasingly focus on preventing poor outcomes wherever possible.

4. Independent Scrutiny

Norfolk adheres to the principles of independent scrutiny as outlined in *Working Together 2018*, (Chapter 3 page 77) and has dedicated resources in place to fulfil this statutory function in our local safeguarding arrangements. The NSCP's scrutiny arrangements include a range of mechanisms, deployed to provide robust examination of performance and practice. This chapter focuses on actions and outcomes from:

- independent scrutiny undertaken by the independent scrutiny team
- observations of frontline practice
- multi-agency audit
- Section 11 self-assessment
- external inspections

Independent Scrutiny

The three statutory partners commissioned the independent scrutiny team to undertake an extensive piece of work looking at the multi-agency response to the 'identification of initial need and risk' within the partnership. This was originally commissioned in response to the Solihull Joint Targeted Area Inspection (JTAI) report published in February 2022. After discussion with the Norfolk Adult Safeguarding Board, it was agreed to do a joined up piece of work with them. The work was therefore undertaken in three phases: desktop analysis, analysis of children's risk assessment and then adults risk assessment. The work was supported by data with input from the senior analyst.

The aim of the scrutiny was to: (a) learn from the findings of the Solihull JTAI and consider the implications for children, adults and families in Norfolk; and (b) consider the multi-agency understanding and involvement in the 'front door' discussions and management of risk in order to achieving good outcomes for children and making safeguarding personal for adults at risk. Specific questions included how well we understood:

- the timeliness of responses – namely to children and families left in situations of 'unassessed and unknown risk'
- the impact of practice of MASH on the rest of the partnership, and children and families
- the experiences of children and families that need help or protection
- how we shared learning from significant incidents
- whether there was consistent and stable engagement in all partnership activities by all partners
- how good was communication and information sharing across and with agencies
- what oversight was there of the MASH performance by both NSCP and NSAB

Phases 2 and 3 included focus groups with partners. Those engaged in the scrutiny saw real benefits in the collaboration between boards: differing perspectives brought out new, useful challenge that provoked excellent reflection. It also allowed us to recognise how language, terminology and understanding of legislation can lead to misunderstanding by those not directly involved in specific areas of safeguarding. This is an important factor to consider if we are to improve understanding of systems across all partners. It is also important to recognise that there is a stark difference in the statutory drivers that are considered in the 'Children's and Adults' world'. At times it was like comparing apples and pears. That said, the overarching principle remains that of safeguarding vulnerable people at the earliest possible opportunity and there should be a recognition that there is cross over between both services where a holistic approach to family situations should be

adopted. This scrutiny will seek to add value to work that is already being or has been completed in this area.

Findings and recommendations

There was a very clear evidence base that the current initial referral system that is in place for both children and adults has the ability to work to an exceptionally high standard. Whilst there are several areas where improvements could be made it is clear that most of these are resource driven. People making referrals, whilst frustrated by waiting times and lack of feedback, were also quick to acknowledge the positive impact professional advice and intervention could have. A total of six recommendations were made based on the findings

This report acknowledges that there were cases brought to our attention where the service and response provided fell short of what would be expected. These cases have been raised with managers so they can be addressed. The findings of this report do not seek to minimise the impact these cases have on individuals, but we have concluded that they are the exception rather than a systemic issue.

Finding 1 – The systems in place in Norfolk offer an appropriate and professional response to initial referrals when resources afford an opportunity to meet demand. Referrals are considered, risk assessed and progressed appropriately using effective triage systems.

Finding 2 – The majority of frustration and discontent felt resulted from resource driven issues. Demand on Children's Advice & Duty Service (CADS) and Social Care Community Engagement (SCCE) has increased and this can lead to longer waits for advice. There is no alternative way of referring to CADS other than by direct contact. The huge demand placed on the two initial sites for referrals needs to be considered. Partners may wish to consider publishing the demand so expectations regarding waiting time can be managed.

> ***Recommendation 1*** – The partnerships should consider ways in which expectations can be managed in terms of speed of response. Partners may wish to consider publishing the demand so expectations regarding waiting time can be managed. Managers in both CADS and SCCE should be encouraged to continuously review waiting times to see if there is scope for any improvement.

Finding 3 – There is a good understanding of the purpose and function of both CADS and SCCE in general terms. We noted that there are some gaps in agencies' understanding for thresholds which can lead to unrealistic expectations of what action is appropriate to deal with a referral. Of concern is a gap in understanding what will constitute a Section 42 response in adult referrals. This also leads to misunderstanding regarding who has responsibility for referrals that do not meet this threshold.

> ***Recommendation 2*** – A shared briefing document is created showing the referral, triage and decision-making process in relation to both adults and children, Encouraging quality referrals, ensuring a holistic approach if both adults at risk and children involved, and identifying alternatives where the threshold isn't reached. This could be referred to prior to making referrals, reducing demand, encouraging appropriate referrals and managing expectations regarding the process.

Finding 4 – Whilst there is a good understanding of the initial referral function there is evidence that some agencies make significantly more referrals than others. This differs in

terms of children and adults. Whilst much of this is understandable given the roles of professionals, there are some areas that merit closer examination.

Recommendation 3 – Individual agencies conduct a dip sample of the referrals made ensuring they are of sufficient quality and have received an appropriate response. This will afford agencies an opportunity to reflect on whether too many or too few referrals are being made. Appropriate action plans to ensure referral pathways are known and appropriately used should then be put in place. Both partnerships should seek assurance that this work is completed.

Finding 5 – The function of the MASH is less well understood across the partnership. Whilst it is clearly understood by its own staff there was less evidence that that is the case amongst all partners. The MASH function is critical to safeguarding and it is imperative that it is understood.

Recommendation 4 – The partnerships seek to promote understanding of the MASH function across all partners.

Finding 6 – Perhaps of greatest concern was the question of whether both children and adults' MASH are truly multi-agency. There was evidence presented that suggests both have aspects of silo working with a social care and police dominance and a lack of direct health involvement as a key statutory partner. This has been exacerbated by working conditions that were the result of Covid restrictions.

Recommendation 5 – A review of multi-agency working in the MASH is considered. This should include co-location and ensuring that all partners are involved in decision making processes.

Finding 7 – There are inconsistent experiences in terms of referrers being able to consult with social care professionals and to obtain advice and support in managing risky situations. Lack of feedback regarding the status and outcome of a referral remains an issue and is the cause of some frustration.

Recommendation 6 – Develop a clear consistent mechanism for obtaining professional advice on making referrals and develop a system for gaining feedback for those referring

Finding 8 – All agencies were able to demonstrate how learning from significant events was disseminated and practice changed. Both partnerships offer a range of multi-agency training and awareness opportunities in respect of key identified themes. Measuring the impact of recommendations on changes to practice is an area of development for both partnerships to consider.

Finding 9 – The overall governance and oversight of MASH performance by the partnerships is appropriate but could be improved upon. There is comprehensive local authority data available to both but variable capacity across the partnerships to analyse and interrogate it. Developing capacity and a multi-agency data picture as an area for future consideration.

The report was presented to Partnership Group in May 2023 and is being shared with the MASH Oversight Group. Encouragingly, many of the recommendations made were already in the MASH forward plan and work is being done to address the learning and make improvements.

Observation of Frontline Practice

Observation of practice is a scrutiny mechanism written into Norfolk's local plan for Multi-Agency Safeguarding Arrangements. Observations were suspended over the pandemic but this year two pieces of work were undertaken on child protection core group meetings and on Joint Agency Group Supervisions (JAGS). Findings are presented to the three statutory partners.

Core Groups

The scrutiny on Core Groups took place in July/August 2022. Six Core Groups were observed. Families consent was sought and it was made clear that no observation would take place without this. All the families were willing for the observation to take place.

A short briefing took place with the social workers, including an outline of the child's plan under review. Whilst the focus of the observation was multi-agency inevitably the social workers needed to act as the contact point and as chairs their role was more dominant. All were extremely helpful, transparent and positive about the opportunity to be observed. All were keen to have a debrief and saw it as a learning opportunity.

