Norfolk Safeguarding Children Partnership

Norfolk Safeguarding Children Partnership

Annual Report
1 April 2025 – 31 March 2026

Partnership arrangements are mature and well established. The DCS is influential in bringing partners together to continue to strengthen and refine the already collaborative approach to safeguarding children in Norfolk. Partner agencies use opportunities through the multi-agency safeguarding arrangements to establish priorities, undertake audits and share learning."

Ofsted inspection findings, February 2026

www.norfolklscp.org

Table of Contents

Foreword by the Three Statutory Partners

I am pleased, on behalf of the statutory safeguarding partners, to introduce the 2025–2026 Annual Report of the Norfolk Safeguarding Children Partnership.

This report reflects a year of strong and effective multi-agency collaboration, supported by mature governance arrangements and a shared commitment to safeguarding children and young people across Norfolk. It provides an open and transparent account of our collective effectiveness, informed by evidence, learning and independent scrutiny, and demonstrates a partnership that continues to evolve in response to both local need and national reform.

During the year, the partnership has benefited from external assurance and inspection activity, which recognised the strength of collaborative, child-centred practice across agencies. This external scrutiny, alongside our own audits, reviews and learning activity, has helped shape improvement priorities and strengthen system-wide practice.

In response to learning, inspection feedback and local intelligence, the partnership refreshed its safeguarding priorities for 2025–26. These include a heightened focus on child exploitation, the delivery of Families First reform, and the introduction of child sexual abuse as a distinct priority area, reflecting its prevalence and impact. At the same time, sustained progress enabled the partnership to step down neglect as a priority, while maintaining appropriate oversight and assurance. This approach demonstrates a partnership that is reflective, evidence-led and proportionate in how it directs its collective efforts.

Central to our work remains a strong commitment to the voice and lived experience of children and young people, whose views continue to inform both strategic direction and service improvement. We also continue to recognise the importance of a skilled, confident workforce and have prioritised joint learning, development and multi-agency supervision to support high-quality practice across the system.

Taken together, the activity set out in this report illustrates a partnership that is dynamic, self-challenging and focused on impact. As statutory partners, we remain resolutely committed to working together to protect children, support families and ensure that Norfolk's children and young people are safe, heard and supported to flourish.

David Buckley
Assistant Chief Constable
Norfolk Constabulary

On Behalf of Norfolk's Named Statutory Partners below.

Norfolk's Named Statutory Safeguarding Partners

	Delegated Safeguarding Partner	Lead Safeguarding Partner
Norfolk County Council	 Sara Tough, OBE Executive Director Children's Services	 Tom McCabe Chief Executive Officer
NORFOLK CONSTABULARY Our Priority is You	 David Buckley Assistant Chief Constable	 Paul Sanford Chief Constable
NHS	 Lisa Nobes Executive Director of Nursing Norfolk & Waveney Integrated Care Board[1]	 Ed Garratt Chief Executive Officer, Norfolk & Waveney Integrated Care Board

[1] From 1 April 2026, Norfolk & Suffolk Integrated Care Board (ICB). As this falls outside of the timeframe for this annual report all references to the ICB relate to Norfolk & Waveney.

Foreword by the Norfolk Safeguarding Children Partnership (NSCP) Independent Scrutiny Team

Norfolk Safeguarding Children Partnership is a mature multiagency organisation that operates in a culture that promotes continuous learning. This culture, promoted by strategic leaders and welcomed by practitioners includes a significant commitment to Independent Scrutiny. This year has seen how good scrutiny can add genuine value to the work the partnership does at all levels, improving learning, practice and outcomes.

NSCP has a team of three Independent Scrutineers, all of whom are experienced safeguarding professionals with differing backgrounds. The team is supported by an outstanding Business Manager and support team. Our role, put in its simplest terms, is to assure the strategic leaders that the partnership is doing all it can to safeguard children in Norfolk. When you read this report, I would like you to be assured that we perform our roles without any restrictions, we are afforded an open and honest view of all aspects of safeguarding, allowing us to advise, challenge and support.

We scrutinise the partnership in a range of ways. We attend and chair some partnership meetings, which helps us build relationships, examine practice and identify learning. We also carry out bespoke pieces of work, often commissioned by partners or prompted by national developments. This work is most effective when it includes direct engagement with practitioners and children, helping us assess how practice and outcomes can be improved. Examples of this work are set out later in this report.

It is also important to recognise that this year we have continued to focus on learning from the many areas of good practice that is taking place everyday in Norfolk. As Scrutineers we believe that when we see good practice it is important that we recognise its value and we cascade learning from it to all professionals.

The scrutiny team meets with the Lead Safeguarding Partners regularly, offering an independent view to those who have ultimate responsibility for safeguarding in Norfolk. This is further evidence of the fact that the partnership are actively seeking out advice and support.

I would like to thank everyone who has contributed to our scrutiny of the partnership's work over the past twelve months. The ability to challenge, learn and support one another is essential to improvement. Norfolk Safeguarding Partnership benefits from people at every level who recognise the value of scrutiny. That not only makes our role more constructive, but more importantly reflects a shared commitment to achieving the best possible support and outcomes for Norfolk's children. Norfolk does not shy away from scrutiny; it actively welcomes it. That is an important strength and, in my view, a key part of the partnership's success.

Your Independent Scrutiny team will continue to scrutinise, challenge and support at every level of safeguarding. We are proud to be a small part of an excellent partnership.

Chris Robson
Lead Independent Scrutineer - NSCP

Introduction

The Norfolk Safeguarding Children Partnership is the body responsible for implementing and reviewing the local plan for Multi-Agency Safeguarding Arrangements (MASA). The MASA was reviewed and reissued in December 2025 and is fully compliant with the statutory guidance set out in Working Together 2026. The MASA is the responsibility of the three statutory partners, i.e. the Local Authority, the Police, and Health. The published arrangements set out how they will ensure all partners fulfil their safeguarding duties. The partnership continues to be mature, collaborative and emotionally literate.

The focus of this annual report is to evidence what the NSCP has done as a result of the MASA, the effectiveness of the partnership and the impact our arrangements have on practice and the children and families we serve. The scope of the report runs from 1 April 2025 to 31 March 2026. The report provides information in relation to:

- the contribution of each safeguarding partner to the functioning and structure of the multi-agency safeguarding arrangements
- any themes emanating from aggregated methods of scrutiny, for example, reviews and scrutineer activity and multi-agency audits and inspections such as JTAIs
- evidence of the impact of the work of the safeguarding partners and relevant agencies, including training, on outcomes for children and families, including the identification of groups of children who may be disproportionately over- or under-represented in services
- an analysis of any areas where there has been little or no evidence of progress on agreed priorities
- an analysis of learning from serious incidents
- a record of key decisions and actions taken by the safeguarding partners in the yearly cycle, including in relation to implementing the recommendations from any local and national child safeguarding practice reviews and the impact this has had
- ways in which the safeguarding partners have sought and utilised feedback from children and families to inform their work and influence service provision
- the breakdown of costs in delivering the arrangements for that period, including the financial contributions of individual partners, any changes to funding and an assessment of the impact and value for money of this funding
- evidence of how safeguarding partners are ensuring the adequate representation and input of early education and childcare settings, schools, colleges and other education providers at both the operational and strategic levels of the arrangements
- an overview of how data is being used to encourage learning within the arrangements and evidence of how information sharing has improved practice and outcomes
- a review of the impact and learning from independent scrutiny arrangements to ensure the leadership is strong and the arrangements are leading to the desired and necessary impact
- any updates to the published arrangement with the proposed timescale for implementation
- evidence that national reforms have been implemented, taking into account key decisions and actions taken by safeguarding partners in response to reforms, and any issues or concerns encountered within the yearly cycle

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.

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 adhere to Norfolk's plan for Multi-Agency Safeguarding Arrangements. This chapter serves as a summary of the effectiveness and impact of governance in 2025 - 2026.

The Delegated and Lead Safeguarding Partners (LSPs and DSPs) named in the MASA are:

- **Norfolk County Council**: represented by the Executive Director of Children's Services, Sara Tough OBE (DSP) and the Chief Executive Officer, Tom McCabe (LSP)
- **Norfolk Constabulary**: represented by the Assistant Chief Constable, David Buckley (DSP), and the Chief Constable, Paul Sanford (LSP)
- **Norfolk & Waveney Integrated Care Board**: represented by the Executive Director of Nursing, Lisa Nobes (DSP) and Chief Executive Officer, Ed Garratt (LSP)

There have been changes to leadership in the last twelve months, namely with the ICB but also a newly appointed police DSP. The new leaders have embraced the partnership and provided fresh insight as we steer through national reforms.

The DSPs meet quarterly and are chaired by the Executive Director of Children's Services, acting as a conduit for the LSPs. The LSPs are provided quarterly written briefings and meet twice a year with the DSP meeting chair to consider MASA milestones as well as to respond to emerging challenges and maintain a strategic overview on the system.

Norfolk fully adheres to the national requirements set out in Working Together 2026. The MASA provides further details of our adherence. In summary:

- **Chairing:** the named Chair for the NSCP is Sara Tough, OBE, as noted above.

- **Education:** Norfolk has representation from all phases of education – primary, secondary, special schools and further education – in an Education Safeguarding Partner (ESP) group. The MASA chair attends every other meeting, and we are exploring ways in which to nominate a single education representative to formally act as a Delegated Safeguarding Partner. All members of the ESP sit on the NSCP's Partnership Group and are invited to the Leadership Exchange & Learning Events. On an operational level, schools' Designated Safeguarding Leads (DSL) networks continue to be a strength of the partnership.

- **Voluntary Sector:** the VS have a place at Partnership Group meetings and continue to play an important role in safeguarding Norfolk's children, with over 500 members from the VS signed up the NSCP's Safer programme.

- **Data and performance intelligence**: the well-established role of the NSCP's data analyst is evident in all aspects of our work, including: regular monitoring of the safeguarding data dashboard; providing data profiles against priority areas and contributing to priority review; underpinning any scrutiny work; informing joint strategic needs analyses; and responding to emerging areas of concern, such as the increase in child suicide.

Independent Scrutiny Team

The 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 Lead Scrutineer, Chris Robson, continues to chair the Partnership Group and attend the DSP and LSP meetings to ensure appropriate challenge and identification of strengths and areas for improvement detected in the safeguarding system.
- The Independent Chair of the Safeguarding Practice Review Group, Jo Procter. Jo is a new member to the team from May 2025 and has additional responsibilities for supporting the Section 11 safeguarding self-assessment process.
- The Independent Chair of the Workforce Development Group, Bridget Griffin. Bridget also leads on specific pieces of work around practice development such as: promoting emotional literacy across the workforce, including overseeing the development of the Joint Agency Group Supervision process and leading a task and finish group in response to the learning from the 2024 - 25 Joint Targeted Area Inspection.

The three members of the Independent Scrutiny Team meet regularly to triangulate their findings from their respective areas and report back to the statutory safeguarding partners. Further detail on specific pieces of scrutiny is included in Chapter 4.

Working Subgroups

The governance structure in the MASA sets out all the working groups. In summary:

- **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. Appendix 1 lists all items discussed at Partnership Group this reporting year.

- **Subgroups relating to Statutory Duties – Learning and Workforce Development:**
  - Safeguarding Practice Review Group and Child Death Overview Panel.
  - Workforce Development Group.

- **Performance and Intelligence:**
  - Multi-Agency Audit Group is responsible for audit and monitoring recommendations from audit, Safeguarding Practice Reviews, scrutiny and Section 11.
  - Joint Strategic Analysis Group responsible for providing quantitative evidence of how well the system is working.
  - Section 11 steering group, overseeing the safeguarding self-assessment process and analysing returns.

- **Local Safeguarding Children Groups:** The NSCP is represented at locality level by six 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.

One of the real strengths of the partnership is its inclusivity. Non statutory partners feel seen and heard. The NSCP has built a strong identity as a trauma informed and resilience-oriented partnership and this promotes trust and confidence in the system beyond the statutory partners. For example:

From the Voluntary Sector – on Partnership Working:

> *"When things weren't working well, we used to see a problem and point fingers and look to blame. These days we see a problem and think 'How do we solve this together?' This change doesn't happen overnight. It came from a lot of joint planning, working, creating workshops where everyone felt equal and listened to, that good ideas were shared, not so much who had the idea but whether it was a good one – this led to developing our shared FLOURISH strategy – everyone was already bought in before it even was launched because they had already been involved. There was no need to "sell" the strategy, it already belonged to everyone.*
> Dan Mobbs, CEO, MAP

From Norfolk's Fire & Rescue Service – to NSCP Business Unit

> *"I would like to personally thank you on behalf of Norfolk Fire & Rescue Service for your timely and helpful response to a significant incident we recently attended. Our prevention team are actively seeking methods to eliminate or reduce the likelihood of these tragic events. I understand you managed to coordinate responses and feedback from three organisations to help us along with our review process within one working day, this is truly remarkable.*
>
> *"We are also grateful for your previous involvement in 2023 which helped us shape our Significant Incident Review process. We believe we are now one of the most forward-thinking FRSs in the Country in this field and this has only been achievable with the support from colleagues like yourself. Thank you."*
> Terry Pinto, Prevention Lead, Norfolk Fire and Rescue Service

These examples demonstrate the willingness to learn and collaborate to ensure that Norfolk children and families get a joined-up response that is both timely and effective. This is only possible due to the leadership, culture and investment Norfolk has made in its partnership arrangements.

Leadership Exchange and Learning Events

In addition to Partnership Group, the Delegated Safeguarding Partners are committed to bringing all members of the wider partnership together and promote learning and best practice. The Leadership Exchange and Learning Events (LELE) are a vehicle for the wider partnership to have dedicated time to focus on specific issues. This year, three events were held focusing on:

- the Families First agenda and what that means for partnership working and practice;
- progress made against learning from the Joint Targeted Area inspection on impact of domestic abuse on children aged seven and under; and
- the emotional landscape of safeguarding, drawing on learning from National Panel publications and promoting emotional literacy across the safeguarding system.

The LELEs are evaluated and the DSPs provide direction on how to further embed joint learning within their agencies. For example, following the session on the emotional impact, Children's Services' Director of Family Help and High Needs invited the speaker to an all-management meeting and the police identified an officer for training in Joint Agency Group Supervision.

In 2026 – 27, the NSCP is planning a LELE focusing on the impact of national reforms and Local Government Reorganisation.

