Nottinghamshire Safeguarding Children Partnership

NSCP Annual Report 2020/21

SAFEGUARDING CHILDREN ARRANGEMENTS FOR NOTTINGHAMSHIRE

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Introduction

Nottinghamshire Safeguarding Children Partnership (NSCP) provides the safeguarding arrangements required under the Children and Social Work Act 2017 and the statutory guidance 'Working Together to Safeguard Children 2018'. The purpose of safeguarding arrangements is to support and enable local organisations and agencies to work together to safeguard and promote the welfare of children.

Vision and values

The Partnership has set out its vision: -

'That children and young people in Nottinghamshire grow up in a safe and stable environment and are supported to lead healthy, happy, and fulfilling lives'.

The Nottinghamshire Safeguarding Children Partnership will:

- Work effectively as a partnership to protect children from harm.
- Build working relationships between partners which support constructive challenge.
- Be transparent and self-critical.
- Learn from local and national safeguarding practice and improve the way children are safeguarded.
- Listen and respond to children and young people and adult victims and survivors of child abuse to guide how services are delivered.
- Ensure services for children and families in Nottinghamshire support children and young people to stay healthy and happy.
- Ensure services for children and families in Nottinghamshire support parents and carers to provide the best possible care for their children.

This report sets out what the Nottinghamshire Safeguarding Children Partnership has done over the past year. It provides an update on progress in relation to the safeguarding priorities for 2020-23 and identifies key areas of work to take forward. A summary is included of the decisions made in relation to local case reviews, the learning from those reviews and action taken in relation to them and the two national thematic reviews that have been published. The effectiveness of the safeguarding arrangements in practice is commented on throughout the report. Evidence of the impact of the work of the safeguarding partners and relevant agencies, including training, on outcomes for children and families from early help to looked-after children and care leavers is included. Examples of the ways in which the partners have sought and utilised feedback from children and families to inform their work and influence service provision are also included.

The safeguarding arrangements in Nottinghamshire are fully detailed in the safeguarding arrangements document published in line with national requirements on the NSCP website https://nscp.nottinghamshire.gov.uk/about-the-partnership/. The arrangements were last updated in January 2020. They include details of the partners to the arrangements and explain how the functions of the Partnership are carried out through a number of different groups and led by the Strategic Leadership Group (SLG).

Safeguarding partnership activities and progress

The following priorities were identified in the NSCP Business Plan for 2020-23 - details of the activities of the Partnership in relation to those priorities, achievements, impact of the work completed and further action that is needed are detailed below.

Priority 1 - Preventing neglect

Child neglect has a lifelong impact on a person's wellbeing, and it is vitally important that as a Partnership we do all we can to prevent it. Both the Nottinghamshire and Nottingham City Safeguarding Children Partnerships recognise that tackling neglect must be a priority if we want to improve our children's life chances and prevent poor outcomes later in life.

A new Nottingham and Nottinghamshire Child Neglect Strategy for 2021-2024 has been developed which identifies three key objectives:

- **Recognise** – ensuring that neglect and the impact of neglect on children is understood and identified.
- **Respond** – ensuring that good quality, multi-agency support, and intervention is available and makes a difference for children experiencing neglect.
- **Reflect and Review** – ensuring that we work together with children, families, and communities to continue to monitor the impact of our work and continue to develop our partnership response.

The Child Neglect Strategy was launched at a Joint Partnership Forum led by members of the Strategic Leadership Group. Shared priorities for the Partnerships under each objective have been agreed and partners are now developing action plans to take forward this work within their organisations.

Key work to take forward

- Review completed partner action plans and monitor progress through the formation of a Joint Child Neglect Working Group
- Develop a comprehensive and clear set of measures, which effectively demonstrates the impact of our work on neglect in the short and long term. Early indicators of success will evidence improvements in the identification of neglect and in the quality and reach of services for children.

Priority 2 - COVID – 19

Ensuring that we understand and respond to the impact COVID-19 has had, and continues to have, on children and young people. Monitoring the impact of any changes to service provision and supporting the retention of good practice developed during the pandemic.

The Safeguarding Assurance and Improvement Group (SAIG), on behalf of the Partnership, monitored the impact of COVID 19 on services for children and provided a sense check of revised operational arrangements to ensure that multi-agency safeguarding work was as effective as it could be. The SAIG moved to virtual meetings and increased the frequency of them to enable it to keep a current overview of the changing situation, meeting 16 times over the past year.

At each meeting the SAIG reviewed how well safeguarding practice was working focussing on key elements of safeguarding practice. It considered the impact of any new working practices, their impact on children and for partnership working. It also sought to identify emerging challenges.