The decision was made not to seek feedback from families on this occasion, meaning we do not know how they experienced the meetings. All the observations had to take place online and practicalities meant that the Core Groups were observed at quite short notice, as were pre-meetings with the social worker as organiser. This meant that other than the social worker, it was not practical to seek feedback/debrief other professionals. In future we aim to resolve this, so that all professionals involved could be better involved.

The checklist used for observing included observation of:

- Attendance and engagement
- Healthy discussion and challenge
- Support for the family to contribute
- Was the plan reviewed as required
- Was there clear decision making and identification of next steps

The overall conclusion was that all the core groups observed met the standards expected and none led to concerns about multi-agency engagement. However, the sample size and other limitations as noted above need to be taken into account in reaching broader conclusions.

Multi-Agency Audits and Monitoring

The NSCP's Multi-Agency Audit Group (MAAG) is chaired by the Head of NSCP Business Delivery and provides valuable information on how well the system is working in practice. In addition to commissioning and undertaking audits, the MAAG is also responsible for monitoring the Composite Action Plan and track the response to recommendations from across all scrutiny work and evidence impact on practice and improvements to the system.

Within the scope of this annual report, MAAG members struggled with capacity and agreed to focus on quality of audits rather than quantity. Over the last 12 months, MAAG completed an audit on children on second or subsequent child protection plans. At the time of writing an audit on children with complex medical health needs was taking place. The MAAG continues to explore ways to increase audit capacity.

Children on Child Protection Plans for a Second or Subsequent Time

The scope of the Child Protection Plan (CPP) second or subsequent times audit, focused on six pre-selected cases of Child Protection Plans. The six cases included:

- CP cases closed in the past 12 months.
- The cases will have previously been CP cases, and therefore re-referrals.
- Three of the cases will focus on large sibling groups i.e., at least four siblings.
- One case from each of the six of the Norfolk localities.

Whilst the audit did not include siblings as separate cases, however, where there were siblings in the family the auditors reviewed the whole family whilst maintaining the focus on the identified child.

The findings focused on four key areas:

- **Engagement of Fathers** was inconsistent across the six cases. There was some good engagement but more evidence of a lack of engagement, particularly where fathers were non-resident. Some of the families were complex with evidence of previous serious domestic incidents and a feeling that sometimes the lack of engagement with the father was due to the potential risks further engagement posed. If this was the case, it needed clearer recording and/or evidence of challenge in supervision.

- **Child Protection Plans:** the 'step up' (from Child in Need (CiN)) and 'step down' (from CP) process appeared to work well in the cases where appropriate, with no systemic issues identified. In two cases, the CP plan was closed on at least one occasion after three months, and the auditors felt that this was insufficient time to embed sustainable change. In one case, the school was part of the decision to cease CP planning but weren't told when the social work team closed the case at time of CIN planning. There needed to be more effective recording of parental engagement in universal services, once the CP plan had closed, if this was the case. There was little evidence seen in the six cases to support universal services engagement. Auditors noted that subsequent CP plans often identified the same risks as previous plans. It was agreed that for most of the families the issues were often cyclical, and risks often remained constant.

- **Timeline of re-referrals:** Whilst not a focused question in the audit, for two cases the audit group noted further/repeated evidence of neglectful parenting and care for the children warranted re-referral to the Social Work Service within 1-3 months of case closure from CIN planning. There is a need to better understand the root factors / causes of early re-referrals.

- **The child's lived experience:** in two of the cases, auditors felt that the case notes did not fully evidence understanding of the child's lived experience. Particularly where there were repeated cycles of crisis and domestic abuse.

Four recommendations were made:

1) More evidence needed of professional curiosity when 'disguised compliance' is suspected, i.e. both parents appear to engage in CP planning but do not follow through.
2) More effective recording of whether parents actually engaged in Universal Services once the CP Plan has closed.

3) Better understanding of the root factors/causes of early re-referrals
4) Better evidence and recording of the engagement of fathers, particularly where they are non-resident and/or there is a history of Domestic Abuse

The Assistant Director responsible for Independent Services has provided assurances that relevant guidance has been given to Independent Chairs and the process of 'step down' is more robust.

The MAAG will monitor the outcomes of these recommendations as part of NSCP priority progress reporting and through its Composite Action Plan which includes recommendations from all scrutiny activity and safeguarding practice reviews.

Section 11 and safeguarding self-assessments

Norfolk continues to be proud of its Section 11 process which has evolved over the years to move beyond compliance checks to a much more nuanced and sophisticated challenge and support process. Process development is overseen by a multi-agency steering group which is chaired by the Independent Safeguarding Practice Review Group Chair. In addition to completing a self-assessment tool, agencies are invited to progress meetings, feedback meetings and thematic panels at different times of the year to review their returns with steering group members and subsequently develop and monitor their organisation's action plan. This ensures that safeguarding self-assessment is a continuous process rather than a one off annual event.

The 2021 – 22 Section 11 recommendations were all completed and closed within the timeframe of this annual report. The 2022 – 23 process has further developed the strengths of our approach: we follow the same format as reported in previous annual reports with self assessment tools completed and analysed and a staff survey sent out to the wider workforce. This year, rather than have single agency challenge and support meetings, we introduced Thematic panels; these panels provided all partners the same opportunity to listen to and share different organisational perspectives on challenges within our system. Through discussion with chairs of the strategic priority groups it was agreed that these thematic panels would not focus on these areas as this would duplicate the multi-agency discussions that occur through these existing multi-agency groups

In total there were 39 Section 11 self-assessments completed and returned. Returns were reviewed by The NSCP's Safeguarding Intelligence and Performance Co-Ordinator (SIPCo) and a steering group member and the quality of returns was noted to be improved from previous years by several steering group members. This may be due to the restructure of the form which asked more direct appreciative inquiry questions (i.e. a description of an example of good practice) and allowed for a more explicit response. In the highest quality returns partners used this as a platform to offer more about how they are responding to the priority areas. To continue the development of the self-assessment nature of the Section 11 process, feedback meetings are available in February and March for partners to discuss their Section 11 return with a member or members of the Section 11 steering group.

Partners were asked at the progress meetings to identify themes for discussion at the Thematic Panels. Four face to face sessions were held in November with two panels focussing on *Children and young people's mental health* and two on *Partnership working to manage risk and promote positive outcomes for children*. Overall feedback from participants was very positive and participants felt that this was a good addition to the learning opportunity that Section 11 provides. The remit for these sessions was to create a window into the system to learn about partners' perspectives and to consider how this

potentially impacts on participant organisation's self-assessment and development plan. This was positively reflected in the vast majority of the feedback with some indicative examples below:

- *This was a good addition to the Section 11 process and I really found it beneficial to meet with others and hear about their own challenges from their perspective.*
- *Much better to hold these sessions in this format, rather than the formal panels. This created an environment for learning and building relationships*
- *Insightful and thought provoking.*
- *Previously S11 panels focused on individual organisation in isolation whereas now we were able to triangulate the information and look at concerns from the wider system perspective*

Discussion and findings, including NSCP Priorities

The Section 11 tool and report also asked single agencies to critically analyse their response to the NSCP priorities: neglect, vulnerable adolescents, protecting babies and promoting a culture of trauma informed and resilience oriented leadership and practice. The analysis was shared with the priority leads. For more information see Chapter 5: NSCP Priorities, Projects and Developments.

A total of four recommendations were made, including one on the Section 11 process:

- **Recommendation 1:** All partners should consider arranging a 30 minute feedback session on their 2022 Section 11 form from the Section 11 Steering Group (contact mark.osborn@norfolk.gov.uk)
- **Recommendation 2:** The Protecting Babies strategy group should develop communications to promote the understanding that protecting babies is everyone's business and organisations should promote this within all staff teams.
- **Recommendation 3:** Any organisations who have not identified a father inclusive practice advocate should contact mark.osborn@norfolk.gov.uk to arrange this.
- **Recommendation 4:** All organisations should ensure that:
  - staff have appropriate levels of exploitation training
  - they have representation at the strategic priority briefings via the LSCG briefing programme to keep their knowledge up to date
  - any relevant learning for their organisation is subsequently internally shared.

