FINDING 1: Despite the expectation in Norfolk that the CAF should operate as a formal ‘early help’ process for children with additional needs, it lacks any of the inbuilt mechanisms for pro-active review and challenge that are present at higher thresholds (Child in Need, CP), leaving cases that are in the system for any length of time susceptible to collusion and drift.

NSCB Strategic Response:
The Norfolk Early Help offer has been substantially revised and now clearly sits within a more comprehensive approach to thresholds and the ‘step-up’ and ‘step-down’ of cases. The new approach is based on principles agreed by NCC Cabinet in April 2014 and detailed in the Early Help Improvement Plan, the Pathways to Support, How to Tackle the Challenge of Early Help (a District Based Model)) and the Early Help Outcomes Framework. The adoption of Signs of Safety as a fundamental approach to risk assessment and planning also ensures that there will be clear mechanisms to eliminate drift in cases.

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</table>
| Case management system to be implemented to track length of time FSP plans in place | Reporting mechanisms in place to monitor:  
• Length of FSP plans  
• Regular review of plans  
• Number/percentage of plans that are escalated to S17  
Audit  
• Shows reviews are pro-active and challenging where appropriate  
• Drilldown into cases open for more than six months | Children’s Services | Sept 2014 | ICT |
<p>| | | NSCB multi-agency audit (PIQAG) | April 2015 | Auditing capacity from partners |</p>
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| Early Help practice standards incorporate findings from this SCR, including triggers for review and escalation. | Practice Standards & learning from SCR developed to ensure that timeliness of reviews are included in FSP and direction on when to escalate Practice Standards incorporated into FSP training and all agencies, including commissioned services, demonstrate their understanding of standards. Monitored through:  
  - Training feedback  
  - Agencies’ supervision records – linked to findings  
  - Audit                                                                                                                                                                                                                                                                          | Children’s Services       | Dec 2014                      | FSP Strategic Manager’s time |
| Mandatory training in FSP for all schools and Children’s Centres.                                            |                                                                                                                                                                                                                                                                                                                                           | Children’s Services/all agencies | Dec 2014                  | Auditing capacity from partners |
| Role of Lead Professional developed to ensure that they have the confidence and skills to challenge and can maintain an independent overview of the case – to be included in Practice standard (see above). | Role of Lead Professionals developed to ensure that they have the confidence and skills to challenge and can maintain an independent overview of the case – to be included in Practice standard (see above).  
  Pool of Family Support Workers to be trained in this role.  
  Appropriate managers in commissioned services, e.g. Children’s Centres, also targeted for this training.  
  Pool of Lead Professionals trained to Practice Standards, with supplementary training on:  
  - Multi-agency assessments  
  - Working with challenging parents  
  - Neglect  
  Teams Around the Family assessed for knowledge base to evidence that there is appropriate skill set to manage difficult cases/cases that drift. Tested against pilot EH Hubs. | NSCB                      | Sep – Dec 2014                  | FSP Strategic Manager’s time |
|                                                                                                                |                                                                                                                                                                                                                                                                                                                                           | Commissioned Service Providers in all sectors | Sep – Dec 2014              | Commissioners time for contract management |
**FINDING:** 2. The CAF process in Norfolk risks being parent – rather than child – focused as a consequence of its being voluntary and consent-led, with the result that the individual needs of children are not adequately addressed.

**NSCB Strategic Response:**
The Board recognises that this finding reinforces lessons from previous reviews and inspections, reflecting the concentration of Norfolk practice and procedures on processes rather than outcomes, based on a priority for the voice of the child.

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<td>Lead Professional trained to ensure that parents are challenged appropriately</td>
<td>• The needs of children are the focus of all FSPs, evidenced through audit</td>
<td>PIQAG</td>
<td>Apr 2015</td>
<td>Auditing capacity from partners</td>
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<tr>
<td>Children’s wishes and feelings are central to the FSP process and parents’/carers’ response to this piece of work monitored and challenged as appropriate</td>
<td>Children and young people’s feedback on FSP is monitored and collated, with specific questions about how well professionals and parents/carers responded to their wishes and feelings, including how children’s news are shared with parents.</td>
<td>Children’s Services &amp; PIQAG</td>
<td>Sep – Dec 2014</td>
<td>FSP Strategic Manager’s time Auditing capacity from partners</td>
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**FINDING:** 3. There is evidence that some professionals most readily recognise neglect in terms of poor home conditions, rather than more general deficits in child-parent relationships and care. This can leave children at greater risk (and parents unsupported) from a range of neglectful behaviours that go unnoticed.

**NSCB Strategic Response:**
The NSCB agreed that neglect would be one of three priority areas for 2013-14 in its Business Plan. A Neglect Strategy has been developed and approved by the Board and the Board has also considered a baseline assessment of the impact and prevalence of neglect across the county. Champions for the implementation of the strategy have been identified within all NCSB partners and training provided to support the identification and response to neglect as a core practice issue.