Impact assessments

Impact Assessments were completed by partner organisations to understand the implications of COVID 19, these focussed on: -

- The impact of COVID 19 on children and families
- Organisations abilities to maintain normal service
- Any changes being implemented and details of how they are being communicated to children and families
- Any negative impacts which may increase safeguarding risks and steps taken to mitigate them
- Any positive impact of new working arrangements and how they are going to be taken forward

The completed Impact Assessments were reviewed by the NSCP Independent Scrutineer and informed his COVID 19 Safeguarding Evaluation which was presented to the SAIG. The Independent Scrutineer concluded that 'professionals individually, agencies and the Safeguarding Partners have responded excellently to the challenges whilst in lockdown and were preparing for the issues which may be ahead'.

Demand data

Quantitative demand data was provided to each SAIG meeting including early help decisions, MASH enquiries, strategy discussions, domestic abuse trends, child protection conferences, children on a child protection plan, repeat child protection plans and children who are looked after.

Outcome

The qualitative and quantitative data outlined above allowed the SAIG to maintain a current understanding of the impact of COVID 19 on services for children and families. It also provided an insight into the effect of the pandemic on children and families; however, it is appreciated that the long-term impact is not fully known at this stage.

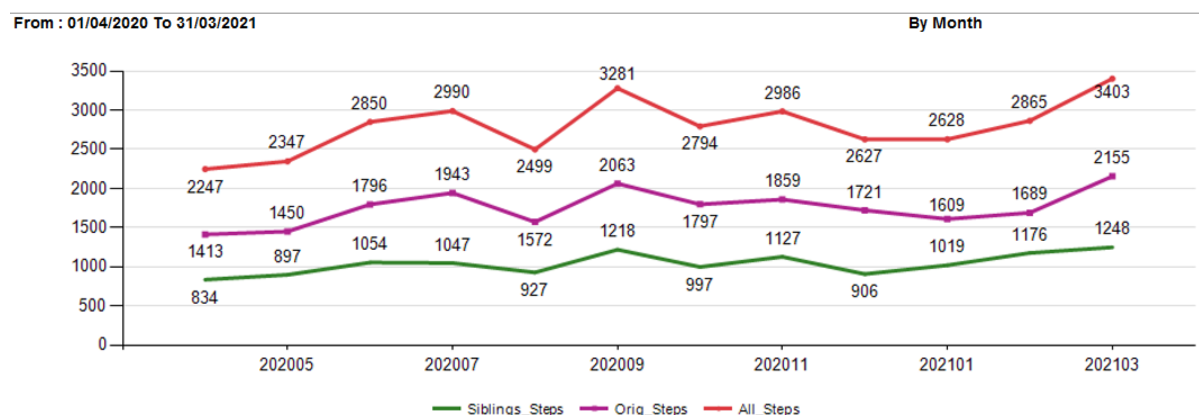
There was no easement or disapplication of statutory requirements around safeguarding children. Thresholds for early help, social work assessment and support and Education, Health and Care plans remained the same.

The SAIG monitored the number of enquiries made to the Multi-Agency Safeguarding Hub (MASH) – **33,517** safeguarding enquiries (including the original child and siblings) were dealt with by the MASH during the course of the year compared with **34,499** the previous year. MASH enquiries fluctuated more than is usually the case due to periods of lockdown and this was largely due enquiries from schools falling during those periods.

Similarly demand for medical assessments initially dropped during the first lockdown period however these were seen to return to more normal levels providing some reassurance that safeguarding concerns were being referred appropriately.

Following the return of schools there was anticipated increased pressure on the MASH, which was highlighted with partners. Action was agreed with partners to enable the effective management of risk with use of the online referral system unless immediate action was needed. Feedback from social work teams, supported by the workflows of partner agencies, indicated that cases being referred during periods of increased pressure were more complex than was previously the case which may reflect children experiencing hidden harm during lockdown.

Mash Enquiries – 2020/21



Safeguarding systems were monitored throughout and shown to be continuing to operate effectively with timely responses to new concerns. Use of technology supported multi-agency working with reports of increased engagement. An audit of social work practice during the pandemic concluded that many families have had a positive experience of the use of technology to engage with them.

Virtual conferences were introduced by the Independent Chair Service and their effectiveness monitored and supported by the SAIG. Professionals responded well to the need to provide their reports prior to the meeting to aid distribution with Chairs reporting that health, police, and education colleagues were providing reports 24 hours before conferences. Excellent participation was reported with professionals joining the calls promptly and reporting positively about the effectiveness of the meetings. Confidential information was also shared ahead of the meetings appropriately.

All families receiving early help or social work support were risk assessed to determine the level of support required. Risk levels determined whether visits were face to face or via phone/videoconference. All families received at least weekly contact.