Strategic Overview: Links to Other Partnership Boards

The MASA provides further detail on links to other boards. In summary:

- The Children and Young People's Strategic Alliance (CYPSA) and the NSCP's commitment to endorsing and promoting the Flourish Strategy.[2]
- The Norfolk Safeguarding Adults Board, including join up on independent scrutiny and learning from safeguarding review activity. The NSAB Chair and Business Manager also meet regularly with NSCP's Independent Scrutiny and Head of NSCP Business Delivery.
- The Norfolk Countywide Community Safety Partnership, including learning from Domestic Abuse Related Death Reviews and supporting on the development of the Serious Violence Strategy. There is strong partnership working in response to children who are victims of domestic abuse.
- The Health and Wellbeing Board, who are sighted on the NSCP annual report as part of its sign off procedures prior to publication.
- Links with Norfolk's seven Youth Advisory Boards (YABs) through the Local Safeguarding Children Groups and Norfolk County Council's Participation Team.

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 job share between two officers), a Workforce Development Officer, Safer Programme Co-ordinator and 3.5 FTE administrators. The team also includes a 0.5 FTE dedicated senior analyst officer, shared with the Children and Young People's Strategic Alliance.

The Business Unit is responsible for supporting on a range of activities including: supporting strategic leadership; monitoring and audit; multi-agency policy reviews; budget oversight; training provision; and key administrative tasks such as setting agendas, minuting meetings, communications, website development and event co-ordination.

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

2. Voice of the Child

The NSCP takes participation seriously and we are committed to ensuring that children's voices are heard and listened to. We are proud of the work we do to ensure that this report is not only shared with them but also to collaborate with them to co-produce a children and young people's version that is accessible and clearly records their views of our safeguarding arrangements. We extend our thanks to all the children who give up their time to support with this.

We are really proud of the children and young people's version of the NSCP annual report and are pleased to publish the CYP version alongside this full report. We hope you enjoy it as much as we do!

The NSCP is committed to keeping the voice of the child at the heart of our learning and improvement. For example, the Safeguarding Practice Review on Case AO (Jasmine) uses her words throughout the report, giving insight and understanding into her lived experience.

The NSCP also seeks direct feedback from children where possible. For example, the Flourish survey, which is sponsored by the Children & Young People's Strategic Alliance, has provided some important messages about each aspect of Flourish. The survey findings were reported to Partnership Group where discussions took place on what children were telling us. The headlines and themes emerging from our analysis reflect some of the well-documented changes to young peoples' lives in recent years within the context of the pandemic, developments in technology, and the ways young people can communicate. Notable themes include:

- Increased online safety risks.
- A notable and growing proportion of children and young people vaping, reflecting findings in national surveys such as 'Smoking, Drinking and Drug Use Among Young People in England' undertaken by the NHS in 2023.
- An overall sense that the proportion of pupils with poor mental health has increased. Several sections of the questionnaire asked directly or indirectly about pupils' mental health, and most of those questions that are repeated from previous surveys show worsening outcomes since 2017. This reflects national findings, most notably from the NHS's 'Mental Health of Children and Young People' surveys from 2017, that show an increase in the prevalence of probable mental disorders between 2017 and 2020 nationally.
- The complexity of circumstances facing children with challenging outcomes. The data shows that many of the more vulnerable groups identified within the analysis (for example those with SEND, who are young carers, or who are eligible for Free School Meals) are more likely to experience poor outcomes in a range of areas (for example reporting healthy behaviours, problems at home or socially, or taking part in activities outside of school). Whilst the analysis does not show why some of these factors coincide, it indicates that children in more vulnerable groups often face multiple challenges.
- An increase in the proportion of pupils who think it is not important to go to school regularly. Findings also suggests key issues impacting school attendance – with notable proportions of pupils reporting that they have missed school in the last year because of their mental health, or because of bullying.
- Complex changes in the way young people feel about their place in the world – with improvements in feelings of inclusivity and involvement generally, but reduced confidence and optimism, and a reluctance to talk about their feelings or ask for help when things go wrong.

Overall, whilst most responses suggest that children and young experience good outcomes in most thematic areas most of the time, the often-small proportion of responses which report poor or very poor outcomes has increased since the pandemic. While it is encouraging that many of these findings correlate to single and multi-agency priorities, it is clear that we need to keep the dialogue open with children and young people to ensure that they not only feel listened to but can report back to us on the impact of any changes to service design and/or any emerging fears that they may be facing, e.g. global conflict and the impact of climate change.

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. The NSCP partners and business unit continue to seek opportunities through Norfolk County Council's Participation Team.

3. Using data and evidence in partnership

Our approach to data and evidence

Data, evidence and analysis underpin the partnership's activity.
Since 2020 a Joint Strategic Analysis Group has brought together analysts across the partnership, and a dedicated resource and role coordinates support to deliver reports and analysis.
There are a number of ways in which these joined-up arrangements support the activity of the NSCP. Examples include:

- Regular multi-agency monitoring of key trends across the partnership, supporting informed planning around issues such as domestic abuse, exploitation and neglect; and the escalation of emerging issues when there are notable changes in activities and outcomes.
- Data sharing in support of partners' reporting. This includes the regular automated sharing between the Police and Children's Services about children who are at risk of exploitation or going missing, and the sharing of data with the Community Safety Partnership about activity around domestic abuse).
- Support for the setting of NSCP priorities – with data supporting decisions to establish, keep and step-down priorities as part of the partnership's annual cycle.
- Extensive Data Reviews of each NSCP priority bringing together multi-agency data to improve our understanding of risks in each area.
- Data support for independent scrutiny activity. In the last year this has included specific analysis to support scrutiny around group-based child sexual exploitation, and intra-familial sexual abuse.
- Support to multi-agency inspection and regulatory activity, supporting both the inspection process, and the delivery of the resulting action plan. In the last year this has included support for the Inspections of Local Authority Children's Services (ILACS), and an assessment of the delivery of the Joint Targeted Area Inspection (JTAI) of support for children who are victims of domestic abuse.

In addition to supporting these regular activities, our maturing approach to data and analysis has supported to important partnership projects.
One example of this from the last year is the Serious Violence Duty Shared Data Set, an analytical project bringing together Police records of serious violence with a child or young person as a victim or perpetrator with education, children's social care and adult social care data, to identify cases of multiple risks. Outputs from this analysis supported the identification of a number of early risk factors that could support targeted interventions.
Another ongoing example is Norfolk Family Connect, an ambitious household-level project and system that enables the sharing of risk 'flags' across a range of systems (Police, District Council, Education, Social Services) to support staff across agencies supporting children and families to ensure multiple and cumulative risks are not missed.
This approach has also ensured broader safeguarding risks are included in wider needs assessments undertaken across partnerships. Within the last year this has meant specific children's safeguarding considerations are included in Norfolk's Joint Strategic Needs Assessment for SEND, within Norfolk's over-arching Flourish Strategy, within its Domestic Abuse Needs Assessment, and in its Serious Violence Duty Strategic Needs Assessment.

Telling our story with data: the scale and range of safeguarding activity in Norfolk

Significant support is provided by a range of partners to children and families every day. To help understand the scale and extent of this activity, it is helpful to review what happens each week across the partnership.

- Around **139** babies are born – a reduction from 147 in 2020.
- There are around **191,000** children and young people aged 0-19. Of these, **124,000** are at school, a similar number to 2020.

Within the context of this, each week there are around:

1,030 A&E attendances for Under-18s and 370 for under-4s' (similar levels to 2022); 17 hospital admissions caused by injuries for under-15s (a reduction from 26 in 2020); and 3 hospital admissions for mental health problems (similar to 2020); and 9 for self-harm (a reduction from 11 in 2020).

9 children are screened for criminal exploitation by the Police (down from 14 in 2020); 99 Police investigations are started where domestic abuse is suspected and there is a child present; 53 children and young people are reported missing to the Police (up from 42 in 2020) and around 20 are arrested (similar to the last 4 years).

Around 921 contacts are made to the Children's Services (an increase from around 765 in 2021); including around 244 from schools and education services, around 185 from the Police, 155 from members of the public, and 114 from health services

Where contacts suggest there may be a risk to the safety or wellbeing of a child, partners work together to agree the best course of action through formal safeguarding routes. Each week this means around:

- 60 referrals are made to prompt a social work assessment, and around 57 prompt a multi-agency strategy discussion.
- 110 social work assessments and 64 Section 47 Enquiries are completed in total.
- 12 children start a Child Protection Plan, including around 3 who will have had a previous CPP. In addition, around 7 children will become looked after each week (with a similar number ceasing to be looked after).
- Between 1 and 2 children and young people enter the Youth Justice system for the first time (a reduction from around 3 in 2020).

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

- **540** children and young people with a Child Protection Plan
- **1,070** Looked After Children (including around **130** unaccompanied asylum-seeking children)
- **145** children and young people receiving Youth Justice Service interventions.

[Note: data about an average week taken from national returns and local systems, using the most recent data available, and using either the most recent snapshot figure or an average figure for the last 12 months].

What our data and analysis has told us in 2025/26

Data and analysis are used to drive the ongoing monitoring of activity and outcomes, support the delivery of partnership priorities, and inform scrutiny activity. The last year has identified some important trends that describe both the context of safeguarding activity in Norfolk, and how multi-agency activity has delivered change.

Improved risk-identification in response to multi-agency priority activity

A repeated finding from analysis in the last year is that, where specific risks are prioritised, this can have a notable impact on the identification of that risk.

Specifically, this has been a finding from analysis supporting the implementation of Norfolk's response to Joint Targeted Area Inspection (JTAI) 2024 focusing on children as victims of domestic abuse; and from work assessing the impact of priority work around child exploitation. For both areas, data shows that rates of the identification of children subject to those risks have increased slightly, but consistently, since activity has been undertaken in response to the prioritisation of each.

It is difficult to make confident conclusions about the exact impact of priority activity on the identification and recording of risks – both domestic abuse and criminal exploitation are complex areas, and moreover there is nothing within the available data that explicitly links instances of risks with priority activities such as (for example) awareness raising or training. Nevertheless, it is likely that the observed trends reflect to some extent improving broader awareness across agencies through the delivery of priorities.

The importance of identifying children and families with facing multiple risks and vulnerabilities

Previous years' reports have highlighted the heightened risks of poor outcomes experienced by children and families with multiple vulnerabilities, and analytical activity this year has continued to improve our understanding of both cumulative risks and how they might be mitigated.

Norfolk's Serious Violence Shared Data Set - coordinated by the Office of the Police and Crime Commissioner, and working with the Norfolk Office of Data and Analytics (NODA) - brought together detailed Police crime data and information from Children's Social Care, Education and Adult Social Care to understand the context of people aged under 25 who had been a victim or suspect of serious violence. This showed that drug and alcohol concerns are an important risk factor for children and young adults, and that children with these concerns often have many other risk factors too. It also found that children and young people who have been both victims and suspects of serious violence often have the highest number of risk factors. School absence was also identified as an important risk factor.

Analysis in the last year reviewing data about neglect and domestic abuse, undertaken to support the Neglect 'Ways of Working' group understand the interplay between the two risk factors. This highlighted that risks around neglect and domestic abuse often coincided with parental mental health and drug and alcohol misuse, particularly for young children. It also highlighted that the emotional abuse most frequently coincided with domestic abuse.

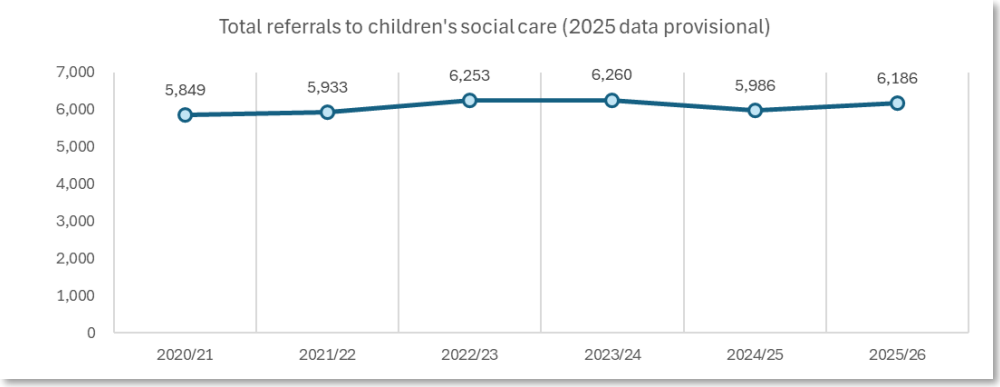
Over time, analyses of the impact of multiple vulnerabilities have prompted service and practice changes and the commissioning of support around parental mental health, school attendance and domestic abuse. It has also prompted the ongoing development of the Norfolk Family Connect system described earlier – enabling practitioners to see where records from different agencies suggest multiple coinciding risks within a household.

Tracking long-term trends in activities and outcomes

With several years of local data available through the partnerships monitoring framework, alongside extensive national data and intelligence, it is possible to assess both changing demand for support and the impact of efforts to improve outcomes for children and young people within safeguarding pathways.

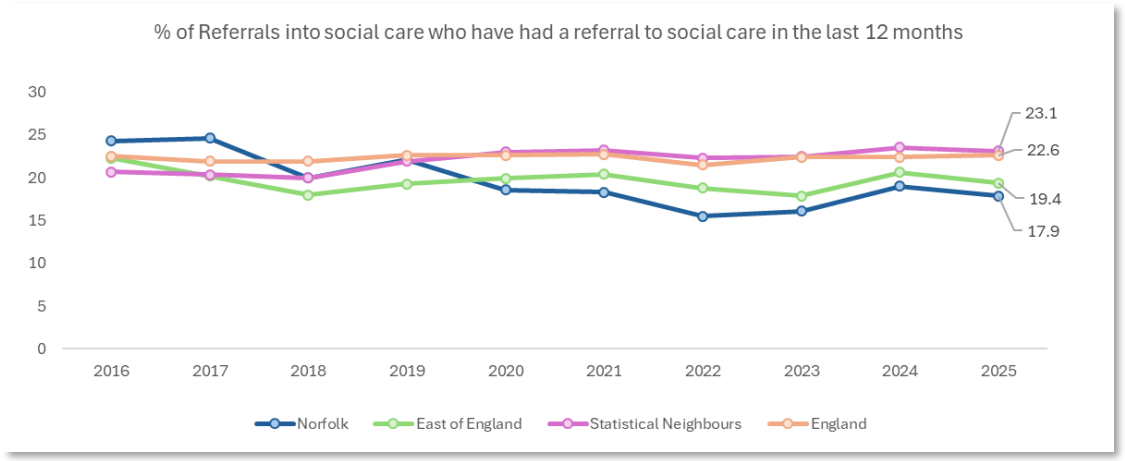
Whilst the story of multi-agency safeguarding, as told through data, is complex a review of the last 6 years of data provides some notable headlines:

- An overall increase in the number of safeguarding concerns raised by partners and members of the public; and an increase in the number of those contacts addressed by Partnership and Communities teams.
- An increase in people accessing partners' online information and advice services, and multi-agency Best Start in Life Family Hubs.
- Relatively stable formal referrals to Children's Social Care (see graph, below).
- Levels of Police Child Protection Investigations and Child Protection Plans that have varied year-to-year, but which have not shown a consistent fall or rise.
- Slightly reducing levels of children who are looked after (excluding those who are unaccompanied child asylum seekers).