External Inspectorates

Norfolk County Council had its first full Ofsted inspection in November 2022; the report was published in January 2023.

The Inspection of Local Authority Children's Services (ILACS) looks at the whole range of support and services offered to children and families from before birth through to adult life. The judgement covers everything from early help and prevention to more specialist support for families with the greatest needs.

Inspectors give four judgements for: the impact of leaders on social work practice with children and families; the experiences and progress of children who need help and protection; the experiences and progress of children in care and care leavers and our overall effectiveness. Norfolk's Children's Services received a judgement of good in each area, with some outstanding features

Inspectors said that "*the vast majority of children in Norfolk receive high quality services and have good relationships with their social workers, which is leading to continued improvements in their circumstances."* The report makes clear reference to the care and understanding we give children and families, the strengths of the relationships we develop and the fact that we are really listening and understanding those we work with. Ofsted used many positive words when describing staff, including *"skilful, creative compassionate, warm"* and *"committed."* This dedication and care is making such an impact – and this is reflected in the best practice examples the Executive Director of Children's Services shares in her weekly blogs.

Inspectors also said children's *"voices, wishes and feelings shine brightly"* in our case records and described children and young people's participation as a strength of the council. Support for care leavers was found to demonstrate *"exemplary practice"* and inspectors said children in care were provided with *"exceptional services."* Ofsted said that adoption services remained a strength, independent reviewing officers are *"strong advocates for children"* and planning and decision making for babies needing early protection was a *"particular strength."* They also highlighted the *"effective support"* of the Targeted Youth Support Service, in diverting children away from criminal exploitation and the skilful work of the social workers taking calls where there were concerns about children (known as the Children's Advice and Duty Services).

In terms of partnership working, the report noted: *"Partnerships have been considerably strengthened, informed by Norfolk's children's services strategic framework, known locally as 'FLOURISH', which provides a shared vision and underpins the transformation agenda. This is seen in the innovative system-wide approach to the delivery of services, particularly early help services supported by community and partnership teams. Strong partnerships are also instrumental in the diverse range of multi-agency support services focused on building resilience and ensuring that needs are met quickly and at the lowest level. The strong relationship-based style of working with families is a strength of this authority."*

As ever, there is always more to do and Norfolk County Council remains committed to continuous improvement and being a learning organisation. Inspectors identified that further work is needed to strengthen our response to children aged 16 and 17 who present as homeless; the recognition and response to neglect, and the support and decision-making for children placed with family and friends.

What is obvious is that Norfolk's Children Services are all collectively ambitious for children in Norfolk and we will want to both sustain and build on this success so that our services continue to get even better and every child and young person in our county can flourish. This means that the Executive Director and her Directors will continue to provide the stable and determined senior leadership to deliver this exciting agenda.

We are anticipating two further inspection reports later in 2023 which involved Norfolk:

- His Majesty's Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS) included Norfolk Constabulary as one of six police forces in a thematic inspection on Group Based Child Sexual Exploitation.
- His Majesty's Inspectorate of Probation included Norfolk's Youth Justice Service as one of 10 local authorities; the focus was on children remanded in detention and accommodation.

Learning and recommendations from these inspections will be reported on in the 2023 – 24 annual report.

5. Norfolk Safeguarding Priorities, Projects & Developments

The NSCP continued to work on its three priorities throughout 2022 - 2023: neglect, child exploitation and protecting babies. The year ended with a priority review/priority setting workshop, assessing the achievements and work outstanding against each area. This chapter evidences the progress we made, as well as reporting on other projects and areas of development in Norfolk.

Each priority area is led by one of the three statutory partners, Children's Services, Police and Health respectively. This ties in neatly to our governance arrangements and reinforces the message of joined up leadership. Strategies have been published against each area and are available on dedicated pages of the NSCP website. The Business Plan includes actions against each priority area and is due for a review in autumn 2023 to reflect the priority reviews and local developments.

In addition to the safeguarding specific priorities, the NSCP is committed to developing trauma informed and resilience oriented leadership and practice. This is followed through in a number of ways, for example, in Leadership Exchange and Learning Events, Section 11 self assessment, through policy review and development and in training.

Neglect

The NSCP Neglect Strategy was revised following the publications of two Safeguarding Practice Reviews and with reference to Children's Services Ofsted inspection, which noted:

> *Family support services actively support children living in situations of neglect. For many children, positive changes are made. But for some, the changes are not successfully sustained after services withdraw, and cycles of neglect continue for these children. Systematic evidence-gathering and use of tools such as the graded care profile in family support services are limited.*

Strategy implementation is overseen by the Neglect Strategy Implementation Group (NSIG) which is chaired by Children's Services Director of Partnerships, Inclusion & Practice. The revised strategy now has two clear workstream:

- Ways of Working, which focuses on using data to better understand contributory factors and best practice in terms of: the needs of children and young people; the needs of parents/carers and the wider family network; and the needs of the workforce and developing a systemwide toolkit for managing neglect cases – led by the Assistant Director of Independent Services & Practice and the Police

- Accumulative Neglect Operational Oversight Forum, which focuses on specific cases requiring strategic leaders to look at barriers to success and themes emerging from an operational perspective – led by the Assistant Director of Family Help & High Needs (social care) and the Named Safeguarding Professional for Cambridgeshire Community Services (0 – 19 Healthy Child Programme)

Section 11 findings in relation to Neglect

In both the staff survey and the Section 11 returns there was a high level of confidence in responding to neglect whilst recognising the difficulty that this area of work presents to professionals. Partners feel that they understand how to recognise neglect as they see it on a regular basis but what they are uncertain about is how to address it effectively.

In the 2021 Section 11 report the responses to the neglect section included anxiety in relation to holding risk and fatigue. In the summer progress meetings holding and managing risk was identified as a theme that would benefit from discussion in our thematic panel meetings, but the Section 11 responses would suggest that this is viewed as an area for development and discussion rather than anxiety. Feedback from the Thematic panels on partnership work to hold and manage risk supported this indication:

- *This* [the Thematic Panel] *created an environment for learning and building relationships*
- *Very useful and positive session which allowed multi-agency reflection*
- *A greater sense of collaborative working.*
- *New connections, deepened relationships, a stronger sense that we are collectively tackling the same issues*

In the Section 11 returns partners were asked what they needed in order to develop and progress their organisation's contribution to this priority and below are examples of common themes:

- Develop more coordinated and integrated planning for all cases shared between the organisations.
- Supporting practitioners to have the confidence to have conversations around neglect and be professionally curious
- Ongoing training and sharing knowledge and information to inform staff on the relevant tool kits, assessments and best practices.
- Supporting the development of any agreed neglect tools to become embedded in practice.
- Developing the role that Neglect champions play

There were no recommendations relating to neglect in the Section 11 report as these common issues are being responded to by the Neglect Strategy Implementation Group through the ongoing implementation of the Norfolk Graded Care Profile, the development of the Flourishing Families tool and the reinvigoration of the Neglect Champions network. The Neglect Strategy revisions took account of the Section findings as well as learning from local/national Child Safeguarding Practice Reviews, audit and data in 2023.

In June 2023, it was agreed that neglect would remain a priority. Data will be used to monitor progress and this will be reviewed in June 2024.

NSIG achievements reported in June 2023 included:

- **Community Engagement and neglect comms:** two animations co-produced with children and young people focusing on feeling safe and loved
- **Understanding Contributory Factors:** development and evaluation of adapted Norfolk Graded Care Profile (NGCP) – implementation plan in place and signed off by the three statutory partners and an established **comprehensive data profile.** Actions

from the Neglect data review included: specifically reviewing and improving the offer to parents with disabilities; specific workstreams to review professional curiosity around neglect and the 'toxic trio' of mental health, substance abuse, and domestic abuse; and further investigations into the way boys and girls are classified as experiencing neglect particularly in older age groups. (See Chapter 4).