Child protection

As at 1st April 2021 **698** children were subject to a child protection plan in Nottinghamshire (compared with **798** at the same point in 2020). Initial concerns at the start of the pandemic about difficulty in progressing child protection plans leading to increasing numbers of children on a plan did not materialise as professionals found innovative ways of taking this work forward.

Initial Child Protection Conferences - **605** conferences took place with **96.7%** within timescales. The conferences related to **1,175** children of which **27** had disabilities.

Review Child Protection Conferences - **1,194** review conferences took place with **98.8%** within timescales.

This evidences that key child protection multi-agency frameworks continued to operate effectively, child protection plans were regularly reviewed and updated to ensure that the children continued to be protected.

Support for Vulnerable Children and Families including Schools Early Years, School and College Settings

Education, Learning and Skills (ELS) staff from Nottinghamshire County Council Partnership and Fair Access organised into COVID Crisis Locality Teams to support Headteachers and mediate provision for key worker and vulnerable pupils.

ELS, Social Emotional Mental Health staff were deployed to provide additional guidance and support to schools around vulnerable children. The Health and Safety Executive (HSE) visited publicly funded schools in Nottinghamshire and the feedback from those visits was that the risk assessment process in the schools was found to be “excellent and exemplary”. In particular their knowledge of the guidance and implementation of controls, and the role of support pathways from the County Council in controlling the risks and infection barriers.

Many schools supported vulnerable families in a range of ways including delivering food, providing activities, and contacting or visiting children they considered most vulnerable.

Partnership working took place with headteachers and academy CEOs to develop contingency hub plans to ensure that provision continued to be offered to vulnerable pupils if individual school sites had to close.

Special School Staff worked together to ensure a continuity of provision for vulnerable pupils who require special school provision and provided additional guidance to mainstream colleagues around SEND pupils whose needs were challenging to manage through the COVID crisis.

Attendance at school throughout the pandemic remained broadly in line or better than national attendance data as produced by the Department for Education. For example, as of 6th October 2020, **92.2%** of children on the roll in the county were attending school compared with a national average of **90.2%.** Figures from the 23 February 2021, while schools were closed to most pupils, showed **21%** of children on the roll in the County were attending school onsite compared with a national average of **16%**.

ELS led and coordinated the ‘Wellbeing for Education Return’ initiative. The webinars, ran over 7 sessions at district level, involved colleagues from Mental Health Support Teams, Child and Adolescent Mental Health Service (CAMHS) and the Family Service, with representation from Parent and Carer Forum. Topics included ‘Resilience & Recovery – Whole School Approaches & Resources’ ‘Supporting Anxiety & Low Mood’ and these were backed up with online resources.

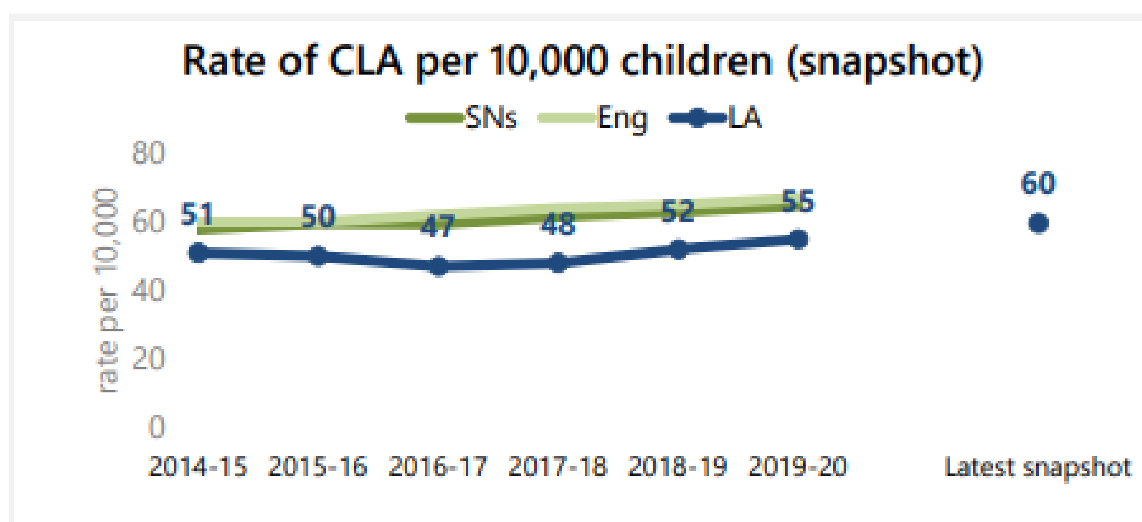
It is clear that significant efforts have been made by schools and other services, to support vulnerable children and families and children of key workers. National reports have identified that those hardest hit by the school closures had regressed in basic skills and learning. Some children had lost stamina for learning and fitness levels and there was also concern around the regression of some young children who had been potty trained and had returned to settings in nappies. A particular concern to Ofsted was vulnerable children being out of sight of schools with falling referrals to social care, raising fears that domestic violence, neglect, exploitation, or abuse has been undetected.

https://www.gov.uk/government/collections/ofsted-covid-19-series.