These overall numbers simplify what is a complex picture. As noted earlier in this report, a more detailed review of the risks captured within safeguarding and child protection data shows an increase in reported domestic abuse and criminal exploitation over this period. In addition, previous years' reports have highlighted other growing risks that impact on safeguarding outcomes for children, including some challenging trends around children's and parents' mental health. Long-term data shows that the proportion of Norfolk's children living in low-income households is notably above East of England and statistical neighbour averages.

Nevertheless, headline safeguarding data suggests that efforts to manage demand for complex child protection interventions, including through multi-agency preventative measures, have been somewhat effective. This suggestion is strengthened through a review of benchmarking data that compares rates of activity per head-of-population with regional, national and statistical neighbour averages. The graph below shows the percentage of referrals that are re-referrals to social care within the last year. This is used as a measure of the effectiveness of the assessment process and subsequent support, with lower numbers suggesting that a higher proportion of referrals are effectively supported 'first time'. The data shows a long-term reduction from 2016 to 2022, with a slight increase since, but with Norfolk's average remaining consistently below geographical comparator averages since 2020.



This positive picture is generally reflected in other measures of activity within safeguarding pathways. Norfolk's rates of referrals and child protection plans per head of population are consistently below national and statistical neighbour averages, and its rate of children looked after is similar to the statistical neighbour average and below the national average.

4. Inspection and Independent Scrutiny

Inspection

The main inspection activity in relation to safeguarding children took place in February and March 2026 with the Inspection of Local Authority Children's Services (ILACS). In addition, the partnership continued to monitor and report against progress made from the Joint Targeted Area Inspection (JTAI) on the impact of domestic abuse on children aged 7 and under including newborns.

Findings from Inspection of Local Authority Children's Services (ILACS)

The ILACS report was published on 18 May 2026, and they received a judgement of outstanding. Following on from the 'Good' judgement in 2022, Norfolk Children's Services have been working relentlessly to continue to improve since then. Ofsted could see that across our services and used words like *"brave," "exemplary,"* and *"strong."*

Inspectors clearly recognised the Local Authority's child-centred and relational practice and consistently said that the teams know children well and that their wishes and feelings shine through. The inspectors also recognised that the department work as one children's team and how Children's Services are supporting Norfolk's children to flourish. They could see the sensitivity in the work with children and families but also the rigour and robustness that are applied when difficult decisions need to be made. The Executive Director wrote to her workforce commending them: *"Every single team and service has played their part and I'm feeling very proud of our whole team. We do this job because we want to improve the lives of children and young people and that commitment and the impact we are having was clearly seen by the inspection team."*

Inspectors provided strong feedback on the quality and consistency of our practice, noting clear evidence of relationship-based work, the voice of the child in records, and effective multidisciplinary collaboration.

The full inspection report found that Norfolk Children's Services was outstanding in every aspect: experiences and progress of children who: need help and protection, are in care and are care leavers. The impact of leaders on social work practice with children and families and overall effectiveness were equally outstanding. Some examples from the report are:

- *"Social workers and family help practitioners know children very well and undertake purposeful direct work and interventions."*
- *"Children in care in Norfolk receive exceptional help and support that enables most to make significant progress."*
- *"Care leavers in Norfolk receive meaningful and ambitious support from the life beyond care service."*
- *"Children in Norfolk benefit from a highly effective and wide range of services, led by a stable and highly aspirational senior leadership team."*

In terms of partnership working, the report found that: *"Partnership arrangements are mature and well established. The DCS is influential in bringing partners together to continue to strengthen and refine the already collaborative approach to safeguarding children in Norfolk.*

Partner agencies use opportunities through the multi-agency safeguarding arrangements to establish priorities, undertake audits and share learning."

The inspectors met with the lead scrutineer as part of their inspection activities and commended the partnership for its investment in scrutiny and data as well as innovations such as the production of the children and young people's version of this annual report and Joint Agency Group Supervision. The NSCP is proud of the Local Authority's recognition and the way we work together to get the best outcomes for children.

Progress since the Joint Targeted Area Inspection on Domestic Abuse

The NSCP continues to learn from inspections by monitoring practice and developing actions in response to inspection findings. In October 2025, a Leadership Exchange and Learning Event was dedicated to providing a progress update to the 2025 JTAI inspection report on domestic abuse. The report recognised significant strengths in the partnership: inspectors said we had *"strong and collaborative"* partnership arrangements in Norfolk that are helping ensure that most unborn and young children who are victims of domestic abuse are getting the support they need. Inspectors also praised the *"synergy"* between partners and the strong governance arrangements. Other strengths highlighted included: our co-production arrangements with children and young people; the early identification of need for most children; the work to support and protect unborn children. These strengths remain evident in the NSCP's culture and approach to keeping all children safe from harm.

The JTAI concluded that there were five areas that needed to be improved:

- **Partners' understanding and engagement in MARAC and the Partnership's oversight of its operation.** A MARAC Steering Group continues to meet regularly, using data to analyse practice and impact, as well as developing communication tools for all partners to better engage with the process.
- **The consistent consideration of the cumulative harm to children aged 0 to 7 from repeated experience of domestic violence**. A Multi-Agency Task & Finish Group with focus on cumulative harm was established and chaired by an NSCP Independent Scrutineer. The report went to Partnership Group in March 2026, recognising some good work in the use of Multi-Agency Chronologies (MACs) earlier in the child's journey and the systems the Children's Advice and Duty Service (CADS - the front door) have put in place to pick up cumulative harm at the point of contact and referral. Recommendations were made to further improve our approach to assessing cumulative harm which the partnership will be taking forward.
- **How well the voices and experiences of individual children who are victims of domestic abuse are listened to, understood and captured by practitioners, across the partnership, and are used to inform children's plans.** Single agencies provided evidence of the work they have done to improve the gathering and recording of children's voices, for example, Probation referenced training programmes, Children's Services undertook an audit and Health providers shared tools.
- **The timeliness and consistency of information-sharing, in a small number of practice areas, related to risk management. This includes digital information sharing of health records.** This has proved more challenging as the recommendation has national implications for health systems, however, there was good evidence of ongoing work in the Multi-Agency Safeguarding Hub (MASH) and CADS, as reported in the MASH Oversight Group reports to Partnership Group.
- **The accessibility of domestic abuse training to practitioners, its take-up by those practitioners, and how well they apply learning to practice.** Surveys were

undertaken across the children's workforce and with the DA champions to better understand the training offer and its impact. The NSCP issued training impact best practice guidance to all partners, and this was included in the Section 11 reporting. The NSCP also established communities of practice for participants who signed up for multi-agency DA training to monitor impact over time. This will be reported in the next financial year.

Other actions taken from the inspection findings include:

- Ongoing data analysis continues to feed into the children and young people DA subgroup.
- The ICB surveyed all health providers against JTAI learning and fed back to NSCP.
- Plan to re-audit DA spring 2026 to further assess improvement made and emerging learning points.

Norfolk was also mentioned as an area of good practice in the national JTAI report on the multi-agency response to children who are victims of domestic abuse, published on 21 January 2026. "*In Norfolk […] domestic abuse is seen as a 'priority for everyone'. Relationships between agencies and strategic leaders are embedded and allow for constructive mutual challenge and problem-solving."* Specific examples included:

- Tackling the causes of DA and supporting all victims of DA.
- Evident synergy between partners and coherent governance arrangements for providing and overseeing the multi-agency response
- Using partnership data intelligently, auditing, and taking into account the voices of children and families gives the local partnership an in-depth understanding of the needs and impact of services that support them
- Good range of quality-assured, suitable accommodation in place to meet need to help parents and their children to live safely in their own homes
- Voices and experiences of children and families are central to needs analysis and service development, and co-design and co-production with children are a strength for the partnership
- Leaders regularly hear from children to learn from their experiences to help improve domestic abuse support and services even further
- Role of IDVAs who are based in acute hospitals, which means that practitioners have an improved understanding of domestic abuse and offer prompt support.
- Partnership is committed to including fathers: assessments include resident and non-resident fathers whenever possible, and its frontline practice includes a range of innovative programmes designed by fathers for fathers.
- 'Rich and detailed conversations' at the front door help to identify the level of need and risk for children and what interventions - an 'ethos of collaborative conversations'.
- Practitioners work closely with children and their families to develop multi-agency safety plans at an early stage, helping to mitigate risk.
- Practice around unborn children at risk of domestic abuse is a particular strength; practitioners undertake early safety planning, and families receive timely access to appropriate services and support.

Independent Scrutiny

Norfolk adheres to the principles of independent scrutiny as outlined in *Working Together 2026*, (Chapter 2, paragraphs 95 - 103) 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. Our three main scrutiny activities are:

- independent scrutiny undertaken by the independent scrutiny team
- multi-agency audit
- Section 11 self-assessment

The three statutory partners commissions the independent scrutiny team to undertake specific pieces of scrutiny. In this reporting year, scrutiny activity included: (1) assessing Norfolk against the findings from Baroness Casey's national audit on group based child sexual exploitation and abuse (CSEA); (2) as an adjunct to the CSEA scrutiny, child sexual abuse (CSA) to baseline practice and provide direction on CSA as an NSCP priority; and (3) a review into the non-fatal stabbing at a Norfolk school in March 2026. This last piece of scrutiny will be completed on the 2026 – 27 financial year.

Child Sexual Exploitation and Abuse: Learning from Casey Report

On 16th June 2025, the Government published the National Audit on Group-Based Child Sexual Exploitation and Abuse (CSEA), following an extensive review conducted by Baroness Louise Casey. The Casey report acknowledges the significant difficulties faced by professionals when responding to group-based sexual exploitation, while also challenging agencies to enhance their practices There are twelve recommendations made, all of them dealing with national issues.

Having considered the Casey report, the NSCP Delegated Safeguarding Partners (DSPs) commissioned the Scrutiny Team to review the Partnership's position regarding the issues raised in the report. They were keen to understand if the NSCP had systems in place to deal with group-based sexual exploitation, if there was learning and how improvements could be made. The objectives of this work were to: review the current position in Norfolk against learning identified in the report; identify areas of strengths and weaknesses; and make recommendations about areas of improvements required.

It was agreed that the Scrutiny would concentrate on five themes that were drawn from the Casey Review. They were:

- Address the link between CSEA and ethnicity
- Information sharing
- Work with victims
- Leadership
- Innovation

The Scrutiny Team utilised a blended approach, using focus groups to gauge practitioners' understanding of systems and their effectiveness, examining existing data and information exchange and where necessary examining existing or past cases. NB There were 11 focus groups with 55 participants, affording an opportunity to seek views from across the partnership. The focussed discussions with those who deal with this issue proved to be a great source of knowledge. The fact that practitioners are empowered to provide honest open feedback in Norfolk was again apparent in our focus groups. There was clear evidence of a learning culture, with people keen to work as a collective, valuing the part different agencies can play in providing the best possible multi-agency approach to this issue.

NB During the scrutiny process, an investigation into allegations of group-based sexual abuse was underway in Norfolk. While the scrutiny did not provide detailed commentary on the case, it serves as a pertinent example of how co-ordinated efforts between agencies resulted in timely support for victims and efficient case management. The investigation showcased the effectiveness of existing systems and multi-agency practices, highlighting the value of collaboration in addressing complex safeguarding issues. This partnership approach was referenced throughout the scrutiny report to provide assurance to all partners, at every level, that they were well equipped to deal with offences of this nature. The scrutineer author noted: *"It exemplifies how a mature, child-focused partnership can deliver the best possible support and outcomes for children, even in the most challenging circumstances."*

A total of five recommendation were made. These have been shared with the NSCP's Partnership Group and, more specifically, the Vulnerable Adolescents Group responsible for delivering against the NSCP child sexual exploitation priority. All recommendations from scrutiny reports are included as Appendix 3.

Child Sexual Abuse

The scrutiny of child sexual abuse (CSA) was commissioned following the publication of a national review by the Child Safeguarding Practice Review Panel (CSPRP)[3] into the national multi agency response to intra-familial child sexual abuse.

The scrutiny report recognised areas of good practice in Norfolk regarding the identification and response to sexual abuse once a disclosure has been made (or when there is evidence gained from police investigations about child abuse images online). However, the confidence in relation to cases where there has been no disclosure is more variable. This finding is concurrent with the findings in the CSPRP report and as the title of their report suggests, children want practitioners/teachers/clinicians/therapists to notice they are being sexually abused – the silence that surrounds sexual abuse keeps it hidden from view.

A child, who was spoken to as part of an historic Serious Case Review (SCR)[4] in Norfolk about intra-familial sexual abuse, was asked what allowed him to disclose the sexual abuse in the family to a trusted adult in the school. He said: *'she knew, but she didn't know'*. The SCR highlighted that 'building a scaffold for disclosure' was critical. Building this scaffold requires supporting practitioners to be equipped and open to hearing a disclosure about sexual abuse. As this child's experiences revealed, it is critical that trusted relationships are built with a child that encapsulates an openness to the awful possibility that a child's behaviour may be communicating that they are being sexually abused.

One of the key findings from the CSPRP national review was that professionals can struggle with understanding, talking about and responding to child sexual abuse, especially when it takes place in the family environment; it is clear that practitioners must be supported to bring words to the silence. The findings in this scrutiny report highlighted that while there are solid examples of good practice in Norfolk, robust strategic leadership and oversight is critical and more needs to be done to support practitioners in facing the challenging nature of this work. A total of seven recommendations were made (Appendix 3b) and at year end the Delegated Safeguarding Partners were identifying strategic leads to take CSA forward as a priority. The recommendations from this scrutiny and from the multi-agency CSA audit (see below) will be included in the CSA strategy development.

[3] The Child Safeguarding Practice Review Panel - I wanted them all to notice, 2024.
[4] Case Y, NSCB, 2018

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, tracking the response to recommendations from across all scrutiny work and evidencing impact on practice and improvements to the system. Within the scope of this annual report, MAAG completed one audit on child sexual abuse. In addition, they followed up on a previous audit on neglect, speaking to practitioners using the Graded Care Profile, and commenced work on re-auditing domestic abuse against the Joint Targeted Area Inspection Framework to test learning from the 2025 JTAI findings.