- **Flourishing Families Tool:** online self assessment tool developed using questions from the NGCP – family friendly focus which was road tested with service users and professionals before going live.
- **Emotional Impact of Neglect**: practitioners have access to opportunities to attend reflective practice sessions and request Joint Agency Group Supervision to reflect on challenges managing neglect cases.
- Reinvigorated **Neglect Champions Forum**: 213 champions in place at the end of the reporting year. Additional support and guidance is now provided to them as well as regular newsletters, Best Practice learning events are scheduled through the year. The May 2023 event was well attended and appreciated: "*Thank you it was great to be in a position to learn how to help vulnerable children and get different ideas on how to think differently."*
- **Developed pathways between hardship and support**. Families identified through an application to Norfolk Assistance Scheme (hardship funding) are provided with an Early Help consultation.
- Revised our **multi-agency neglect training learning outcomes** – now focused on developing skills to work alongside families to empower them to address neglect, enabling sustainable change, using resources to identify neglect.
- **Longitudinal review into neglect**
- **SPR roadshows**: disseminating learning from Cases AK & AL in a solution-focused learning event (see Chapter 6)

Case Study: Flourishing Families Tool

This tool was developed for families to better understand how neglect might impact on their children and provide signposting to help and resources. It was road tested with families before being launched in February 2023. With the launch, a comms package was developed and partners fed back on how they used the resources. For example, the Senior Adviser for Inclusion - Early Intervention and Prevention in education reported that she was supporting professional working in schools through e-courier and communication networks including Elective Home Education families. She also did a 'brief walk and talk through' at Designated Safeguarding Lead webinars, Relationships & Sexual Health Education Lead sessions, Steps Lead Professionals, Mental Health & Wellbeing network attendees and SENCO's. This supported the successful recruitment to our pool of neglect champions

Child Exploitation: Vulnerable Adolescents

The Vulnerable Adolescent Group (VAG) is chaired by a Detective Superintendent. The VAG's focus is on extra-familial harm, with an emphasis on child exploitation (both sexual and criminal), serious youth violence and radicalisation. The NSCP's Strategy to Protect Vulnerable Adolescents from Extra-Familial Harm has four clear strands of work: Awareness Raising; Early Help and Identification; Safeguarding Exploited Young People; and Identifying and Disrupting Offenders. In order to deliver against the strategy, the VAG is supported by:

- a Vulnerable Adolescent Partnership Forum, including the voluntary sector;
- an Exploitation Operational Oversight Forum responsible for a detailed data dashboard that is capable of drilling down to individual child level to monitor risk and impact of intervention;
- a Contextual Safeguarding Sub-Group to develop Norfolk's response to safeguarding in 'places & spaces'; and
- a Child Exploitation Training Sub-Group

The VAG also has strong links with the following groups, which sit outside of the NSCP structure, but which are fundamental to the system-wide approach to child exploitation:

- County Lines Strategic Group which reports on areas of drug supply, exploitation and emerging themes and trends associated with county lines; this sits under the Norfolk Countywide Community Safety Partnership which is also responsible for delivering the Serious Violence Duty agenda
- The Children and Young People Strategic Alliance which has governance over the Youth Strategy
- The New Roads Board.

The VAG also oversees a Youth Endowment Fund project in Norfolk, working in partnership with Right to Succeed to target community interventions at ward level to reduce and prevent youth violence and criminality. They recently received additional funding from the National Lottery and at year end were preparing the recruitment packs to further expand their workforce in the Nelson Ward in Great Yarmouth. With this they will be setting up a youth panel and creating two 'Safe Spaces' once the recruitment is complete. They also provide Post 16 transition support for young people in the ward, working with those at the highest risk of NEET. There is evidence of strong partnership working, for example, the Mancroft Advice Project (MAP) [2]are completing a heat map of what is available and finalising the consultation piece which will guide where funding goes next with delivery from September. They also work closely with schools in the local area.

[2] MAP is a voluntary organisation, providing advisers, counsellors and youth workers who work together to provide the best help we can in a way that makes sense to you. We also provide education and training for young people, parents, carers and other workers. We work from our centres in Norwich and Great Yarmouth.

Section 11 Findings in Relation to Vulnerable Adolescents and Exploitation

As with the responses from 2021 there is a good level of confidence across the partnership that the framework and foundations for tackling child exploitation are in place. There also appears to be a reasonably good level of awareness about how Norfolk is tackling this priority area. At the same time, many partners want more information to build their own understanding and levels of confidence in how to keep up to date with developments with this priority. The following are examples of how organisations feel that they need to develop:

- More information to build understanding and levels of confidence in how to keep up to date with developments.
- All teams have identified child exploitation as a continued area of training need
- Attendance at early help hub meetings to share and gain relevant information
- Continue to build relationships with other professionals
- Greater joined up working including increased collaboration with agencies working with vulnerable adults

There were a number of health partners who felt that they needed a "wider health response" to exploitation. Reference was made to the need to build a closer understanding of, and potential input into, the workstream, more involvement in multi-agency audits and greater linkage and communication between health partners particularly in relation to this priority.

It is essential that all staff have an awareness of this priority and are alert to, and able to identify, any concerns at the earliest opportunity. It is not an area that all practitioners need to have expertise in, however it is important that all staff have a good level of confidence that their knowledge is at the right level. Different levels of training are available via the NSCP website[3] and there are regular briefings through the LSCG briefing programme. A recommendation was made to support workforce development in this area.

In June 2023, it was agreed that vulnerable adolescents would remain a priority for the next 12 months. In this time, the data profile will be completed, case studies will be sought and the strategy will have its three year review.

The Vulnerable Adolescent Group's achievements reported in June 2023 included:

- **Support to YEF Neighbourhood Fund Project –** from concept through to implementation in Central Great Yarmouth

- **Review and updating of online resources** – housed on NSCP website

- **Consolidation of training** – implementation of online Introduction to Exploitation package and whole day Tier 2 Vulnerable Adolescent Training

- **Coordination across partnerships** – County Lines Strategy Group, New Roads, Youth Justice Board, Pathfinder Project

- **Embedding, improvement & promotion of MACE Processes** – CE Screening and alignment of Multi-Agency Child Exploitation (MACE) Team, Youth FAST (social care) & Targeted Youth Support Service

[3] https://www.norfolklscb.org/people-working-with-children/nscp-priorities/child-exploitation-resources/

- **Strengthening of operational oversight and scrutiny -** through the Exploitation Operational Oversight Forum (EOOF)

- **Development of CE Data Dashboard –** helping to inform oversight work of EOOF

- **Multi-Agency Audit on children at risk of exploitation**– completed and lessons absorbed into EOOF

- **Development of Good Practice Guide for Managing CE** – disseminated and added to online resources

- **Development of Serious Youth Violence Good Practice Guide** – including notification to partnership senior leadership and joint management of immediate risk

- **Support to schools to reduce permanent exclusion** – including the provision of an Inclusion Support Directory

- **Delivery of exploitation related schools programs** – including St Giles, Tricky Friends and Safer Schools Partnership sessions

In the next 12 months VAG will be focussing on: its Partnership Communication Strategy; completing a multi-agency review on an 18 year old homicide and disseminating the learning; Locality Contextual Mapping Meetings; improvements in joint response to missing children – including embedding the Philomena Protocol; and the Child Exploitation Data Review.