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<td>The threshold guide is reviewed to ensure that signs of neglect are clearly identified, assessed for risk and signposted to the appropriate services so children and young people get the right interventions at the right time</td>
<td>Learning from is included in consultation process on threshold review, alongside data and intelligence from audit. Revised threshold is signed off by Board</td>
<td>NSCB Business Manager</td>
<td>NSCB Board</td>
<td>Jul – Nov 2014</td>
<td>NSCB budget: venues across the county</td>
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<tr>
<td>The Neglect Strategy implemented including the roll out of Graded Care Profile (GCP) training</td>
<td>Strategy launched with reference to learning from this case included in NSCB Best Practice Group workshop GCP training rolled out, with particular focus on Health Care professionals and social workers</td>
<td>NSCB Workforce Development Officer</td>
<td>WDG</td>
<td>Jul 2014 – Jun 2015</td>
<td>NSCB budget: BPG event</td>
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<td></td>
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<td>Aug – Dec 2014</td>
<td>Staff time for training</td>
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### Objectives
Effective & simple guidance produced, i.e. the Neglect Identification Tool (NIT), to ensure that professionals dealing with neglect cases have the tools in place to monitor and record the impact of neglect on the children they are working with.

### ACTIONS
Closer monitoring of neglect cases in terms of:
- Data on referrals, re-referrals, CiN/CP plans focusing on neglect
- Pathways for neglect cases
- Length of time neglect cases open without change
Effectiveness of assessments and interventions, measured through audit

### Evidence
- Children’s Services/NCC Business Intelligence
- PIQAG

### Owner
- PIQAG

### Timescales
- Jul 2014 onwards
- April 2015

### Resources
- Business Intelligence resources
- Auditing capacity from partners

### Objectives
Features of neglect cases analysed to identify strengths and weaknesses in case management, with a focus on assessment

### ACTIONS
Audit to consider features including:
- Age of child/children
- Disability
- Ethnicity/cultural background
- Mental Health issues
- Parenting capacity, including age of parent and their safeguarding history
- Triggers for escalation
- Triggers for re-referrals

### Evidence
- PIQAG

### Owner
- PIQAG

### Timescales
- April 2015

### Resources
- Auditing capacity from partners
**CASE L Action Plan**

**FINDING:** 4. There is no system to track/recognise patterns of missed appointments, within and especially across agencies, making it harder for professionals to share a critical sign of neglectful parenting.

**NSCB Strategic Response:**
Interagency information sharing have been identified as a high priority for the whole systems leadership for improving Children’s Services. Implementation of the Digital Norfolk initiative will enable some of the technical difficulties to be overcome.

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<td>Practice Standards at all levels of safeguarding and child protection ensure that partners regularly share information on missed appointments at multi-agency meetings: chairs of meetings – Lead Professionals, CIN Social Workers, core group and CP Conference Chairs – regularly record appointments missed and assess the impact that this may have on the child/children.</td>
<td>TOR for multi-agency meetings developed to have standing item solely to record missed appointments to enable chairs to assess impact on children. Agencies &amp; providers colleagues to ensure that all missed appointments are logged so that they can be reported. Audit shows where missed appointments act as trigger for escalation/re-referral.</td>
<td></td>
<td>Children’s Services Health &amp; Education care providers</td>
<td>Aug 2014 onwards</td>
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**CASE L Action Plan**

**FINDING:** 5. There is a tendency for professionals to make allowances for struggling parents, which militates against a recognition of neglectful behaviour and child-focussed practice, leaving children at risk of long-term harm.

**NSCB Strategic Response:**
This issue has been recognised within the NSCB Neglect Strategy and is also addressed through the establishment of a new model for social work intervention using the Signs of Safety. This will minimise bureaucracy and maximise direct intervention with families. It will support change through recognition of family strengths, giving frontline social workers and other practitioners the skills and tools to work more directly with families and ensuring the management, supervision and support to support this.

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<td>CP/Safeguarding/FSP Plans are clear about expected outcomes for children so that they are overt and link to the children’s needs not the parents.</td>
<td>Children and young people’s feedback on their plans are monitored and collated, with specific questions about how well their needs are met and what difference the plans have made to them. Assessment through effective plans of whether outcomes for the child are being met.</td>
<td>Children’s Services &amp; PIQAG</td>
<td>Sep – Dec 2014</td>
<td>FSP Strategic Manager’s time Auditing capacity from partners</td>
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<td>The findings from this SCR are included in the evaluation of the planning process, at all levels, but with a particular focus on FSP.</td>
<td>Early Help Programme Board to ensure that all FSP activities, including training and monitoring, emphasise the need to be child focussed. Audit shows: • The voice of the child • Challenges to parents • Appropriate interventions</td>
<td>Early Help Programme Board PIQAG</td>
<td>Jul 2014 onwards</td>
<td>EH Hub Co-ordinators’ time Auditing capacity from partners</td>
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**CASE L Action Plan**

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| The NSCB, with particular support from the EH Programme Board and – more specifically – CSLT, monitor the implementation of improvements to the FSP process to ensure it is child focussed and needs led with clear evidence of impact and outcomes. | Quality Assurance systems put in place to monitor FSPs to ensure that standards are applied to:  
- Referrals  
- Plans  
Meetings & reviews | PIQAG | April 2015 | Auditing capacity from partners |
**CASE L Action Plan**

**FINDING:** 6. There is a pattern whereby routine attribution of a label such as ADHD to a child distracts attention from what may be the result of poor parental care, resulting in a range of the child’s particular needs not being recognised and not met.