Child Sexual Abuse

Like the child sexual abuse (CSA) scrutiny, the NSCP's thematic audit on intra-familial CSA found strong multi-agency collaboration and effective safeguarding responses post-disclosure. However, significant systemic challenges persist in early identification, risk management, and long-term planning. Missed opportunities to act on indicators, inconsistent inclusion of key partners, and record inaccuracies compromise proactive safeguarding. While post-disclosure practice is generally good, pre-disclosure responses require improvement, with professionals needing greater confidence to name concerns and challenge assumptions. Recommendations focus on strengthening early detection, improving information-sharing, embedding transitional safeguarding, and ensuring holistic risk management. Implementing these changes is critical to achieving a consistently strong, proactive safeguarding response to CSA in Norfolk.

A total of four recommendations were made. As with the CSA scrutiny, these recommendations will be taken forward with the CSA priority subgroup and incorporated into the CSA strategy in 2026 – 27.

Neglect: Follow up on Graded Care Profile

In 2024 – 25, MAAG completed an audit revisiting the use of the Norfolk Graded Care Profile[5] (NGCP). The final report included a recommendation to complete a follow up activity: *Recommendation 4 - The learning from this audit would be greatly enhanced with a follow-up activity, specifically hearing from practitioners involved in the selected cases to understand how they are using the NGCP and how training has shaped their practice in this area. A follow up to this audit could give greater insights into the quality of training, the impact it has and the effectiveness of the tool in practice. This in-depth qualitative approach should be considered by MAAG with a view to embed this approach within the methodology of any future MAAG audits.*

The NSCP Lead Audit Officer met with professionals to discuss various aspects of the NGCP: identifying neglect, training, the role of the neglect champion, suggestions to improve the NGCP, multi-agency collaboration and family engagement. The follow-up activity provided valuable insights into the practical use of the NGCP by practitioners and the impact of training on their practice. Overall, practitioners demonstrated a strong commitment to using the NGCP collaboratively with families and multi-agency partners, highlighting its importance in identifying neglect and shaping interventions. While confidence in recognising neglect and applying the NGCP was generally high, the findings also revealed areas for improvement - such as enhancing the clarity of the tool's language, better supporting families with additional

[5] The Graded Care Profile (GCP) is an evidence-based assessment tool used by practitioners to objectively measure the quality of care a child receives, specifically identifying neglect.

needs, and strengthening multi-agency collaboration, particularly with education and early years. The feedback underscores the need for ongoing training, improved recording processes, and greater awareness of Neglect Champions within agencies. These insights will be critical to refining the NGCP's effectiveness and embedding a more qualitative, family-centred approach in future audits and practice development.

The report was shared with the Neglect Operational Group who maintains oversight on practice and improvements in this area.

Composite Action Plan

The MAAG monitors the outcomes of audit recommendations - as well as learning from scrutiny, Section 11 and Safeguarding Practice Review - through its Composite Action Plan (CAP). The recommendations in the CAP are broken down into the Partnership's priority subgroups, who take ownership of the actions. Where a recommendation does not fit with priorities, they are either sector specific or 'other'. Each of the sections is further broken down into subcategories: leadership; workforce development; tools and resources; and communications. This enables MAAG to analyse and summarise progress over time. Inevitably there is an ebb and flow of the volume of recommendations held in the CAP as actions are completed and new learning comes to the fore. At year end a total of 39 recommendations were outstanding.
The recommendations linked to the corresponding priorities are included in the strategy documents to maintain a clear focus on areas of improvement and ensure that the learning is incorporated into the action plans.

Section 11 and safeguarding self-assessments

Section 11 of the Children Act 2004 places duties on a range of organisations and individuals to ensure their functions, and any services that they contract out to others, are discharged having regard to the need to safeguard and promote the welfare of children. The NSCP has a statutory function under Section 14 of the Children Act 2004 to 'to coordinate what is done by each person or body represented on the Board for the purposes of safeguarding and promoting the welfare of children in the area; and to ensure the effectiveness of what is done by each such person or body for those purposes.' The NSCP fulfils the latter part of this function through the Section 11 self-assessment and associated Challenge and Support panel meetings with partners. Norfolk has developed a dynamic approach to Section 11 which includes attention to development, quality and improvement for individual organisations and the partnership. This year saw a few changes to the Section 11 process partly due to the need to respond to the findings from the Joint Targeted Area Inspection (JTAI) on domestic abuse as well as the NSCP priority setting process, which necessitated altering the timing of Section 11 this year.

The 2024 - 25 Section 11 report made three recommendations. Progress is summarised below:

The Partnership continues to keep Family and Community Networking and father inclusive practice as a priority for the next year to allow momentum to continue.	The NSCP set out new priorities for this year and agreed that Families First would be one of these. Family networking and father inclusive practice are incorporated within the priority and remain an area of focus and development for all partners. The Section 11 Steering Group decided that the 2025 return from partners focuses on self-assessment of family networking and father inclusive practice for this year as the Families First priority will be a new area for

	many partner agencies. This recommendation is completed.
Organisations identify father inclusive practice champions to join the existing network to promote and foster cultural change and sustainable good practice in this priority area of work.	As of December 2025, there were 72 father inclusive practice champions in the network and good representation from different sectors across the partnership. These champions meet on a regular basis to share resources and promote good practices. This recommendation can be closed.
Accumulative Neglect Operational Oversight Forum (ANOOF) and the Neglect Ways of Working subgroup to develop and disseminate expertise regarding the operational approach to tackling this challenging area of practice.	Learning from ANOOF has been disseminated through Bitesize briefings on Intergenerational Neglect, Medical Neglect, Patterns of Disengagement; a briefing on Impact of Domestic Abuse is in development from the November ANOOF meeting. In December 2025 the Neglect Strategy Operational Group accepted a proposal to modify ANOOF and hold quarterly face to face meetings with ANOOF members and case holders to look at themes rather than individual cases. A well-planned cycle of meetings is in place for 2026, including work with neglect champions feeding into ANOOF which will inform the Ways of Working work programme. These meetings are then followed by a Neglect Operational Group, which was put in place when it was agreed to step neglect down as a priority in June 2025. Neglect monitoring remains on the NSCP reporting calendar and this recommendation is completed.

This year, in response to the JTAI on domestic abuse, the NSCP included a self-assessment survey on domestic abuse within the Section 11 cycle. This was completed in May and the findings shared with Partnership Group. Apart from this addition, the rest of Section 11 remained the same as the previous two years with workshops held before and after the completion of agency returns to bring partners together to share knowledge and learning. The stages of the 2025 process were as follows:

1. May 2025: Domestic abuse survey
2. July 2025: Self-assessment audit tool and staff survey shared with organisations in Norfolk.
3. July 2025: Section 11 priorities workshop
4. October 2025: Completion and return of the self-assessment audit tool.
5. December 2025: Reflective workshops.
6. January 2026: Final report with recommendations to Partnership Group
7. February and March 2026: Feedback session for individual organisations.

In total there were 46 Section 11 self-assessments completed and returned (see Appendix B for a list of returning organisations). This is a 24% increase from the number of returns (n=37) received last year. Returns were reviewed by the Safeguarding Intelligence and Performance Coordinator (SIPCo) and a steering group member.

Good practice Section 11 workshops

In December two workshops were held to share good practice and take the opportunity to learn from partners about their practices. The two themes for these sessions were:

i. Voice of the child and understanding the child's lived experience
ii. Understanding the impact of training and learning on practice

These workshops were attended by 39 colleagues and were round table discussions with one presentation from Paul Webb, Norfolk Participation Network Lead. The two themes were chosen in order to explore the subject in greater detail than had been evidenced in the returns. Table discussion allowed for richer conversation and greater sharing of knowledge and experience. This provided a less formal format which encouraged colleagues to share ways in which they are working which they might not have thought about when completing the written responses.

Conclusions and Section 11 Recommendations

Over the last three years the Section 11 process has shown that when safeguarding priorities are backed up by clear guidance and leadership from strategy implementation groups, good practice is in greater evidence in agency returns. When there is limited steer from the centre there is a greater emphasis on everyday practices taking place and less evidence of inspiring and influential approaches. Section 11 in Norfolk is designed not only to provide self-assessment but to allow reflective space for organisations to share learn and develop alongside each other. This process is designed to facilitate good practice and innovation to flourish. Clarity and guidance about what constitutes good practice enables innovation and learning to build within individual organisations and across the partnership.

The effort that goes into Section 11 from all partners is significant and should not be underestimated. The process in Norfolk is robust and provides valuable insight into the functioning of the partnership, in addition to this, it provides reflection time for organisations to consider their practices over the year and to raise concerns that they may have. Feedback from partners supports the Norfolk approach to Section 11 report that the developing dialogic approach is more collaborative and not only supports greater confidence with partnership working but also encourages a healthy approach to self-assessment.

A total of six recommendations were made:

1. The partnership should strengthen how it promotes and supports practice that places the collective voice of the child and a clear understanding of children's lived experience at the centre of all safeguarding activity.
2. The Section 11 steering group should consider how to make the 2026 process more interactive and enable a reflective process to develop greater self-assessment whilst maintaining a high level of accountability.
3. Norfolk County Council should develop a safeguarding policy which is accessible and applicable to all departments and members of staff.
4. To develop this priority (CSA) across the partnership a strategic implementation group will need to provide clarity, guidance and resources to support the outcomes, outputs and actions that are needed to achieve best practice.
5. Organisations that have identified that staff need further training on father inclusive practice should access the NSCP website where there is a wealth of learning resources for this area of practice.
6. Norfolk's Families First Partnership Programme Board should provide clarity, guidance and resources to further develop and embed a family networking approach across the partnership.

For further detail on Section 11 findings, see Chapter 5 on NSCP priorities.

5. NSCP Safeguarding Priorities and Projects

The NSCP continued to work on its priorities throughout 2025 - 2026. In June 2025, Partnership Group held its annual priority review/priority setting workshop, assessing the achievements and work outstanding against each priority area: neglect, child exploitation and family and community networking. It was agreed that neglect would be stepped down as a priority due to improvements made, as reported in the 2024 – 25 annual report and a Neglect Operational Group would oversee and monitor ongoing practice in this area to ensure progress was sustained. It was also agreed that family and community networking would be changed to supporting the Families First agenda and that child sexual abuse would be adopted as a priority this financial year.

Each priority area is led by one of the three statutory partners, Children's Services, Police and Health. This ties in neatly to our governance arrangements and reinforces the message of joined up leadership. The Business Plan includes high level actions against each priority area and was updated following the priority review. This chapter serves as a summary of achievements against each priority as well as a record of ongoing projects aimed at improving practice and multi-agency collaboration.

Child Exploitation: Vulnerable Adolescents

The Vulnerable Adolescents Group (VAG) is co-chaired by a Detective Superintendent and the Integrated Care Board's Designated Nurse. 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.

The VAG has strong links with both the Serious Violence Duty Board as well as the Children and Young People Strategic Alliance which has governance over the Youth Strategy. Both Boards sit outside of the NSCP structure but are fundamental to the system-wide approach to child exploitation. In addition, from July 2025, a separate fortnightly meeting has been held, providing strategic oversight on an ongoing police investigation into child exploitation; this is chaired by the Executive Director of Children's Services.

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. Right to Succeed are delivering the Central Great Yarmouth Place Project. This is a co-designed project utilising young people, residents, charities and professionals to achieve improvements in literacy, youth offer, education and employment and training. Right to Succeed report to VAG at its monthly meetings.

In spring 2026, VAG conducted a comprehensive evaluation of progress against its five-year Strategy to Protect Vulnerable Adolescents from Extra-Familial Harm, which was reviewed and updated in 2024. The strategy has four clear strands of work: Awareness Raising; Early Help and Identification; Safeguarding Exploited Young People; and Identifying and Disrupting Offenders. To deliver against the strategy 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.

In addition, VAG has also responded to the independent scrutiny report for the NSCP (see Chapter 4 on scrutiny). This is a reflection on the NSCP's position post Baroness Louise Casey's report into group-based child sexual exploitation.

Section 11 Findings in Relation to Vulnerable Adolescents and Exploitation

Levels of confidence about identifying and responding to Child Exploitation are good across the partnership. In examples shared by organisations, the strength and value of multi-agency working is clear. Building relationships with children and young people as well as with partner agencies was in evidence as good practice. There were numerous good practice examples that highlighted positive working relationships with young people where their voice is prioritised and an essential component of the safeguarding response.

> "*Practitioners use a range of creative and flexible engagement tools such as art, journaling, and storytelling to support CYP to express their experiences in ways that feel safe and accessible. These methods are particularly effective for those who may struggle to articulate trauma verbally or who have experienced coercion and control*." The Matthew Project

There were clear examples given of how young people were actively involved and at the centre of care and safety planning. There were good examples also given of how the collective voice of children and young people is utilised. For example, Norwich City Council described the different ways in which young people were involved in the planning and development of parks and open spaces to create greater safety and with the aim to *"design out crime*".

Whilst confidence levels are good, there is also a common acknowledgement that this is not an area for complacency and that vigilance is required to keep up to date with an area of safeguarding that continues to develop:

> *"we recognise that this is an area of developing knowledge and understanding with exploiters continuously developing their methods… …as professionals, we remain behind the curve of development."* Break

The Vulnerable Adolescent Group's achievements:

The strategy review noted the following achievements:

- **Support to Youth Endowment Fund - Neighbourhood Fund Project –** from concept through to implementation in Central Great Yarmouth – Right to Succeed are delivering the Central Great Yarmouth Place Project. A co-designed project utilising young people, residents, charities and professionals to achieve improvements in literacy, youth offer, education and employment and training.
- **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 – Tier 2 training has been completed in six sessions delivered by external training partner (Interface).
- **Coordination across partnerships** – For example, County Lines Strategy Group, New Roads, Youth Justice Board, Pathfinder Project – The chairs of CLSG and VAG attend the other respective meeting (or appoint a member of their group to attend) to ensure cross representation and understanding.

- **Embedding, improvement & promotion of MACE Processes** – Child Exploitation Screening and alignment of Multi-Agency Child Exploitation (MACE) Team, Youth FAST (social care) & Targeted Youth Support Service
- **Strengthening of operational oversight and scrutiny -** through the Exploitation Operational Oversight Forum (EOOF), including learning from local audits and national reports.
- **Development of CE Data Dashboard –** helping to inform oversight work of EOOF – CE Dashboard is fully functional and forms part of EOOF oversight/review.
- **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 video and Safer Schools Partnership sessions.

Summary of Vulnerable Adolescent Data

The strategy review included analysing data between 2021 and 2024, using intelligence from Norfolk Police and Children's Services social care who jointly identify and screen young people at risk of child sexual and criminal exploitation (CSE and CCE). 2021-2024 saw a reduction in screening likely reflecting improved recording processes and pandemic related impacts. Mid 2024 onwards the 12-month rolling average has shown a steady rise with notable month-to-month variation. This may indicate increasing underlying need and / or better identification of at-risk adolescents. CSE declined consistently between 2021-2024 and then showed an upturn from 2024 whilst CCE has shown a clear upward trajectory with a more marked increase observed in 2025. The most consistent trend is rising CCE related activity signalling growing complexity and possible criminal exploitation pressures.