Case Study: Locality Contextual Mapping

In September 2022 the Norwich City College hosted a **contextual safeguarding multi-agency meeting:** Designated Safeguarding Leads (DSLs) and Senior Safeguarding Officer met with Norfolk Police youth violence team and Youth Offending Team Manager to discuss a number of cases new to the college this year where the young person enrolled is active to police investigation and vulnerable to criminal exploitation. The College requested the meeting after receiving information sharing updates post enrolment. The meeting covered matters of: the College's approach to Admissions and Review Panels in cases where a young person is active within the criminal justice system, risk assessing and the concept of transferable risk and how we manage this in a multi-agency way, bail conditions, pre-charge and post-charge conditions and what this means from a college perspective and a young persons' enrolment on their course, local affiliation, tensions, gangs and education around knife crime and information sharing going forward. The College's approach to multi agency working was validated in a round table meeting with Norfolk County Council colleagues in November, where Youth Offending Officers and local Guidance Advisers formally thanked the College for the positive and restorative approach taken in enrolling young people with complex backgrounds.

The College is part of the new **CCE (child criminal exploitation) Network in Norfolk (28/9/22.)** This is an important link as there has been a significant shift in the local context of serious youth violence within the Norwich over the past two years. Two high profile murders in Norwich and Ipswich have led to a shake up of structures in local gangs and this has increased the risk to some young people within the college community where they are vulnerable to exploitation, as the worry is that they have been asked to 'step up' and prove their loyalty.

Protecting Babies

The Protecting Babies Steering Group (PBSG) was chaired by Cambridgeshire Community Services Head of CYP Services in Norfolk until March 2023, when the Deputy Designated Nurse picked up the chairing role. The Protecting Babies Strategy has four strands of work: Non-Accidental Injury to babies (NAI); safer sleeping; concealed or denied pregnancy, including pre-birth assessments; and a communications campaign on All Babies Cry, which signposts parents of newborns to the Just One Norfolk website for resources and support.

In November 2022 the strategy was reviewed and revised to reflect the many achievements of the PBSG. The successful implementation of the strategy was framed around five 'C's': Creativity; Connectivity; Communication; Community; and Consultation. In the previous month, October 2022, the data profile on this priority was completed and presented to the NSCP's Partnership Group providing further evidence of impact on practice. It also provided a basis for using data more effectively, for example, exploring the rates of Infant Mortality and admissions within 14 days of birth to ensure there were no consistent safeguarding or child protection concerns driving recent increases; there weren't, but it was vital to check, and the added weight of evidence from reviewing early health checks and was a further opportunity to test our mature approach to data use in order to understand the safeguarding system.

Section 11 Findings in Relation to Protecting babies

There was a wide range in the responses to the work that organisations are delivering against this priority. For some there is clearly an understanding of more work to be done and for others a good indication of the work that is being progressed and a clear understanding of how the priority relates to their practices. There were excellent responses which evidenced where their work related to the activity being progressed through the Protecting Babies action plan, i.e. directly linking the impact of strategy to practice.

The Section 11 report recommended that the NSCP develop work within relevant services working with vulnerable young people to ensure they address the need for preparation and support for young parenthood. As a baseline, there should be an expectation that all practitioners across the partnership understand the relevance of this priority to their work and have an awareness of the basic aspects of the Protecting Babies priority and the resource that is available to parents and parents on the Just One Norfolk website. Partners also highlight the need for more understanding about how they can become more father inclusive in their practices. Norfolk is taking a partnership systemic approach to becoming more father inclusive and further details of this are available on the NSCP website[4]

In June 2023, it was agreed that good practice in protecting babies is now embedded, particularly in terms of health professionals' awareness of and adherence to relevant policies to identify and prevent harm to unborn and non-mobile babies. It was agreed that this could be stepped down as a priority. The caveats to this were the completion of the review of the pre-birth assessment protocol and ensuring that the communications campaigns would be

[4] https://www.norfolklscb.org/people-working-with-children/nscp-priorities/father-inclusive-practice/

continued to be promoted across the partnership. A Protecting Babies Operational Group remains in place to provide ongoing oversight of policy development and implementation. This group is co-chaired by social care and health and continues to link in with the Neglect Strategy Implementation Group to raise any practice issues if and when they arise.

The Protecting Babies Steering Group's achievements reported in June 2023 included:

- **Innovative engagement and communication with families -** through use of accessible videos and social media
  - All Babies Cry - content on Just One Norfolk and social media comms campaign
  - Safer sleeping - series of co produced videos promoted at identified periods of risk – such as Christmas

- **Using creativity to make policies more accessible to the wider workforce** e.g. **Medical examinations policy** updated and **concealed pregnancy policy** developed and promoted

- **Creation of a video** to support understanding of bruising on non mobile infants

- **Engagement of Norwich City Football Club players** to promote key messages and importance of fathers

- **Ongoing development of Just One Norfolk digital platform** to support parents, families and professionals

- **Strengthened partnership working -** with committed membership of steering group and working parties to complete actions and also seeking additional cross system opportunities

- **Learning across the system about non-accidental injuries to babies,** for example, using **Joint Agency Group Supervision** to support front line workers and the professional network to have a safe space to reflect upon the challenges of a difficult case.

- **Protecting Babies systemwide briefings** leading to opportunities for discussion of how services can support each other, for example, the Healthy Child Programme changing delivery of antenatal contacts to all face to face as a result of hearing midwifery challenges at the time

- **Report from NAI workshops** which included **multi agency consultation** and **service users including fathers** who were interviewed to inform understanding of non accidental injuries and risks to babies

- Feedback from families and communities to **develop Just One Norfolk Protecting Babies content**

- **Data and Business intelligence** used by the partnership to examine the strategies effectiveness and assurance.

To further evidence and celebrate the work of the PBSG, the NHS Designated Safeguarding Team is planning to write a Case study for the department of Health and World Health Organisation.

Case Study: Warm Baby Initiative

In response to the cost of living crisis, the North Norfolk district early childhood advice network instigated a Warm Baby Bags initiative, which was led by Community Focus Officers. In total, 76 Warm Baby Bags were put together. Each bag contained one winter coat, two baby sleeping bags, two fleece baby grows, one hat and baby mittens; these were approved by health colleagues and information around safe sleep also included in the bags. Distributions points were libraries and foodbanks, and bags could also be requested by parent and toddler leaders for specific families and three bags were given to social care and family support teams. All 76 bags were distributed to families in need, helping to alleviate some worry for parents of very young children, who were not yet able to regulate their body temperature, where they were faced with the hard decision around heating their home or eating. The team is exploring how this can be rolled out on a bigger scale in North Norfolk by collaborating with the district council.

Trauma Informed and Resilience Oriented Leadership & Practice

Since 2019, the NSCP has been promoting a trauma informed and resilience oriented culture. This was crucial to leading the workforce and our service users through the pandemic and remains a key component to Norfolk's culture and approach to the safeguarding system. Over the past four years the messages have remained constant as this was seen as an overarching priority.

Section 11 Findings in Relation to Trauma informed practice and leadership

The Section 11 returns gave an average score of 6.3 out of 10 for trauma informed leadership. The staff survey did not ask this question and there is therefore no comparator. Three Section 11 trauma informed practice and leadership workshops were held in 2022 – 23 to allow partners to share their knowledge and experience. These had an average attendance of 17 partners and the feedback was very positive. One session had a specific focus on the role of supervision in developing a trauma informed culture and this is one of the common threads in the 2022 Section 11 returns. One exemplar response is below:

> *"Safeguarding supervision policy – includes a full refresh of the model using a standardised and reflective, supportive model. There is an embedded evaluation and peer review process involved with the supervision model and allows for greater emphasis on practitioner wellbeing, emotional containment and embeds learning from child practice reviews, incidents, and investigations. There has been one review of the model, and this evidenced positive experiences and allowed for minor amendments to the model reflecting this feedback. Annual reviews of the model to ensure a dynamic development of this is in place."*

The need to review and apply a trauma informed lens to policies was a common thread and this will be addressed in the next Section 11 trauma informed leadership workshop. In addition to these workshops, trauma informed training is available in 2023 via the Workforce Development Group training programme and therefore there was no need to create a recommendation for this priority in this report.

