

CASE L Action Plan

Objectives	ACTIONS	Evidence	Owner	Timescales	Resources
<p>Early Help practice standards incorporate findings from this SCR, including triggers for review and escalation.</p> <p>Mandatory training in FSP for all schools and Children's Centres.</p>	<p>Practice Standards & learning from SCR developed to ensure that timeliness of reviews are included in FSP and direction on when to escalate</p> <p>Practice Standards incorporated into FSP training and all agencies, including commissioned services, demonstrate their understanding of standards. Monitored through:</p> <ul style="list-style-type: none"> • Training feedback • Agencies' supervision records – linked to findings • Audit 		<p>Children's Services</p> <p>Children's Services/all agencies</p> <p>PIQAG</p>	<p>Dec 2014</p> <p>Dec 2014</p> <p>April 2015</p>	<p>FSP Strategic Manager's time</p> <p>Auditing capacity from partners</p>
<p>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).</p> <p>Pool of Family Support Workers to be trained in this role.</p> <p>Appropriate managers in commissioned services, e.g. Children's Centres, also targeted for this training.</p>	<p>Pool of Lead Professionals trained to Practice Standards, with supplementary training on:</p> <ul style="list-style-type: none"> • Multi-agency assessments • Working with challenging parents • Neglect <p>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.</p>		<p>NSCB</p> <p>Commissioned Service Providers in all sectors</p>	<p>Sep – Dec 2014</p> <p>Sep – Dec 2014</p>	<p>FSP Strategic Manager's time</p> <p>Commissioners time for contract management</p>

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.

Objectives	ACTIONS	Evidence	Owner	Timescales	Resources
Lead Professional trained to ensure that parents are challenged appropriately	<ul style="list-style-type: none"> The needs of children are the focus of all FSPs, evidenced through audit 		PIQAG	Apr 2015	Auditing capacity from partners
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	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.		Children's Services & PIQAG	Sep – Dec 2014 Audit April 2015	FSP Strategic Manager's time Auditing capacity from partners

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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.

Objectives	ACTIONS	Evidence	Owner	Timescales	Resources
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 is included in consultation process on threshold review, alongside data and intelligence from audit. Revised threshold is signed off by Board		NSCB Business Manager NSCB Board	Jul – Nov 2014 Dec 2014	NSCB budget: venues across the county
The Neglect Strategy implemented including the roll out of Graded Care Profile (GCP) training	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		NSCB Workforce Development Officer WDG	Jul 2014 – Jun 2015 Aug – Dec 2014	NSCB budget: BPG event Staff time for training

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.

Objectives	ACTIONS	Evidence	Owner	Timescales	Resources
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.	<p>TOR for multi-agency meetings developed to have standing item solely to record missed appointments to enable chairs to assess impact on children.</p> <p>Agencies & providers colleagues to ensure that all missed appointments are logged so that they can be reported.</p> <p>Audit shows where missed appointments act as trigger for escalation/re-referral.</p>		<p>Children's Services</p> <p>Health & Education care providers</p>	Aug 2014 onwards	

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 address 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 that skills and tools to work more directly with families and ensuring the management, supervision and support to support this.

Objectives	ACTIONS	Evidence	Owner	Timescales	Resources
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.	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.		Children's Services & PIQAG	Sep – Dec 2014 Audit April 2015	FSP Strategic Manager's time Auditing capacity from partners
The findings from this SCR are included in the evaluation of the planning process, at all levels, but with a particular focus on FSP.	Early Help Programme Board to ensure that all FSP activities, including training and monitoring, emphasise the need to be child focussed. Audit shows: <ul style="list-style-type: none"> • The voice of the child • Challenges to parents • Appropriate interventions 		Early Help Programme Board PIQAG	Jul 2014 onwards April 2015	EH Hub Co-ordinators' time Auditing capacity from partners

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<p>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.</p>	<p>Quality Assurance systems put in place to monitor FSPs to ensure that standards are applied to:</p> <ul style="list-style-type: none"> • Referrals • Plans <p>Meetings & reviews</p>		PIQAG	April 2015	Auditing capacity from partners

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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.

Objectives	ACTIONS	Evidence	Owner	Timescales	Resources
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	<p>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</p> <p>Drilldown to analyse where there are higher rates of ADHD diagnoses and analysis undertaken of wider safeguarding/community issues</p>		<p>Children's Services</p> <p>Public Health</p>	<p>Dec 2014</p> <p>Dec 2014</p>	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	<p>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</p> <p>Briefing to be included in learning events planned to highlight findings from this SCR</p>		<p>Health (ADHD Teams)</p> <p>NSCB Team</p>	<p>Oct 2014</p> <p>Oct 2014 – Jan 2015</p>	<p>Health professionals capacity</p> <p>NSCB budget: venues for learning events</p>
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	

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Engage with UEA research project on involving men to improve practice	Allocate identified professionals' time to participate in research project as part of their CPD		Workforce Development Group	Sep 2014 – Jun 2015	Staff time

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.		NSCB Business Manager	Jul 2014 – Nov 2015	NSCB budget: venues across the county
	Revised threshold is signed off by Board		NSCB Board	Dec 2014	
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		NSCB Workforce Development Officer	Jul 2014 – Jun 2015	NSCB budget: BPG event
	Workforce survey to measure how often policy is used and what outcomes are had		NSCB Monitoring & Evaluation Officer	Jan 2015	

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Referrers are provided with clear and timely response to their referrals, including information on the rationale for no further action, so that understanding of risk and protective factors is supported through regular dialogue	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.		PIQAG	Jan 2015	Auditing capacity from partners