Wider partnership Indicators: CSE and CCE concerns peaked in 2022–2023 before declining, reflecting reduced levels of initial partner worry after this period. CCE concerns show a gentle downward trend, though figures remain volatile month-to-month. CSE concerns have been broadly stable since 2025, following earlier reductions. These indicators reflect initial worry at referral, not confirmed exploitation, and should be interpreted as early-stage partner perception rather than prevalence.

Benchmarking against other areas: More benchmarking data is available for CSE than CCE (CCE only formally recorded since 2022). Norfolk historically shows higher rates of CSE/CCE assessments than comparators; this is likely due to strong local prioritisation and recording focus since 2020. As of 2025 Norfolk's CSE-related crime rate is like the national average and "most similar forces." There is no consistent long-term pattern, and the latest increases in local data are not yet reflected in benchmarking (which only covers up to March 2025).

Data Conclusions:

- New exploitation workspaces are rising, especially after mid-2024, possibly indicating increasing demand or better identification/support.
- Contacts, assessments and screening show more complex or stabilising patterns, emphasising that no single dataset gives a full picture.

- Benchmarking suggests Norfolk is broadly consistent with comparable areas, though past peaks likely relate to proactive local emphasis on awareness and recording.
- Recent stabilisation and slight increases in exploitation activity may represent a clearer, more realistic picture of underlying need

An overarching finding is that, while rises in contacts and assessments are clearly visible in the structured data, we cannot definitively determine what is driving these increases without detailed multi-agency case examination. Current patterns most likely reflect improved detection and/or better recording practices, given that police-recorded crimes and investigations have not risen at the same rate. It is important to emphasise that this remains an inference rather than a confirmed causal explanation. As with many structured datasets, the information tells us what has happened but not why, underscoring the need for deeper case-level analysis to understand underlying drivers

In conclusion, the Vulnerable Adolescents Group (VAG) will continue as it provides the critical multi-agency leadership, governance and coordination required to protect young people from extra-familial harm, including child criminal exploitation, child sexual exploitation, serious youth violence and radicalisation. VAG is central to delivering the NSCP's adolescent safeguarding strategy and has driven significant system improvements, including strengthened MACE processes, enhanced multi-agency training, updated online resources, a comprehensive CE data dashboard, improved cross-partnership alignment, and structured learning from serious incidents. The implementation of multi-agency child protection teams - such as the Risk Outside the Home Team (ROTH) and the Phoenix Team established in response to a major police investigation - further strengthens Norfolk's ability to respond consistently to risk, aligning with VAG's aim of building a coherent and integrated exploitation pathway. Rising CCE-related activity and increasing complexity underline the continued need for strong strategic oversight. VAG provides a single, coherent forum for aligning partners, interpreting exploitation trends, ensuring consistent practice, and maintaining a joined-up preventative and protective approach for vulnerable adolescents.

Families First Partnership Programme Board

In June 2025, it was agreed that the previous priority focus on family and community networking would be better served by having the Families First agenda as an overarching priority. This supports multi-agency governance and oversight of implementing and complying with national guidance, ensuring that all partners are engaged with reform activity, including making sense of the latest iteration of Working Together. The partnership is united to achieve systemic reform, seeing the shift from crisis management toward proactive support. The areas of focus against this priority are:

- **Family Help Services:** A unified system providing earlier, non-stigmatising support for families, merging traditional "early help" and "child in need" provision.
- **Multi-Agency Child Protection Teams (MACPTs):** Specialist teams consisting of police, health, and education professionals to provide expert, integrated protection.
- **Family Networking and Group Decision Making:** Earlier involvement of the wider family in decision-making and increased support for families to care for their children at home.
- **Integrated Front Door:** a centralised, multi-agency hub for handling referrals regarding child safety, early help, and social care.

The Families First Partnership Board is co-chaired by Children's Services Directors of Family Help, Care & Protection and Safeguarding, Partnerships & Opportunity. The co-chairs

facilitated a Leadership & Learning Event in October 2025 on Families First and report regularly to the NSCP's Partnership Group. As this was a relatively new priority at the time the Section 11 self-assessment tool was issued, the full scope of the Families First agenda was not included this year.

Families First achievements

- Establishing the Multi-Agency Families First Partnership Programme Board (FFPPB) with representation from all partners in workstreams dedicated to: family help/single plans and assessments; integrated front door; and MACPTs.
- Numerous workshops held across all workstreams to ensure multi-agency opportunities for co-design and clear objectives for the year ahead.
- Establishing a shared vision and objective for each workstream to ensure there is consensus on what "good" looks like for each area of work.
- Creation of Enhanced Family Help Team, Court Work Service and Phoenix project in alignment with the delivery of this programme.
- Family Practitioners have been trialing holding some Child in Need cases with the appropriate supervision and oversight.
- Stakeholder Engagement was prioritised across strategic group, voluntary sectors, schools, education and health.
- Setting out challenges and success criteria for the NSCP.
- Developed multi-agency offer for Family Networking and Family Group Decision Making Foundation training, with first sessions starting from March 2026.

Communication underpins our aim to transform the system with messages going out to the wider partnership from the FFPPB as well as presentations and discussions happening at Local Safeguarding Children Groups.

Child Sexual Abuse

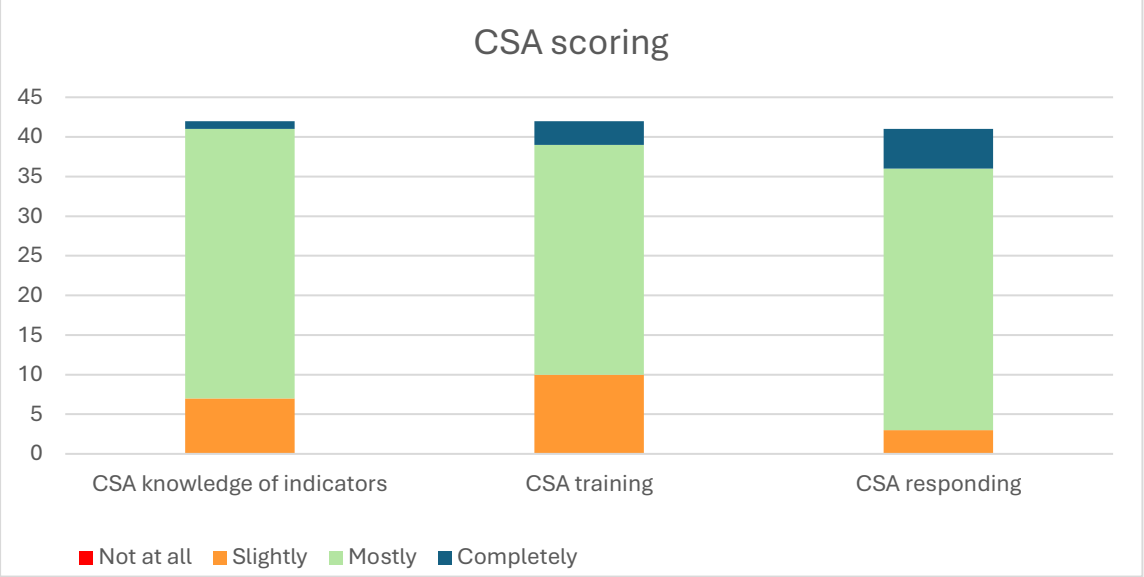
In June 2025, child sexual abuse (CSA) became an NSCP priority. This was in response to national publications, including the National Child Safeguarding Practice Review Panel's report on CSA "I wanted them all to notice". It was agreed that there was insufficient evidence on Norfolk's practice in this area, so a multi-agency audit and piece of scrutiny were commissioned to provide direction (see chapter 4 for further detail). By year end, the NSCP had a coherent picture of what needs to be improved and will be convening a priority subgroup and writing a strategy in 2026 – 27.

Section 11 findings and Child Sexual Abuse

Child Sexual Abuse (CSA) became a priority shortly before partners were asked to report on the work that they are doing, and this short notice is reflected in brevity of the returns on this area of work. Organisations were asked to identify:

1. how knowledgeable their staff were about the signs and indications of CSA;
2. how confident they are that staff are suitably trained; and
3. how confident their staff were in responding to CSA.

The majority of responses to each of these questions was “mostly”.



Many agencies consider they have a reasonable level of knowledge and confidence in their ability to respond to CSA which is based on, and evidenced by, their levels of basic safeguarding training and does not show comprehensive understanding and appreciation of CSA in their returns, particularly in relation to the estimated majority of abuse not currently being disclosed or reported.[6]

There were examples of good practice put forward by a number of partners and these tended to focus on specialist teams or practitioners who have expertise in this area. Returns suggest that when there are disclosures there is a good level of confidence in the multi-agency response, but a common concern was the need to build greater confidence and knowledge across all staff in an area of safeguarding practice that appears to be viewed as being managed by specialist roles. Within the workshops and the returns, partners identified the need for clarity and guidance as well as learning resources to develop this area of their practice: “*Staff’s confidence will improve once the profile of CSA as the priority is raised*.[7]” Within the profile of more training around CSA, partners identified the need for specific guidance when there are cultural differences, learning needs, communication needs, as well as training regarding the ever-changing picture of on-line abuse.

Transitional Safeguarding

At the June 2025 priority review meeting it was agreed that the NSCP would only prioritise Transitional Safeguarding if it was done jointly with the Norfolk Safeguarding Adults Board (NSAB). While outside the scope of this annual report, work on this priority area was formally initiated by both the NSCP and the NSAB and will be reported on in the next financial year.

[6] According to one survey, fewer than one in 10 adults who were sexually abused in childhood had told someone in an official position when it happened. (Office for National Statistics, 2020 https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/datasets/childsexualabuseappendixtables)
[7] NYJS

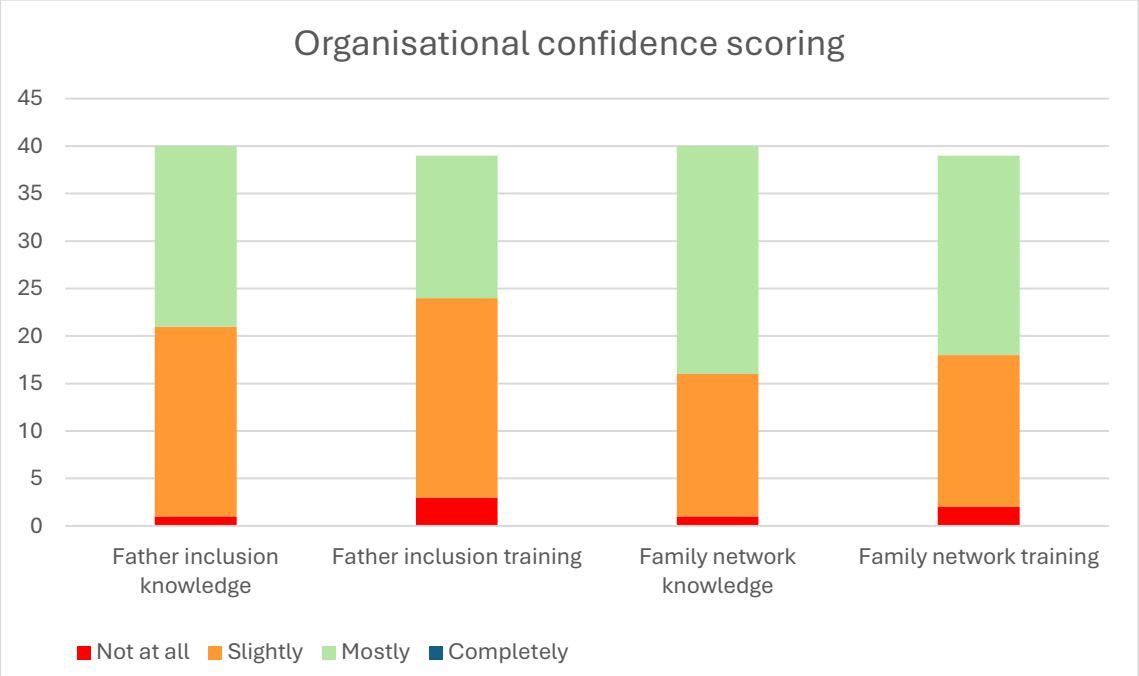
NSCP Projects and Local Developments

Father Inclusive Practice

The Father Inclusive Practice commenced in 2022 following the National Child Safeguarding Practice Review Panel's report on the Myth of Invisible Men. Reporting on this previously sat under the family and community networking priority, however, it remains very high on the partnership's agenda without being part of or a standalone priority. The role of Father Inclusive Practice champion has been further developed this year with 79 champions identified across the multi-agency who have added this responsibility to their existing practice. Champions have held eight network meetings over the year. An additional 130 staff have been trained in Father Inclusive Practice in 2025/26 bringing the overall total to just over 600 staff.

Section 11 findings and Father Inclusive Practice

Organisations were asked to identify (1) how knowledgeable their staff were about father inclusive practice and family networking; and (2) how confident they are that staff are suitably trained.



Examples of cases where family networking has been employed are given and there is evidence of how this is being progressed and monitored:

> *"Think Family principles and terminology have been embedded within policy and practice. These approaches are now widely adopted, with clear evidence in assessment documentation, case records, and introductory information provided to individuals as they enter services*."
> Norfolk & Suffolk Foundation Trust (NSFT)

Examples of good practice within family networking in the returns usually referenced working with both parents and immediate family but there were also examples of a broader

appreciation of what a child's network could constitute, particularly when the child's voice is paramount:

> *"Regular audits show the wider network is being explored and incorporated into planning and review cycles."* Cambridgeshire Community Services (CCS)

> *"In our Accommodation settings, the initial interview process includes questions such as, "Who in your life is important to you?" and "Who can help you achieve your goals?" This approach helps identify key relationships and support networks. Some young people choose not to involve family members, instead highlighting other significant individuals in their lives, which can provide insight into where family networks have not been supportive or beneficial."*
> The Benjamin Foundation

As with 2024 - 25's Section 11 returns, there was clear evidence of innovation and development of father inclusive practice. Examples ranged from curiosity and persistence being used to bring about greater levels of care and safety for children and young people, through to a greater focus on improving accessibility: "*Libraries are also starting to develop more sessions that fathers may be attracted to, for example, Swaffham has Pokémon group and many libraries have Lego clubs."* Norfolk County Council – Communities and Environment and Infrastructure Departments

Organisations described how father inclusive practice champions were being used within their organisation and how systems were being used to check impact and progress: "*A policy and SOP* [standard operating procedure] *has been developed for record keeping management and audits are undertaken to ensure practice is improving in this area*." CCS

As with last year there were clear examples of the impact this is having: "*We have seen an increase to at least 50% of online parenting course attendance being male carers*" Early Childhood and Family Services

Father inclusive practice achievements

In March 2026 the third annual Father Inclusive Practice conference was held with a focus on the development of work in the county, hearing directly from fathers about their experiences, and the impact of the work of the champions. Champions highlighted the work being developed to support fathers to establish their own peer support groups. Another presentation from champions shared the Father Inclusive Practice development program in Family Help, Children's Services, West and Breckland area which has worked with staff and evidenced:

- Increased understanding and awareness of father-inclusive practice
- Greater confidence engaging fathers and male caregivers
- Improved trauma-informed responses when managing risk
- Better insight into drivers behind father hostility
- More routine inclusion of fathers in practice

This has resulted in changes in practice including:

- Proactive contact with fathers, including flexible timings

- Trauma-informed conversations to uncover barriers
- Ensuring fathers' voices are included in assessments
- Sharing information equally with both parents
- Using reflective tools such as timelines and scenarios

Even within organisations that were sharing some of the best practice examples of father inclusive practice, there was acknowledgement that greater consistency and continued focus and development is required to embed this work into everyday practice. Similarly greater knowledge of family networking and robustly embedding this into practice across the whole partnership will need to be addressed through the development of the Families First framework.