Achievements reported in June 2023 included:

- **Leadership Exchange and Learning Events:**
    - 'Building Back Better' September 2021- facilitated by Dez Holmes from Research in Practice[5] - looking critically at our systemic response to Resilience and Trauma
    - 'Leadership Learning from SPRs' April 2023 - including moral and ethical challenges for leadership

- **Complex Health Needs Workshops** – 2021-22, which included presentation by Family Voice on 'The trauma and challenge of having a child with complex health needs'

- **Serious Case Review/Safeguarding Practice Review Roadshows** – 2021 and 2023, focusing on the Emotional Impact of Neglect and understanding secondary and vicarious trauma

- **Health Education England (HEE) Wider Children's Workforce Mental Health Training**: Norfolk is one of three pilot areas for this pilot training – facilitated by **the Anna Freud Centre** in 2023 which includes 24 training events and nearly 400 members of staff across Norfolk currently signed up. The training helps all workers who come into contact with children, ensuring that the wider workforce receives the same basic training in emotional health.

- **Trauma Informed Practice Task and Finish Group** have put together a **package of learning options** across adults and children's workforce, including:
    - Half day Trauma Informed Practice Introductory sessions
    - Full day Trauma Informed Practice and Supervision Skills training across 2023-24
    - Half day 'Trauma Toolbox' sessions facilitated by Norfolk and Suffolk Foundation Trust – introduction to tools to help staff to address their own trauma responses
    - 2 Day Conference for senior leaders on 'Organisational and secondary trauma including a focus on wellbeing' facilitated by Dr Karen Treisman [6](June 2023)

The 2 day conference noted above was well received, however, it was disappointing that attendance was at half capacity. People who did attend fed back on the value of the training:

- *Goodness it was all really useful and I have taken a lot away - I do think it would be useful to have more people trained and would highly recommend. I think in a system that is under pressure there are some really good things that we can all do, but we need to embed into our daily lives, and it would be useful to have more people having a greater understanding so we can build collective momentum.*

- [What you will be putting into practice]: *Definitely spending more time on my own wellbeing, but also helping those around me. I have already encouraged others to have soothing boxes and have been thinking about how we can build more positivity into our working days. Understanding it's not what you, it's not what you do, it's how you make someone feel. Also about breaking the silence – you have to name it to tame it.*

[5] Research in Practice brings together academic research, practice expertise and the experiences of people accessing services. We then apply this knowledge to develop a range of resources and learning opportunities, as well as delivering tailored services, expertise and training.

[6] Dr Karen Treisman, MBE, is an award winning Highly Specialist Clinical Psychologist, organizational consultant, and trauma specialist who has worked in the National Health System and children's social services for several years. For more information see her website: Safe Hands Thinking Minds

It was agreed in June 2023 to step this down as a formal NSCP priority but to ask the Workforce Development Group to ensure that they continue to prioritise trauma and resilience in their work.

Inclusive Father project

The Inclusive Father project was established in 2022 – 23 in a local response to the National Child Safeguarding Practice Review *The Myth of Invisible Men*, published September 2021, which outlined the pressing need to engage with fathers and father figures more effectively.

> *"It is the recommendation of this review that all local safeguarding partnerships respond comprehensively to these challenges and develop local strategies and action plans to support improved practice and effective service responses."*

While improving the way we work with fathers is not an official priority it was discussed at the priority review/priority setting workshop in June 2023. The Project Lead is the NSCP's Safeguarding Intelligence and Performance Co-ordinator and he reported the following achievements:

- **Awareness raising** across the workforce
- **Exploration of barriers** experienced by practitioners
- **Input from fathers** about their experience of services in Norfolk
- **Partnership Good Practice Guidance** agreed. Practitioners have identified what they need and want to see in the way of guidance
- **Policy and procedure change** is beginning to happen
- **Toolkit of training and resources** currently in development
- **Testing of training and resources** planned

The importance of the role of fathers in keeping children safe was acknowledged and Norfolk should be proud of the resource given to this project, which has the support of national expert advisers and key stakeholders, including organisations dedicated to working with fathers and fathers themselves. It was agreed that we would make family and community networking a priority and incorporate the Inclusive Fathers project to sit under there.

The Good Practice Guide will be formally launched in November 2023.

NSCP projects and Local Developments

Joint Agency Group Supervision

The NSCP's Joint Agency Group Supervision procedure (JAGS) was introduced in 2020 and continues to be monitored to understand impact on practice. The procedure was developed to provide a safe forum for exploring complex or challenging cases where there is drift has been a recurrent theme in several SCRs/SPRs, including cases published recently. JAGS purpose is to empower and enable multi-agency professional networks by:

- promoting a better understanding of children's lived experiences
- ensuring we take a trauma informed view
- increasing awareness of different perspectives, and
- promoting system wide learning.

Senior managers from Children's Services, health and education filmed a short infomercial on JAGS as part of the work to further promote this initiative and ensure people are clear about its purpose.

In November 2022, JAGS was nominated for the 'Outstanding contribution to population health through innovation award' at the NHS innovative award ceremony and was highly commended. The commendation was supported by the following commentary:

> *The Joint Agency Group Supervision (JAGS) initiative is an impressive nomination with strengths in child protection, creativity, collaboration, and impact. The panel thought that group supervision in a joint agency context is a challenging endeavour, not only to coordinate, but in the consideration of different perspectives and priorities of each agency. Although the impact upon child protection may appear indirect, they believed this style of supervision richly impacts practice with positive repercussions for children and young people. It was explored how such a setting can create a safe, reflective space to share ideas, think the worst, verbalise anxieties, feel contained, develop confidence, and face difficult decisions that may need to be taken to protect children and young people. JAGS is an important initiative and excellent example of partnership working leading to increased communication and understanding of roles, responsibilities and access to resources and the panel highly commended their efforts*

Overall, the procedure is viewed positively with anecdotal reporting of increased confidence and clarity in terms of roles and the impact that JAGS can have on the professional network. At the time of writing, one of the NSCP's Independent Scrutineers is undertaking observations of JAGS and will be reporting to the three statutory partners on the findings in July 2023.

Continuum of Needs Guidance

The Norfolk Threshold Guide was last issued in 2018 and was due for a revision. Throughout 2022 – 23 the Head of NSCP Business Delivery has been working with a multi-agency Task & Finish Group to undertake this important piece of work. The direction was set by the three statutory partners who gave a clear brief that they wanted to move away from the language of 'thresholds' and 'tiers' and describe a more dynamic system that recognised that the needs of children and young people are on a continuum which require a nuanced and thoughtful approach to assessing risk and need. It was also an opportunity to update the guidance with reference to local and national developments, including the social care reform consultations.

The starting point for this review was surveying the workforce to understand what they liked about the current iteration of the Threshold Guide and what changes they would like to see as a result. It was reassuring that many people felt that the Guide was fit for purpose and helpful so that meant that there was nothing urgent to amend and we could take the time to get it right. An interim draft was signed off at Partnership Group in February 2023 and the survey was then shared with the workforce for further feedback. The final draft is going to Partnership Group in July 2023 and an official launch date is planned for September 2023.

6. Learning from Safeguarding Practice Reviews and Rapid Reviews

The NSCP's multi-agency Safeguarding Practice Review Group (SPRG) is chaired by Sian Griffiths, one of the Independent Scrutiny Team. SPRG oversees all aspects of child Safeguarding Practice Reviews and annually refreshes its local guidance in line with national learning and local feedback. This chapter sets out: activity against Rapid Reviews and SPRs, including publication of reviews; learning from Rapid Reviews and specific actions taken or planned in response to reviews published in the last 12 months; and a summary of dissemination of learning.

Learning from child death is reported in a separate annual report produced jointly by the Norfolk and Suffolk Child Death Overview Panels.

SPR and Rapid Review activity

Between July 2022 and June 2023, the NSCP published two SPRs: Case AK, in January 2023 and case AL in December 2022. The reports are available on the NSCP website for 12 months following publication. The recommendations from these SPRs have been incorporated into the Composite Action Plan and are monitored regularly.

No further SPRs were commissioned. However, the Local Authority submitted one Serious Incident Notification (SIN) within this period, triggering a Rapid Review, but this case did not proceed to SPR.