**NSCB Strategic Response:**
This finding presents an important challenge to the NSCB and will be addressed through continuing dialogue with clinicians working across the County. The appointment of a new designated doctor for the Board will enable this to be taken forward and will be a high priority for their attention.

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| Practice focuses on the child not their diagnosis and ensures that plans are put in place that define strategies to test behaviours against parenting skills | Drilldown into number of children with ADHD that are on CP plans and dip sample cases to ensure parenting capacity assessments have been completed to inform case management  
Drilldown to analyse where there are higher rates of ADHD diagnoses and analysis undertaken of wider safeguarding/community issues | Children’s Services | Dec 2014               | CS Audit team     |
| Improved understanding of ADHD as a clinical condition and how parenting is assessed and supported as part of the diagnosis, including access to services and interventions | ADHD Teams to provide briefing; to include some case studies for partners to learn from, with clear links to interventions for and challenges to parents  
Briefing to be included in learning events planned to highlight findings from this SCR | Health (ADHD Teams) | Oct 2014               | Health professionals capacity |
| Engagement with clinicians in hospital and community settings to prepare revised protocols for multi-agency input to diagnostic discussions and planning of treatment and support plans | NSCB designated safeguarding team to support engagement with clinicians | NHS Designated Safeguarding Team | Oct 2014 – Jan 2015 | NSCB budget: venues for learning events |
**CASE L Action Plan**

**FINDING: 7.** Professionals involved in the CAF process are not commonly seeking the active participation of the less visible parent (usually the father), making them less visible to the professional process as well, and risking the loss of valuable information about parenting and children.

**NSCB Strategic Response:**
This is a common and frequent finding from Serious Case Reviews and the steps identified below will ensure that the NSCB has a better understanding of the barriers and opportunities for the involvement of all parents and carers.

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<td>Early Help Practice Standards document to include guidance on involving both parents and wider family members who may be protective factors. To be underpinned with guidance about men who pose a risk and directions on how to assess that risk.</td>
<td>Improve ways of ensuring that both parents have equal access to FSP meetings and are kept informed of plans and outcomes, including: • Assessing the risks posed by absent parent • Recording the reasons for exclusion based on evidence of risk • Speak to both parents to ensure that any literacy issues do not exclude one or the other from the process Audits to demonstrate • how parents’ relationships are assessed, the risks managed and inclusion promoted. How other family members are assessed/included in process</td>
<td>Children’s Services</td>
<td>Sept 2014 onwards</td>
<td>FSP Strategic Manager’s time</td>
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<td>Consent is a guiding principle for FSP and is sought from both parents where applicable</td>
<td>Audit to demonstrate that consent is sought and reasons why it was not obtained</td>
<td>PIQAG</td>
<td>April 2015</td>
<td>Auditing capacity from partners</td>
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### CASE L Action Plan

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<td>Engage with UEA research project on involving men to improve practice</td>
<td>Allocate identified professionals’ time to participate in research project as part of their CPD</td>
<td>Workforce Development Group</td>
<td>Sep 2014 – Jun 2015</td>
<td>Staff time</td>
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#### FINDING: 8. Multi-agency partners tend to perceive CSC thresholds as either inconsistent or too high, resulting in uncertainty about how referrals will meet the criteria for acceptance. As a result, some children may not receive appropriate and timely referrals for intervention.

#### NSCB Strategic Response:

The Early Help Strategy and the development of Signs of Safety as a model for assessment and intervention across all levels of need will provide a consistent and common approach to thresholds. It will be key priority for the NSCB to monitor that the introduction of these new ways of working result in appropriate and timely referrals for intervention and the appropriate direction of referrals to the relevant service.

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| The threshold guide is reviewed to ensure that signs of neglect are clearly identified, assessed for risk and signposted to the appropriate services so children and young people get the right interventions at the right time. | Learning from this SCR is included in consultation process on threshold review, alongside data and intelligence from audit.  
Revised threshold is signed off by Board | NSCB Business Manager                                                  | Jul 2014 – Nov 2015  
Dec 2014                                    | NSCB budget: venues across the county                                  |            |
| The NSCB’s policy on Resolving Professional Disagreement is used regularly by the workforce | Policy promoted in learning events planned to disseminate learning from this SCR  
Workforce survey to measure how often policy is used and what outcomes are had | NSCB Workforce Development Officer  
Jan 2015                                      | NSCB budget: BPG event                                                  |            |
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<td>Referrers are provided with clear and timely response to their referrals, including information on the rational for no further action, so that understanding of risk and protective factors is supported through regular dialogue</td>
<td>Dip sample audit on cases where referrals have resulted in NFA focusing on the quality of the response provided. To include cases that have been re-referred to understand when and how risks were escalated.</td>
<td>PIQAG</td>
<td>Jan 2015</td>
<td>Auditing capacity from partners</td>
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