Joint Agency Group Supervision

Joint Agency Group Supervision (JAGS) was originally introduced to Norfolk in 2020 as a means to build stronger working relationships within professional networks and promote best practice for working together. This was in response to learning from local and national Safeguarding Practice Reviews which showed that lack of professional curiosity and divides in the professional network compromised professionals' ability to jointly safeguard children. The full JAGS procedure can be found on the NSCP website.

Recent reports from the National Panel for Child Safeguarding Practice Reviews, such as the Learning Support and Capability Project (May 2025) and the Protecting All Vulnerable Babies Better national CSPR (Feb 2026) reinforce the need for understanding the impact of grief and trauma as well as the need for multi-agency reflective space and developing an emotionally literate safeguarding system. The report findings are clear drivers for supporting an innovative approach such as JAGS, which demonstrates not only the NSCP's ambition to support our services to learn and improve in order to get the best outcomes for children and families, but also our ability to be creative and solution focused when it comes to addressing known barriers to effective safeguarding.

A separate evaluation report of JAGS activity between 1 April 2025 and 31 March 2026, including its impact, was provided for the Delegated Safeguarding Partners. Headlines from that evaluation are including in this annual report and case studies of impact are provided as Appendix 4.

JAGS Pool of Facilitators

As of 31 March 2025, there were 43 active JAGS facilitators. Numbers were decreasing during the course of the year as some facilitators had dropped out due to change of jobs or capacity, so a further 12 were trained in March 2026. An agency breakdown [8] for facilitators is included below.

[8] Health – Community includes Cambridgeshire Community Services (CCS), the 0 – 19 Healthy Child Programme Provider and Norfolk Community Health & Care (NCHC).

Children's Services	22
Education	2
Early Years	1
Health - Community	9
Health - ICB	4
Health - NSFT	2
Police	1
Voluntary Sector	2

We continue to deploy facilitators in pairs, generally one from Children's Services and one from another agency. There benefits of this approach include:

- Peer support during the JAGS
- Modelling joint working and redressing any perceived power imbalances for the JAGS participants

The facilitators are independent of the case and are responsible for: liaising with the requesting partner to agree the date and time of the JAGS; providing a safe, containing space which nurtures relationships and stimulates professional curiosity away from operational functions; gather feedback from participants; and report on themes emerging to the NSCP business unit.

The NSCP recognises the weight of responsibility for supporting on cases in this capacity and have regular JAGS facilitator network sessions throughout the year. These sessions are led by one of the NSCP's Independent Scrutineers and Chair of the Workforce Development Group alongside the Head of NSCP Business Delivery. The network sessions are opportunities to:

- Provide ongoing support and a reflective space for the facilitators.
- Discuss themes emerging and feedback from JAGS participants.
- Consider how JAGS feeds into wider learning, e.g. responding to recommendations from local and national Safeguarding Practice Reviews.
- Facilitator led sessions provide opportunities to review and develop supervision tools and approaches as well as consider any emerging research or publications.
- Support communication and consult on JAGS development.

Facilitators have fed back how much they value the network sessions as an opportunity to consolidate their community of practice and will prioritise them in their diaries when possible. The sessions add value as the emerging themes can be discussed in greater depth. They also provide the scrutineer and business manager greater insight into day-to-day practice and the strengths and challenges in the safeguarding system.

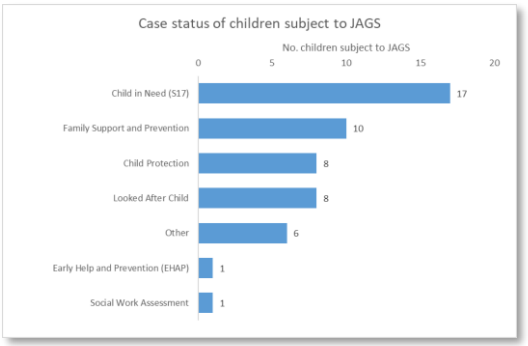
JAGS Requests and Delivery

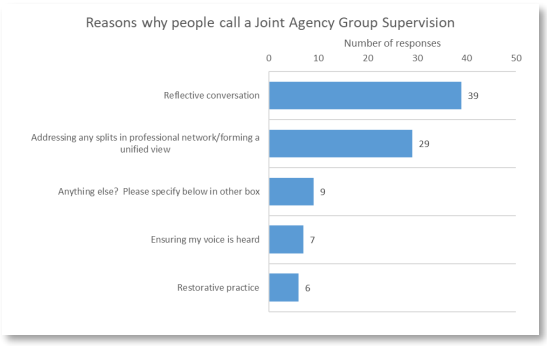
Between 1 April 2025 and 31 March 2026, a total of 51 requests were received.
Of the 51 cases requested, only 35 proceeded to JAGS. Where a JAGS did not proceed, monitoring found that:

- The case required a more urgent operational response, and JAGS would have not be helpful in the context of crisis and risk management.
- A TAFS (Team Around The Family Supervision – led by Children's Services responsible Team Manager) was held and the professional network agreed this was sufficient.
- The request was not multi-agency.
- The professionals within the network did not engage.
- Delays to deployment meant that the case had moved on, e.g. was reallocated to another team, and a JAGS was not felt necessary at that point in transition.

- One request was duplicate, i.e. more than one professional in the network requested a JAGS and communication was not joined up.

In addition to relevant information in terms of name, agency, contact details etc, the requesting partner is asked to provide a summary of the case, reason for calling a JAGS – or outcomes sought - from a drop down menu, where the case is held in terms of the child's journey and any other useful information for the facilitator. In terms of outcomes sought, we understand from the requests that the need focuses predominantly on reflective conversations and addressing any splits in the professional network/forming a unified view. (NB More than one box can be ticked.)





Feedback from JAGS Participants

All participants are asked to feedback before the JAGS session is included. This is done either on MS Forms or on a handout which is then entered into the system. Participants are asked what difference the JAGS has made and the feedback is positive overall and largely respond to the themes pulled out by the facilitators. A sample of comments is below clearly linking the JAGS to the impact on the participant.

- *Understanding/appreciating that we are all working together with the same aim.*
- *Seeing the strengths that we have as a whole.*
- *Having challenging conversations in a safe space.*
- *A space to reflect – an honest space.*
- *Sharing worries openly.*
- *Learning about a child – strengthening our understanding as a whole.*
- *A chance to hear each other - hearing multiple perspectives.*
- *Strengthened our work together.*
- *Validating & sharing feelings.*
- *Opening doors to new ways of working/safeguarding the child and family.*

While the feedback has been generally positive, we recognise that the process still has challenges and difficulties as evidenced from both the JAGS that did not go ahead and from some JAGS which were delivered and both participants and facilitators felt unresolved. The NSCP will continue to learn from all JAGS cases.

JAGS – Next steps

JAGS is recognised by strategic leaders across Norfolk as a valuable process to support their staff to work together and develop emotional resilience in partnership with colleagues.

Looking ahead, there are a number of areas that we will be exploring in 2026 – 27.

- Survey participants to get feedback on longer term impact of JAGS.
- Deploy the scrutineers to observe JAGS in practice.
- Respond to recommendations from local SPRs.
- Explore developing thematic JAGS to build relationships in localities and/or address ‘wicked issues’ such as mental capacity.
- Develop systems to measure and analyse attendance at JAGS by agency.
- Support other areas to develop JAGS as requested.
- Continue to grow and develop the pool of facilitators according to demand.

6. Learning from Safeguarding Practice Reviews and Rapid Reviews

The NSCP's multi-agency Safeguarding Practice Review Group (SPRG) is chaired by Jo Procter, 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 review activity 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.

Child Safeguarding Practice Review (CSPR) and Rapid Review activity

Between April 2025 and March 2026, one CSPR, Case AO – Jasmine, was published on 13 January 2026. The case concerned a 17-year-old looked after child who died from a drug overdose. The report was written to the Transitional Safeguarding framework and the learning and recommendations will be informing the work of the Transitional Safeguarding priority subgroup (see Chapter 5, NSCP priorities).

A second CSPR, Case AM - commissioned in January 2024, was completed and the report was signed off in April 2025. Case AM concerned a child who moved from Suffolk to Norfolk and was subject to Fabricated or Induced Illness (FII) and concerns about the levels of risk getting lost or obfuscated as the child moved across boundaries. There have been significant delays to publication due to ongoing criminal proceedings, however, work has been ongoing to implement the learning.

No further CSPRs were commissioned between 1 April 2025 and 31 March 2026.

Serious Incident Notifications and Other Cases of Concern

The Local Authority submitted a total of two Serious Incident Notifications (SIN) within this period that triggered Rapid Reviews; neither case proceeded to an SPR. One of these involved non accidental injury to a baby and, the second child exploitation. A further four cases of concern were raised at SPRG by health colleagues from Norfolk & Waveney Integrated Care Board and Cambridgeshire Community Services (CCS, 0 – 19 Health Child Programme provider). The themes emerging were:

- two involving **child suicides**, one of which prompted a discretionary review, As a result of these concerns and an increase locally and nationally in child suicide, the NSCP took the following actions:
    - pulled together a position statement and national context for child suicides which was shared with the DSPs
    - planned a multi-agency learning event scheduled for 1 May 2026
- a third case involved a 17-year-old with **significant mental health issues** and disagreement over risk and pathways for support. As a result, the ICB's Designate Team have reviewed the policy, and further action is planned to join up middle and senior management through thematic Joint Agency Group Supervisions where they can address issues away from the tension of individual cases. In addition, specific risks to adolescents

in terms of their mental health will be a primary focus for our transitional safeguarding priority working group from April 2026.
- the final case involved a large sibling group where there was **cumulative neglect and suspected child sexual abuse**. The case was included in the CSA audit to ensure learning was captured (see Chapter 4).

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

Type of Activity	No.	Date and Presenting Issues
SINs/Rapid Reviews – not proceeding to CSPR	2	• July 2025: infant with non-accidental injuries. Local learning around parental mental health and risks posed to babies being taken forward by a task and finish group, including the Protecting Babies Operational Group co-chairs. • Nov 2025: child sexual exploitation and abuse (CSEA). This is a highly sensitive police operation with ongoing multi-agency oversight at the highest level. An SIN was submitted on the direction of the DfE and National Panel, however, it is not appropriate to take forward to CSPR at this time. The Rapid Review did, however, evidence Norfolk's commitment to learning and actions taken in response to Baroness Casey's report into CSEA. See also Chapter 5 on NSCP priorities.
CSPR commissioned	0	None required following Rapid Reviews – see above.
CSPRs published	1	Case AO, published 13 January
Non-SIN cases raised	4	As noted above.

Norfolk also had ongoing involvement with:

- a Safeguarding Adults Review (SAR), involving the suicide of a young adult who had previously been identified as a young carer. SAR Douglas was published on 19 February 2026 and the report and findings presented at NSCP's Partnership Group in March 2026. Again, the learning from this review will be taken forward under the Transitional Safeguarding priority working group in 2026 – 27.
- a Domestic Abuse Related Death Review (DARDR – previously Domestic Homicide Review or DHR), which included the death of two children. This report is subject to DARDR processes and will anticipate that it will be published in 2026 – 27. Members of the NSCP are actively contributing to this review.
- Out of county Rapid Reviews/CSPRs: Norfolk had information requests from three other LSCPs, however, we only had significant involvement through an acute trust with a Cambridgeshire case; this case is proceeding to a CSPR. Norfolk remains committed to improving cross boundary working and welcomes opportunities to collaborate with other LSCPs on systemic learning.

The National Panel provided guidance on 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 CSPR, the key lines of enquiry emerging. SPRG continues to monitor and improve its internal processes, using feedback from the National Child Safeguarding Practice Review Panel to refine the systems.

Learning from Local Child Safeguarding Practice Reviews and Rapid Reviews

There was considerable good practice in Case AO, however, learning highlighted challenges in working with hostile fathers and supporting adolescents to recognise and navigate risk. A total of six recommendations were made and progress is summarised in the table below.

	Recommendation (Summarised)	Impact and Progress
1	The partnership needs to conduct a specific, comprehensive mapping pathway of the mental health system and report back to DSPs within six months of publication.	The ICB have made good progress on this, working with NHS providers. More work is being undertaken to understand the voluntary sector service offer. This will be reported back to the DSPs in July 2026
2	Promote the good relational practice with young people and professionals that was evident in this review through a programme of dissemination.	CSPR Roadshows planned for April 2026 to disseminate learning. Focus on Jasmine's voice, family networking, working with fathers, therapeutic interventions when working with adolescents and the emotional landscape of safeguarding.
3	Use existing mechanisms to strengthen multi-agency communication, reflection and accountability across services provided for adults and children: promote the use of the Joint Agency Group Supervision (JAGS) where transitional safeguarding is featured and report back to DSPs within six months of publication.	JAGS facilitators will be surveyed on transitional cases in summer of 2026. Contacts have been made with the Heads of Service/their equivalents working with this age group - including: Youth Justice Service, Targeted Youth Support Service, Risks Outside the Home Team/Phoenix, Preparing for Adult Life (PfAL), Further Education and secondary school education partners – to promote the use of JAGS. This will be monitored and a report will be going to the DSPs in September 2026.
4	The partnership should develop specific resources (e.g. training and a toolkit) for working with men when interactions between fathers and staff are seen as confrontational, lacking co-operation and proving ineffective.	The Father Inclusive Practice lead delivered training for Probation in spring 2026 and in return they will be working with the NSCP Business Unit to develop materials for this recommendation.
5	Agencies working with children at risk of exploitation should evidence how they support staff to develop skills to map and work with the extended family network.	Family networking and group decision making is a key cornerstone in the Families First agenda. By year end family networking and group decision making foundation training in was included in the NSCP multi-agency training offer. This recommendation – and the impact of training – will be monitored against the wider implementation of the FF agenda. In addition, family networking is a dedicated session at the April CSPR roadshows. The session material was co-produced with Jasmine's paternal grandmother.
6	Each agency needs to review their processes to debrief and support staff following an unexpected death of a child or young person.	The partnership has been committed to developing a trauma informed and resilience-oriented culture for some years now, however, systems to monitor this recommendation require further development.