Three referrals were made to SPRG from other agencies – two from Cambridgeshire Community Services (0-19 Healthy Child Programme Provider), and the third from the Norfolk Adults Safeguarding Board (NSAB). These referrals did not meet the criteria for an SIN. The CCS referrals related to long term neglect and in one of these cases it was agreed to commission a local Rapid Review to better understand the chronology and detail of the case. In both instances, the presenting issues and potential learning were discussed and it was agreed that the actions under the Neglect Strategy Implementation Group would address the concerns raised.

The referral from the NSAB involved the suicide of an 18 year old care leaver and resulted in a local Rapid Review.

A summary of cases and issues is included in the table below:

Type of activity	Presenting issue
SPR - AK	Death by overlay – neglect an issue – published January 2023
SPR – AL	17 year old death, suicide – published December 2022
Rapid Review	Non-accidental injury to infant under 2 (non fatal and not known to services)
Referral: non SIN	Long term neglect. Local Rapid Review conducted and assurances provided; children removed
Referral: non SIN	Long term neglect: assurances provided on operational management
Referral: non SIN	Suicide of 18 year old care leaver:
Total number of cases looked at 2022 - 2023 (July – June)	• **2 on babies (1 x SPR/SUDI, and 1 x NAI)** • **4 on teenagers (1 x SPR/suicide, 2 x long term neglect and 1 x 18 year old care leaver suicide)**

The prevailing issues – babies at risk of harm, neglect and drift, and vulnerable adolescents - are linked to the NSCP priority areas to a greater or lesser degree and where recommendations have been made, these have been incorporated into the relevant strategies and their underpinning action plans.

The National Panel agreed all our decisions and fed back positively on the Case AK report: *"We thought it was a very well articulated review which provided important learning points, action focused recommendations and clearly expressed the individual perspectives of all the children in the family."* Other areas have approached the NSCP to learn about our processes and the direction taken to achieve this level of distilled learning.

In addition to local cases and referrals, Norfolk supported two other Local Safeguarding Partnerships: we concluded our involvement with Brighton's report on Child Delta (published November 2022) and are providing information on a Rapid Review being conducted by Kent LSCP.

SPRG continues to monitor and improve its internal processes, using feedback from the National Child Safeguarding Practice Review Panel to refine the systems. The National Panel agreed all decisions made and feedback has helped us improve the way we draw out the key issues from SPRG discussions, including the key points that we agreed on and, where a decision was reached to proceed to a local SPR, the key lines of enquiry emerging. The local guidance was updated to align with the National Panel guidance and incorporated key prompts around intersectionality in our decision making framework.

Learning from National CSPRs

Within the scope of this annual report, the National Panel published its national Child Safeguarding Practice Review on *Safeguarding Children with Disabilities in Residential Settings* (April 2023). This piece of work involved a data collection from all Local Authorities to better understand the risks and vulnerabilities of children placed in specialist settings. As part of this, Norfolk Children's Services joined with health to review all relevant cases.

Learning from Rapid Reviews

As noted above, many of the Rapid Reviews are captured in the ongoing work against the NSCP priorities. For example, the Neglect Strategy Implementation Group revised their strategy and have established an Accumulative Neglect Operational Oversight Forum (ANOOF). The intention is that in the future referrals that do not meet the criteria for an SIN are taken to ANOOF for actioning in real time.

Dissemination of Learning from Serious Case Reviews

This reporting year the NSCP organised a series of SPR roadshows following the publication of Cases AK and AL. The two SPRs appeared very different on the surface: one involved involves a six week old baby who died from suspected overlay while his mother was under the influence of drugs and alcohol (although the inquest verdict later came in as open);l the other involved a 17 year old suicide with a history of familial mental health issues and parental substance misuse. However, there were some startling common denominators, namely:

- Long term, chronic neglect
- Parental substance misuse (and in the case of AL, mental health issues)
- Working with fathers and understanding their role and influence within family dynamics.

A total of seven roadshows were delivered in February and March 2023: six via Microsoft Teams and one face to face for members of the Local Safeguarding Children Groups (LSCGs). The NSCP is responsible for disseminating learning from reviews and these roadshows were planned in response to those cases. The roadshow was titled '*A Solution Focused Approach to Neglect'* and was used as an opportunity to showcase the work of the NSCP's Neglect Strategy Implementation Group as well as explore trauma and the role of fathers.

The learning outcomes of the sessions were to:

- Have a greater understanding of how familial trauma impacts on mental health: how professionals recognise and respond to patterns of behaviour
- Have knowledge of practical methods for engaging with fathers and the wider family network as a response to neglect
- Have established a shared understanding of how neglect impacts on the child as an individual and supporting the professional network to stay child focused
- Have awareness of, and have an opportunity to feedback on, resources and tools developed by the Neglect Strategy Implementation Group

The presentations are available on the NSCP website and have been circulated to the participants after the last roadshow on 16 March 2023.

Attendance for all roadshows was monitored in order to establish engagement by agency and evidence reach. A total of 355 people attended. Of these, 154 (43.4%) completed an evaluation and evidenced some of the most positive feedback we have ever had, with 99.5% positive responses overall and 100% agreeing or strongly agreeing that the roadshows met the learning outcomes. There was consistently positive feedback around the solution focused approach and a sense of optimism that Norfolk is prepared to learn and do things differently to get better outcomes for children who are neglected. One person committed that the most useful thing about the session was it was "*forward thinking - equipping not disabling by being solution focussed*."

One of the unexpected and wonderful outcomes of the roadshows was that we recruited 48 neglect champions in real time, increasing the pool from 82 at the start of the roadshows to 130 by the time we concluded. (This number has grown again and is 213 at year end.) There was consistently positive feedback about the support that neglect champions can expect to fulfil their roles as well as the tools and resources.

In addition to disseminating to the frontline, the Leadership Exchange and Learning Event held in April 2023 focused on how strategic leaders were going to implement the learning from SPRs. The evaluation report from the roadshows was shared there and there were opportunities to reflect on the practical and ethical challenges to neglect and the emotional impact on leaders in terms of supporting their workforce and on them as individuals responsible for keeping child

7. Training and Workforce Development

The 2022-23 training year was a time of transition for the NSCP training unit with the departure of the long-standing Workforce Development Group (WDG) Independent Chair, Natasha Rennolds, and the recruitment of a new Chair, and member of the Scrutiny Team, Bridget Griffin. This year also saw the departure of the Safer Programme Co-Ordinator, Joanne Hutchings, and the recruitment of Gemma Hampton to the role.

Norfolk Safeguarding Children Partnership Multi-Agency Learning Offer

The 2022-23 training year has continued the trend of an increased multi-agency training offer being administrated by the NSCP training unit, delivered by both our contracted multi-agency training provider – InTrac Training and Consultancy - and by local practitioners.

The multi-agency training contract came finished at the end of the 2022-23 training year. Procurement has taken place and a new training provider, Interface Enterprises, has been commissioned to take over facilitation for the 2023-24 training year.

In the 2022-23 financial year, In-Trac delivered 42 training sessions: four were delivered by an externally contracted trainer and local practitioners delivered 130 sessions. This is a slight increase on the year previous but represents a continued upwards trend.

Intrac Training Offer (APR – MAR)	No. of courses	Places available	Places Taken	% take up	Did Not Show
2021 - 22	35	706	559	79.2%	114
2022 - 23	42	702	601	85.6%	130

(Comprehensive attendance data is not available for sessions delivered by partners as not all partners report attendance figures due to administration pressures.)

Delegates who signed up but did not show or cancelled within seven working days were charged a fee.