In terms of Case AM, despite delays to publication, Norfolk is working with Suffolk on the recommendations made with cross LSCP learning events on FII and Supervision Orders planned for summer 2026.

The Rapid Reviews followed robust procedures allowing the NSCP to draw out relevant learning and make proportionate decisions, including how actions will be monitored. For example, in the non-accidental case, an anonymised case study was developed in order to share the learning with the Protecting Babies Operational Group.

Learning from National CSPRs

Within the scope of this annual report, the Child Safeguarding Practice Review Panel (National Panel) published:

- A research paper on its Learning Support and Capability Project (May 2025), which explored the emotional impact of safeguarding. This report was used as a building block for the NSCP's Leadership Exchange and Learning Event in January 2026 (see Chapter 1).
- The report on Protecting All Babies Better, a national SPR following the death of baby Victoria Marsden had particular resonance in Norfolk. It was shared widely, including our Protecting Babies Operational Group as well as our JAGS facilitators. Not only does it speak to the need for further embedding our understanding of grief and trauma, but it also reinforces the need for multi-agency reflective space. Our ongoing development of the JAGS process and how we monitor the impact provides evidence of our commitment to supporting the workforce in the challenging work of safeguarding children. (See also Chapter 5 for more information on JAGS.)

Both of these reports have been used to promote learning from leadership to the wider workforce. For example, content has been referenced at the Leadership Exchange and Learning Events and the Father Inclusive Practice conference.

Dissemination of Learning from Safeguarding Practice Reviews

As noted above, plans are in place to disseminate learning from Case AO with four sessions planned, including three face to face learning events. The roadshows will be evaluated, and the reach and impact will be reported in the NSCP's annual report in 2026 – 27. This approach to monitoring will also be applied to the Case AM learning sessions. Both the national CSPRs noted above are included in these learning events.

More broadly, we continued to promote learning from local and national SPRs through our priority workstreams, Leadership Exchange and Learning Events, bespoke project work and specific best practice sessions. Learning from all CSPRs is shared with the multi-agency trainers and members of the NSCP Workforce Development Group so that single agency training is up to date with local and national reviews.

Learning options are written into Norfolk's local Child Safeguarding Practice Review guidance

7. Training and Workforce Development

In the 2025 - 26 training year, the NSCP continued to provide an extensive programme of learning opportunities, both commissioned through our training provider as well as delivered by local practitioners. The training needs of the workforce are informed by statutory guidance, national and local Child Safeguarding Practice Reviews and by members of the Workforce Development Group (WFDG) who may identify a gap or a specific training need emerging in their service's areas. Fourteen separate courses were commissioned from our training provider, Interface, with a total of 49 sessions delivered through a mixture of virtual and face to face delivery. The commissioned courses covered:

- Neglect
- Vulnerable Adolescents
- Trauma Informed Practice
- Working with Families
- Domestic Abuse
- Assessing, Managing & Holding Risk
- Emotional Wellbeing
- Impact of Poverty
- Child Sexual Abuse
- Children with Disabilities / Complex Health Needs
- Professional Curiosity & Challenge
- Reflective Supervision Skills
- Voice of the Child
- Serious Youth Violence

In addition, the commissioned training programme was supplemented by an extensive programme of courses offered by partners or commissioned from other providers. In the 2025 - 26 training year, 136 sessions were delivered by other partners, including sessions on:

- Family Networking & Group Decision Making Foundation Training
- Child Protection Conferences
- Early Help Assessment and Planning
- Gypsy Roma Traveler Cultural Awareness
- Substance Misuse in the Family
- Harmful Sexual Behaviour
- Adultification Bias
- CADS Briefings
- Every Relationship Matters in Norfolk (ERMiN)
- The role of the Local Authority Designated Officer
- Protecting Babies
- MASH Briefing
- Working with Children's Services
- An introduction to multi-agency working for new practitioners
- Questions for Success
- Gangs, Grooming and County Lines
- Restorative Approaches
- Graded Care Profile
- Working with Fathers

Quality assurance of these various courses is achieved by a system that includes: members of the WFDG observing the training and providing feedback; quality assurance mechanisms within singe agencies reporting into the WFDG; and evaluations received from participants. Some example quotes include: "*I have recommended the course to all of my colleagues, as it was fantastic" (Trauma Informed Practice Course)*. *"Trainer was excellent"* (Impact of Poverty Course). *"Really lovely experience, one of the best training courses I've been to, especially on safeguarding"* (Safeguarding Children with Disabilities Course).

Here again, Norfolk's success is based on the excellent relationships we build and maintain. The NSCP training provider, Interface Enterprises, fed back:

> "*We have been delivering a range of courses through the safeguarding partnership with Norfolk for the past three years and are delighted to share what a*

positive experience it has been. An open and collaborative working relationship is extremely important to us, and Norfolk truly embodies this. Both [the NSCP Workforce Development Officer and Business Support Officer] have been consistently available, responsive, and open to ideas. The quality assurance of delivery has always been constructive and reflective, demonstrating Norfolk's genuine commitment to both the content being delivered and the overall experience of staff, not simply a "tick-box" approach.

Although our trainers are based across the country, many continue to choose to deliver to Norfolk because of the strong, supportive relationships we've built with the lead staff. Administrative and contractual processes have been seamless, and regular review meetings are some of the most enjoyable and productive we attend. We greatly value our ongoing partnership with Norfolk and look forward to continuing to work together in the future."
Clare Joyce, Training Manager. Interface Enterprises

Multi-Agency Practice Week

Multi–Agency Practice Weeks are run two times per year and are supported by the NSCP/WFDG. These took place in May and November 2025. The focus of the May Practice Week was *'Understood, Not Overlooked – Takeover Week'* where the whole programme was produced and led by children and young people; there were resources produced on understanding life at school, relationships, communities, mental health and wellbeing and 'us and our future'. Over 2500 emails containing resources were delivered to practitioners. A comment from one practitioner on what they had taken from it was *"Re-enforcing the importance of young people's voices. Young people are experts by experience and when adults work collaboratively with young people the best solutions are made".*

The focus of the November Practice Week was *'Resilience Makes Brilliance'* with contributions made directly by the NSCP Business Unit. Over 450 individuals attended the practice week workshops. 99% of evaluation respondents indicated that they felt their attendance would have a positive impact on their work with children and families.

Both Practice Weeks featured a conference on the Wednesday afternoon.

In August 2025 there was also the annual Leadership Exchange Programme with sessions on Family Help, School Attendance, SEND in Schools and Supporting Adolescents. These are online events run for a national audience. There were 289 attendances across the four sessions from 49 local authorities 3 district councils and 14 health organisations. Feedback from delegates on what they would take away from the sessions included: *"Collaboration across the partnership is impressive"* (SEND session) and *"So much - love your focus on children and how to support them so it really is helpful - It sounds so personalised and focused"* (Supporting Adolescents session).

Trainers' Events

Trainers' events happen twice a year and bring together those delivering and designing safeguarding children training in Norfolk. The aim is to achieve a balance between providing information to ensure trainers are up to date with safeguarding children developments in Norfolk, and opportunities for skills development and discussion. These also provide regular opportunities to share good practice and innovation in training as well as networking.

The combined total attendance for these events was 42 multi-agency practitioners, managers and trainers. The trainers' events receive consistently positive feedback with delegates valuing the opportunity to attend.

Trainers' events in 2025-26 training year ran in July and December. Topics focused on

- recent safeguarding reports published by the National Panel: understanding Norfolk's response and how to apply the learning to training.
- awareness of the prevalence and impact of Neurodiversity and Speech, Language and Communication Needs within the Youth Justice Service.
- current safeguarding developments in Norfolk and networking opportunity.
- Making sleep part of the jigsaw: The role of sleep in youth mental health and resilience and where to access help locally' (NSFT). 'An intro to COM and the risks posed' (Norfolk Constabulary).

Feedback received included: *"Very thought provoking and re-emphasised the importance of curiosity, information sharing and keeping young people informed"* and *"A really informative and eye-opening session"*

Training Impact

The need to measure the impact of training is highlighted both locally and nationally. In Norfolk, relevant recommendations have been made in LCSPRs, scrutiny activity and in the Joint Targeted Area Inspection. The Workforce Development Group issued Training Impact Best Practice Guidance in June of 2025. Partner agencies were then asked to self-assess against the Best Practice Guidance and feed back to the Workforce Development Group. A report amalgamating these responses was presented at the March 2026 Workforce Development Group meeting where there was evidence that agencies demonstrated clear safeguarding training expectations aligned to their agency's operational needs. Agencies were also able to demonstrate evidence of in-house training impact measurement.

In addition, work has been undertaken this year to develop a trial Community of Practice learning model around the Domestic Abuse and its Impact on Families training course, to support embedding the learning into practice. Delegates attending courses across December 2025 to April 2026 have been invited to attend two follow up sessions at three and six months post attendance. These follow up sessions commenced in March 2026 and there was an initial positive response. Further analysis of the trial will be undertaken once completed.

Trauma Informed Practice Training

Learning opportunities around Trauma informed Practice continued to be offered during the 2025-26 training period supported by the funding received from Health. In 2025-26 sessions were offered around a full day Trauma Informed Practice training and a two-day Reflective Supervision Skills training. The remaining funds went towards the ongoing development of the network of Joint Agency Group Supervision (JAGS) facilitators to support them in their role as containing the containers.

Neglect

The NSCP Workforce Development Officer continued to support work around Neglect in Norfolk. Following an audit looking at implementation of the Norfolk Graded Care Profile the

delivery of training on the tool has moved from single to multi-agency. The organisation, and a considerable amount of the delivery of the training, is now managed by the NSCP Workforce Development Officer supported in delivery by local partners.

The NSCP Workforce Development Officer continues to support the multi-agency Neglect Champions network through the production of newsletters, organisation of training briefings and the bi-annual Neglect Champions' Forums, which provide opportunities for learning as well as networking.

Additional Work Streams

Alongside the standard programme of multi-agency training, the NSCP Workforce Development Officer also supports additional workstreams. During 2025 - 26 this has included:

- Supporting the planning and delivery of CSPR roadshows and suicide learning events in spring of 2026.
- Supporting the planning and delivery of an event focusing on suicide of children and young people in Spring 2026.
- Delivery of Questions for Success training.
- Continuing to work alongside the Office of the Police and Crime Commissioner and other partners to commission training around Adultification and Gangs, Grooming and County Lines.
- Chairing the regional LSCP Workforce Development Network.

The WFDG has a detailed workplan which is reviewed annually by the Delegated Safeguarding Partners. Details of what is included within the 2026 - 27 workplan can be found in Appendix 5.

Safer Programme

In addition to our multi-agency offer, Norfolk is unique in the provision of a Safer Programme which is in place to provide additional support and training to the voluntary and third sector. This is a self-sufficient programme which provides additional revenue for the partnership. A separate standalone annual report is published on the NSCP website.

8. Funding

The three statutory partners contributions to the NSCP pooled budget is equitable. Children's Services and Health costs for the Child Death Overview Panel, including the independent CDOP Chair and the electronic data system, is included in their contributions.

Additional income decreased from last year due to a reduction in external grant funding, which meant that money was taken from NSCP reserves.

Delegated Safeguarding Partners' Contributions

Contributor	Value of Contribution
Norfolk County Council	£139, 250
Norfolk & Waveney Integrated Care Board	£98,760
Norfolk Constabulary	£60, 290
Total Statutory Contributions	**£298,300**
Additional Income (see below)	£184,948
Use of NSCP reserves	£26,516
NSCP Budget: Grand Total	**£509,764**

In addition to statutory partner contributions, other sources of additional income are:

- Training income – including charges to non-contributing partners and fees for late cancellations or non-attendance (£100,497)
- The Safer training programme (£44,926)
- The seven District Councils (£35,525)
- Probation (£4,000)

This represents a reduction in income from 2024 – 25 of £562, 459, meaning the NSCP delivered its business programme with £52,695 less to work with this financial year.

9. Next Steps

This report provides an overview of the Norfolk Safeguarding Children Partnership's many achievements over the last 12 months. It is written as a review of our activity and does not account for the uncertainties ahead such as global conflict and the economic impact that will have. During this period, we worked with government reforms in health, social care and policing, which will continue to have an impact on how we work, particularly as Norfolk works through the changes required to deliver Local Government Organisation. Despite the challenges ahead, we remain committed to keeping children safe and their wellbeing is our priority. 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.

Our joined-up approach to systemic learning, combined with the energy and commitment to getting things right for Norfolk children and families, will provide the governance and leadership to navigate the challenges ahead. Our local safeguarding system is flexible and responsive with the systemic resources in place to understand family life and fulfil our duty to protect children.

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 2026 - 27 include:

- Supporting the Local Authority to work through the Local Government Reorganisation
- Ensuring the partnership's strengths underpin the implementation of reform and responding to changes in legislation such as the Children's Wellbeing and Schools Act
- Continuing to work on our priorities with a particular focus on establishing strategies and workstreams for transitional safeguarding and child sexual abuse
- Learning from inspection, scrutiny and audit and implementing action plans
- Continuing to utilise the performance intelligence, data and qualitative feedback to ensure we are targeting our resources correctly and addressing any gaps
- Further developing our approach to Joint Agency Group Supervisions and sharing our processes with other areas
- Multi-agency audits planned on domestic abuse
- Disseminating and implementing learning from local and national Safeguarding Practice Reviews and local Rapid Reviews
- Ongoing monitoring and review of learning and actions against recommendations from scrutiny, Child Safeguarding Practice Reviews, Section 11 and audit
- Delivering on the Workforce Development Group forward plan with a particular focus on measuring the impact of training on practice through community of practice groups
- 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.

Appendix 1: Items discussed at Partnership Group

NB Priority updates are rotational, with at least one priority presenting on progress at each meeting. There are also regular data updates throughout the year. Other agenda items were:

- Reports from the MASH Operational Group
- Voice of the Child: the Flourish survey
- A summary evaluation of the Father Inclusive Practice project
- Education:
    - perspective of primary school
    - 2024 – 25 scrutiny of children who are severely absent
    - Safeguarding self-assessment
- DA single agency self-assessment – a follow up from the JTAI inspection – and a Task & Finish Group report on cumulative harm
- Local government reorganisation
- Developments in Children's Advice & Duty Service (CADS - Children's Services front door)
- Evolution of the Practice Model, i.e. Signs of Safety
- The Casey report
- Families First agenda
- Final evaluation of the Father Inclusive Practice project
- Annual reports: NSCP, Independent Services – including the LADO – Child Death Overview Panel (CDOP) and the Local Safeguarding Children Groups (LSCGs)
- Update from Early Years, including progress towards piloting Encompass with EY providers
- Evaluation of the Leadership exchange summer programme
- Case AO summary
- A suicide review from the Norfolk & Suffolk Foundation Trust
- Children's Services report on their response to neglect
- Section 11 safeguarding self-assessment report
- Scrutiny: scrutineers' reports on Child Sexual Exploitation and Child Sexual Abuse (CSEA) as well as the CSA multi-agency audit
- Data governance arrangements
- Safeguarding Adults Review, Douglas, and learning for children's partnership
- Terms of Reference review

Appendix 2: Data Sources

The following data sources were used in compiling the 'Using data and evidence in partnership' chapter in Section 3. The data sources below are in addition to data collected from local systems, and as part of the Flourish Survey, which are not available publicly.

Data	Description of source	Link
Population estimates	NOMIS website – part of the Office for National Statistics	Population estimates - local authority based by five-year age band - Nomis - Official Census and Labour Market Statistics
Births	Births data via Public Health Fingertips	Births Data
Deprivation and children in low-income families	Data describing the percentage of children in an area living in low-income households.	Children in low income families: local area statistics - GOV.UK
School Population	Education Statistics – School population data	Schools, pupils and their characteristics, Academic year 2023/24 - Explore education statistics - GOV.UK
Health data	Child & maternal health profile, from Public Health Fingertips. Also, data from local systems provided by Norfolk and Waveney ICB and by East of England Community Health and Care Trust.	https://fingertips.phe.org.uk/profile/child-health-profiles/data#page/1/gid/1938133230
Police data	Data from local systems provided by Norfolk Police	-
Youth Justice data	Data from Youth Justice Statistics	Youth Justice Statistics - GOV.UK
Social Care data	A range of statistical returns, notably the Children In Need publication, and the Children Looked After publication. Also, data from local systems provided by Norfolk County Council.	https://explore-education-statistics.service.gov.uk/find-statistics/children-in-need/2024 https://explore-education-statistics.service.gov.uk/find-statistics/children-looked-after-in-england-including-adoptions/2024

Appendix 3a: CSEA Scrutiny Recommendations

1. Operational data and collection:
   a) Explicitly identify and record group based CSEA in all relevant datasets, this is an issue for all agencies.
   b) Consistently recording ethnicity and nationality for all victims and suspects. We must empower all practitioners to seek out and record ethnicity. The Partnership should develop training that will support practitioners from all agencies to record ethnicity.
   c) Accelerated implementation of/preparation for key recommendations of the Casey review, including the unique ID for each child.

2. Strategic data and analysis:
   a) Clear data sharing provisions, agreements and routines that ensure the timely dissemination of over-arching data (including around emerging risks) to statutory partners.
   b) Ensure oversight of aggregated/strategic data between statutory partners (through Joint Strategic Analysis Group), ensuring a joined-up analysis of overall risk (e.g. bringing Police, council and NHS together within needs assessments and indicator sets where relevant).

3. The NSCP Learning & Development sub-group should review and enhance the current training offer for all partners. The revised training should focus on:
   - Early identification of CSEA.
   - Listening to and amplifying the child's voice.
   - Use of appropriate, non-blaming language.
   - Understanding and preventing adultification.
   - What can we do about ethnicity, prevention and post abuse interventions.
   - How to ensure practitioners are comfortable seeking and recording information about ethnicity.
   - Clear pathways and referral methods.

4. The NSCP leadership recognised the need to do more in terms of engagement with children and develop prevention / post abuse strategies. This should include:
   - Developing a wider plan to educate young people in Norfolk. This plan should include a whole system prevention plan to help young people understand what is / what is not safe and to have a better understanding of what is available.
   - Utilise healthy relationship advice/education already being delivered to provide preventative work.
   - Develop post abuse recognition, interventions and multi-agency systems that can provide appropriate therapeutic support to children.

5. The NSCP should develop a comprehensive strategy to improve online safeguarding. This should include:
   - Appointment of a Strategic Lead to oversee development and implementation.
   - Identification and adoption of best practices, with input from expert advisors as needed.
   - Clear guidance covering all aspects of exploitation, including online grooming and other forms of CSEA.
   - Regular review and evaluation to ensure the strategy remains effective and responsive to emerging risks.

Appendix 3b: CSA Scrutiny Recommendations

1) A practitioner workshop is undertaken, to ensure that the themes and findings identified within this scrutiny are explored and validated with a broader and more representative practitioner cohort.

2) The NSCP should establish a task and finish group to oversee the implementation of the recommendations arising from both this piece of scrutiny and the multi-agency child sexual abuse audit. The task and finish group must be accountable through a clear governance framework which includes robust monitoring and oversight by the DSP's.

3) Strengthen agency understanding of intra-familial child sexual abuse by ensuring training goes beyond basic safeguarding and clearly distinguishes child sexual abuse from sexual exploitation. This should include focused learning on the complexity, prevalence, and hidden nature of child sexual abuse to improve confidence and practice consistency across the partnership.

4) Undertake a comprehensive mapping of all commissioned child sexual abuse services. Current gaps in visibility mean some support offers are not widely known or used, creating an assurance risk. Mapping provision will give the partnership a full picture of available services and help maximise access for children and families.

5) The partnership should develop a comprehensive child sexual abuse strategy to strengthen its collective response, clarify priorities, and ensure consistent practice across agencies.

6) The partnership should undertake a full review and refresh of its child sexual abuse tools, forms and website content to ensure they reflect contemporary best practice, with explicit alignment to the Centre of Expertise on Child Sexual Abuse's latest guidance, tools, and language.

7) Undertake further analytical work around data to deepen the partnership's understanding of child sexual abuse, with a focus on victim–perpetrator relationships, intersecting social care factors, correlations with wider vulnerabilities, and referral pathways.

Appendix 3c: Multi-Agency Thematic Audit on Child Sexual Abuse Recommendations

1. **Strategy Discussions**
   a. Applicable to all Strategy Discussions
      i. ensure all relevant professionals are invited including schools (even during school holiday periods) Early Years settings, professionals from the voluntary sector.
      ii. Invitations should be sent directly to the Headteacher or Designated Safeguarding Lead (DSL) to ensure compliance with data protection not school's generic email addresses.
   b. CSA specific – ensure SARC and Probation (where relevant) are invited.

2. **Talking to children directly and specifically about CSA to improve identification and consider the impact of other complicating factors (i.e. domestic abuse and neglect)**
   a. Utilise appropriate health appointments to speak to children about CSA if they are showing repeated signs and indicators.

b. Routine PANTS work (or equivalent that is applicable to their age and development) to be carried out with children who have been on a child protection plan under the category of neglect for 6 months or more and/or they have been on a child protection plan on more than 2 occasions.
c. Utilise Neglect and Domestic Abuse Champions to raise awareness of CSA.
d. Resource specific toolkit to be developed to develop practitioners with the necessary skills and knowledge to confidently manage potential disclosures – which will include resources to domestic abuse and neglect.
e. If the professional network identifies signs, behaviours and indicators of possible CSA within a Multi-Agency Chronology or within a Team Around the Family meeting, professionals should utilise the Joint Agency Group Supervision process to use the reflective space to discuss further and enhance their professional curiosity.

3. Support for the whole family

a. All practitioners working with children and families need to familiarise themselves with the CPS guidance around children accessing support whilst there is an ongoing investigation.
b. Work to be carried out with non-abusing parents in terms of assessing new partners and future risk.
c. Consider how to address and alter the perpetrator's behaviour to reduce risk and prevent future harm.
d. Safety planning - restrictive safety plans are always compatible with family life, bring network in.

4. Assessment and planning of people presenting risk of sexual harm

a. Parents who are due to be released from prison, with licence conditions that prohibit them from spending time with children must be referred to CADS at least 6 weeks prior to their release date but best practice would be 12 weeks (depending on the offence, sentence, licence conditions, behaviour etc). CADS should progress the referral to ensure an assessment can be completed to understand what risk a parent may pose, Probation must contribute to the assessment.
b. Bail conditions – must be communicated to all safeguarding partners and those working directly with the children and family, including when they change. When bail conditions are breached, this needs to be reported to the police. Police must take appropriate action following breached bail conditions.

Appendix 4: Joint Agency Group Supervision Impact Case Studies

JAGS case study 1: Improving Communication and Relationships
This case study was compiled by Team Managers from Children's Social Care and Transforming Care Navigator (NHS Norfolk & Waveney Integrated Care Board).

What the issue was?
After a number of months with a large professional group working with a family, it was clear that there was a great deal of professional worries, disagreement and frustrations.

After a Team Around the Family Supervision (TAFS) meeting (led by Children's Services and at one point were being held weekly) the social care Team Manager got the sense that the Team Manager from the Transforming Care Navigator Team was feeling as frustrated as Children's Services as to the lack of coordination and it was meaning that the family were not clear about who was doing what to support them. Family were making regular complaints to all services, and it felt that things were escalating within the home.

What we did about it?
This Team Managers took a risk with trusting each other to open up about how frustrated they were feeling about another service not providing the interventions that were agreed. They both quickly realised they were feeling the same and agreed a shared approach as to what they could do to solve some of the issues to bring people together.

Children's Services requested a JAGS to support with this but alongside this the Team Managers agreed there needed to be some ongoing agreement between all managers to ensure the professional network was on the same page; this would allow the workers 'on the ground' working directly with the family to have better direction.

Children's Services and the ICB raised their concerns and analysis to all the other team managers as a way to try and problem solve. Although this didn't have the ongoing impact they had hoped, it did allow professionals to understand each other's perspectives, even if there was disagreement. The two lead Team Managers also agreed who was best to attend the JAGS and felt strongly this needed to be for the professionals working directly with the family and not everyone: no managers went to the JAGS, which allowed the workers to really share their feelings together and not feel any judgement from management being in the room.

What was the impact?
Professionals supporting with the family were able to attend the JAGS and all were very honest about their feelings and the impact of the actions on others. It took bravery of the workers to go into the JAGS and be so open with each other and for apologies to be made to each other during the session for any misunderstandings. This has built relationships within the network and, although this has not solved the wider issues for the family, it has meant the family have had a more co-ordinated response and there have been less complaints and less issues that cannot be de-escalated. The divides within the professional network were effectively addressed which improved ongoing communication and co-ordination.

The social care Team Manager shared her reflections: *"Personally I feel I have been able to use this experience with these specific professionals to take my understanding of their service/ways of working and personalities forward into other casework, which again isn't always easy. I have felt more trust from and with other professionals and their decision making and reasons for this. It is also true for other workers in the network that they can take the learning forward for other casework and similar issues. I know all these professionals have contact with each other for different families at times and this has really built a firm understanding of what each role looks like and some empathy towards each other when pressure is on."*

JAGS Case Study 2: The Voice of the Child

What the issue was?

A request was made by NCHC concerning a 17-year-old with learning difficulties and disabilities. As the child approached his 18th birthday the professional network's anxiety was increased due to worries about transitional safeguarding. In the JAGS request the reasons for calling a JAGS were noted as:

- Concerns about the young person's current care agency's care and them being 'stuck' and their narrative hard to shift, despite support from professionals in training, weekly meetings, phone calls, feedback from visits.
- Worried that as a result, the multi-disciplinary team isn't working as effectively as it could be and this is affecting the young person's day to day experiences and their mental health
- Need a space to reflect on our thoughts and feelings and keep the young person as the centre is needed in the hope this can support a shift within the care agency's narrative.

What we did about it?

An initial JAGS was convened in spring of 2025, however, there was limited engagement. The facilitators worked with the requesting partner to explain the purpose and the value of JAGS to the professional network and provide assurances that this was reflective process to bring people together. A follow up JAGS was convened, which allowed the network to jointly share the emotional impact of this case in a safe, containing space.

What was the impact?

The NCHC Manager shared her reflections: *"Both [facilitators] from the start of this process have been really responsive, kind and compassionate. I've felt heard and listened to; they helped me to feel safe and brave in a system that has been really tricky for me both professionally and personally. I've really appreciated all the time they've given me and how child-centred they both are. I was very impressed by the 'additions' they brought to the JAGS to try and support everyone to keep the young man at the centre, either through shoes to represent the young man across his lifetime or different things to reflect his interests. I felt they really understood the young man despite not meeting him – they had him at the heart of it all at all times. Their support and skills have really supported the system to think differently, and I've just been so impressed with them. I've been so thankful to be supported by them, it truly has been such a pleasure to meet and work with them both."*

Appendix 5

WFDG Workplan 2026 – 2027
Continued evaluation of training including the ongoing trial of the Community of Practice model.
Training observations to take place across 2026 – 2027, including new Child Sexual Exploitation course, amalgamated Serious Youth Violence and Vulnerable Adolescents course, and revised Child Sexual Abuse and Risk courses.
The development of a new Anti-Racist Practice training course will continue to address the findings of the National Panel's 'Race, Racism and Safeguarding Children' report.
Findings from NSCP Scrutiny will continue to be reviewed to identify relevant work for the WFDG. A task and finish group will continue to progress the work identified by the NSCP scrutiny of '**Transitions'** and in relation to '**Children Missing Education'** (once completed in 2025). The findings from the Child Sexual Exploitation and Abuse Scrutiny Report and Child Sexual Abuse audit will also be implemented.
Continue to support with the role out of the **Families First Partnership Programme** including delivery of the Family Networking and Family Group Decision Making training programme.
Domestic Abuse Joint Targeted Area Inspection (JTAI) 2024 continue to support with workforce development related actions identified by the Task and Finish Group.
Continue to support training funded by **Serious Violence Duty** in collaboration with the Office of the Police and Crime Commissioner.
Annual multi-agency training review will take place towards end of 2026.
Continued awareness raising of the learning arising from **Rapid Reviews, Child Safeguarding Practice Reviews and reflective learning reviews** in Norfolk
Continuing to support the delivery of multi-agency **Neglect Graded Care Profile** training and the development of the **Neglect Champions Network**.
Planning and delivery of **Best Practice Events** 2026 – 27
Trainers Events x 2 to be designed and delivered
Various Work streams associated with issues discussed in this report will be progressed at the direction of NSCP designated partners.

Norfolk Safeguarding
Children Partnership