The In-Trac training courses on offer can be found on the NSCP website. Partners and the NSCP training team supplemented the offer with learning sessions including:

- Restorative Approaches (11)
- Harmful Sexual Behaviour (28)
- Substance Misuse (5)
- Child Protection Conferences (4)
- Signs of Safety (6)
- Family Networking (5)
- LADO Process (2)
- Safer Sleeping (6)
- Intro to Multi-Agency Working (1)
- Trauma Informed Practice Intro (2)
- Children's Advice and Duty Service briefings (5)
- Early Help Assessment and Planning (29)
- Reducing Parental Conflict (14)
- Working with Central and Eastern European Migrant Families (2)
- Gypsy Roma Traveller Awareness (1)
- GamCare (1)
- Trauma Toolbox (2)

In addition, there were two development sessions for Safeguarding Children Trainers.

Impact of training

Work has continued in 2022-23 to measure the impact of the training delivery. The project was extended to cover the Domestic Abuse, Voice of the Child and Assessing, Managing and Holding Risk courses. Initial response rates to the questionnaires were poor and administration of the project was time consuming. The issue was revisited at WDG and the decision was taken to

introduce an alternative way of sending out the links to the questionnaires with diary invites. The working group will report back to WDG in December 2023.

Strengthening links between NSCP and the Children & Young People's Strategic Alliance

The WDG Terms of Reference state that "*The Workforce Development Group (WFD) is a joint subgroup of the NSCP and CYP Strategic Alliance, (CYPSA) responsible for developing and implementing the actions to facilitate workforce development issues*". However, it has been acknowledged in the last year that representation on the group and the focus of much of the work has been on NSCP rather then CYPSA. In light of this, the Terms of Reference have been reviewed to ensure there is an equal emphasis on both organisations and the membership has been reviewed with additional CYPSA representatives invited to join the group. This is an ongoing piece of work.

Trauma Informed Practice

In 2022, the NSCP received a lump sum from Norfolk and Waveney Integrated Care Board to provide learning opportunities around Trauma Informed Practice for staff in Norfolk working with both children and adults at risk. A working group of representatives from across the adult and child workforce was created and devised a programme of learning opportunities for staff at different levels. Delivery of this programme started towards the end of the 2022-23 training year and will continue into 2023-24. This programme will include:

- Trauma Informed Practice e-learning
- Half day Introduction to Trauma Informed Practice Sessions
- Half day Trauma Toolbox sessions with a focus on staff wellbeing
- A two day conference facilitated by Karen Treisman for senior leaders

Health Education England Wider Children's Workforce Mental Health Training

During the 2022-23 training year Norfolk successfully bid to be a pilot area for Wider Children's Workforce Mental Health Training in a project lead by the Anna Freud Centre, Charlie Waller Trust and the National Children's Bureau. Norfolk is one of only three pilot areas and as such this is an exciting development for Norfolk's workforce.

Implementation work has been undertaken with delivery of an extensive training programme scheduled between April and September 2023. The NSCP training unit is supporting the pilot through administration of the training and data submission.

Norfolk Graded Care Profile

The NSCP Workforce Development Officer co-ordinated a trial of an alternative version of the Graded Care Profile (adapted by Jane Wiffin[7]) in 2021 with evaluation of the trial taking place in Spring 2022. The Neglect Strategy Implementation Group agreed a county wide roll out of the tool which commenced in 2022-23, with the Implementation Group led by Children's Services. The NSCP have supported the roll out through delivery of Train the Trainers sessions on the tool.

Practice Week

NSCP have supported the transition of Children's Services Practice Week into a more multi-agency focused learning opportunity during 2022-23. These events run twice a year and have a specific focus each time with representatives across the multi-agency network invited to present short sessions which delegates can join virtually. For each practice week there is also a conference with national guest speakers invited. The focus of the November 2022 practice week

[7] **Jane Wiffin** is a Practice Improvement Adviser and social worker by profession; has over 25 years experience of practice across Children's Services in safeguarding roles.

was ‘The Power of Positivity – Celebrating Strengths in Norfolk’ and the May 2023 focus was ‘Helping Minds Flourish – Considering different aspects of mental health and wellbeing’.

The NSCP Workforce Development Officer delivered a session at Practice Week in November 2022, after which one delegates stated:” *It was really useful and easy to take in the information, they provided lots of advice and links, as well as encouragement to become a Neglect Champion*”; she was also involved in the planning for the May 2023 Practice Week.

These Practice Weeks are growing in popularity with over 300 individuals attending in November 2022 and nearly 600 separate individuals attending the May 2023 events – a significant increase. This included over 500 attendances at events by partners from outside of Norfolk County Council. Feedback indicated that 98.3% of respondents indicated that they felt attendance at the events would have a positive impact on their work with children and families.

Best Practice Events

The NSCP training unit ran four best practice sessions in 2022-23. Two specifically for those designing and delivering safeguarding children training in Norfolk, one focusing on Adolescent Neglect and one for individuals involved in commissioning services for children.

All of these events were well received. One delegate at the Adolescent Neglect event, when asked what the best part was responded: “*All of it really. The intro and first presentation to get us thinking and then the group work. Good to work with & hear from so many working in different agencies*”.

The event for commissioners was something the NSCP had not delivered previously and was well attended with 39 commissioners and representatives from across the partnership attending with one delegate commenting in feedback: “*Initially I was concerned that my attendance wasn't relevant, but as a small provider who is on the procurement list and takes referrals from Children’s Services, it has provided an insight into safeguarding within the commissioning process. We are hoping, as part of the Family Hub framework, to increase our availability to vulnerable families across Norfolk and this has been very useful*”.

Safer Programme

The NSCP’s Safer Programme is a service provided by the NSCP Business Unit to meet the safeguarding procedural, policy and training needs of the voluntary, community and private sectors of Norfolk. Safer produces a standalone annual report.

As previously stated, November 2022 saw the departure of the Safer Programme Co-Ordinator, Jo Hutchings, and the recruitment of Gemma Hampton to the role. Safer has continued to grow during the 2022-23 training year with membership at its highest number to date. Initiatives such as the Facebook group and monthly briefings to support members have continued to be developed in the last year and the feedback received through the annual survey illustrates how members value the programme. As one member stated: ‘*I just wouldn't have felt as confident working with children as I do without the support and services from Norfolk Safer’*.

8. Conclusions and Formal Summary Statement

This report provides an overview of the Norfolk Safeguarding Children Partnership's many achievements over the last 12 months. We continue to be proud of the mature and successful relationships strategic leaders have established which underpin the way we work together to safeguard children and protect them from harm. This work has been recognised through national awards and nominations and we continue to approach systemic learning with energy and commitment to improving our services so we get things right for Norfolk children.

This is not to say that we are complacent in any way nor are we naïve about the challenges that lie ahead. We anticipate that the cost of living increases are going to hit families hard across the country and will have a direct impact on our work to protect children. We are also mindful of the changing policy landscape and the implications that will have on our local safeguarding system.

While this report records many achievements, we also recognise the work that still needs to be done. Our challenges and ambitions as we move into 2023 - 24 include:

- Addressing the partnership challenges of evolving and adapting to the Independent Review of social care, the national response to the Stable Homes Built on Love agenda, the Independent CSA Inquiry and anticipated changes to Working Together
- Independent scrutiny on multi-agency chronologies and transitional safeguarding
- Ongoing evaluation and understanding impact of Joint Agency Group Supervisions and legacy planning for the trauma informed training offer
- Continue to utilise the performance intelligence, data and qualitative feedback to ensure we are targeting our resources correctly and addressing any gaps
- Developing our learning offer and measuring the impact of training on practice
- Increasing the number of multi-agency audits completed
- Finalising and launching the Continuum of Needs Guidance and ensuring all multi-agency policies adhere to national policy change
- Disseminating and implementing learning from local and national Safeguarding Practice Reviews and local Rapid Reviews
- Working directly with the children, young people and families of Norfolk to ensure that their voices are heard and they contribute directly to strengthening the safeguarding system
- Continuing to promote and support the FLOURISH agenda
- Continuing to promote equality and inclusion and celebrate diversity in Norfolk

The Norfolk Safeguarding Children Partnership is well placed to build on its strengths and meet the challenges set out above, with the commitment and resources that are in place. The NSCP's Business Unit is funded to support this work and ensure that organisational memory and good working relationships across the partnership continue into the future.