The universal Catch-up premium for all pupils and the National Tutoring Programme (NTP) which can provide additional targeted support for disadvantaged children and young people who have been disproportionately affected by the pandemic will be used strengthen education provision moving forwards. Schools in the most disadvantaged areas will also have access to academic mentors. These are trained graduates who can provide intensive catch-up support to pupils.

Children who are looked after –

As of 1st April 2021, there were **996** children in care, compared with **923** in April 2020. The number of children looked after in Nottinghamshire has increased, however rates of children looked after children have been lower than statistical neighbours and the England average for some years and current comparable data is not available at this time.



Children who are in care have continued to be encouraged and supported to express their wishes and feelings in care planning processes. There were **2,635** looked after children reviews during the year with children attending and participating in over **43%** of them - sometimes with the support of an advocate. A further **49%** of reviews had the views of children who did not attend conveyed through others on their behalf. Independent Reviewing Officers are working in collaboration with the Children in Care Council to develop a film to explain to children and young people which adults will support them through their looked after journey and the reasons why. Progress has been delayed due to the pandemic, but it is planned to complete the work during the summer of 2021.

COVID 19 has impacted on children in care with the vast majority of children in care contact with birth families arranged to take place remotely during lockdown restrictions. Staff numbers in local authority residential homes were also affected by COVID 19 and support was provided through flexible working by suitably qualified staff from other services, particularly the Youth Service.

The Independent Scrutineer, Dr Mark Peel, was asked to review Nottinghamshire's approach to the use of unregulated children's homes for children under the age of 16 by the SLG. Dr Peel found clear evidence of both the highest standard of professional safeguarding practice being applied to these circumstances, and a view that such placements must only be used in extremis, and usually where to do otherwise would be contrary to the best interests of the individual child.

Children who are looked after –

Initial Health Assessments (IHA) for children who are looked after provide a comprehensive assessment which is then used to make recommendations regarding the child's future health.

During COVID 19 restrictions, IHAs have been undertaken by telephone and the impact of this approach, and the need for follow up if required, was raised at the SAIG along with ongoing challenges around the timeliness of IHAs. This includes IHAs for children placed out of area that are completed by an external health provider.

The increase in children being taken into care in Nottinghamshire and placements by other local authorities has impacted on the health service providers and their ability to support and further work is required to consider this issue. Assurances have been provided to the SAIG regarding arrangements for follow up and the Nottinghamshire CIC Service Improvement Forum (SIF) is overseeing a partnership approach to improve the timeliness of health assessments. The progress with this work will continue to be monitored by the SAIG.

There has been a noticeable unwarranted variation in CAMHS provision nationally that is impacting on our looked after children placed out of area. Many areas will not/are reluctant to provide a service for other local authority children placed there. As part of the Nottinghamshire Children in Care Service Improvement Forum a locally agreed escalation pathway has been written to support when concerns are raised by the local authority (social workers) around CAMHS provision externally. This has resulted in the Designated Nurse for Looked After Children and commissioners having greater awareness of this issue and being able to challenge barriers and support on a case by case basis. This issue has also been escalated to the Nottingham and Nottinghamshire Safeguarding Children Partnerships for ongoing monitoring.

Priority 3 - Improving the initial multi-agency response to safeguarding concerns

Strategy discussions

Case reviews, audit and inspections have identified the need to improve multi-agency working in relation to strategy discussions which play a key part in coordinating the initial response to safeguarding concerns. A joint working group, led by a Group Manager from Nottinghamshire Children's Social Care, was formed to coordinate this area of practice improvement.

A new pathway for engaging health professionals in strategy discussions has been implemented and this led to a significant improvement in compliance with the requirements set out in statutory guidance. The MASH Health Team now represent health at strategy discussions for all new safeguarding concerns and this accounts for the majority of the improvement in performance.

Latest performance data -

The Assessment Service (North and South) are responsible for organising almost **60%** of the strategy discussions

27.5% of strategy discussions result in a joint investigation between children's social care and the police

*Involvement of agencies**

Education	Health	Police	Social Care	Voluntary sector
17.1%	51.2%	97.7%	91.7%	4.3%

Prior to the action being undertaken by the Joint Working Group, health involvement in strategy discussions averaged **11.8%** so there has been nearly a **40% increase** in health involvement in strategy discussions as a result of the action taken.

*Working Together to Safeguard Children states a local authority social worker, health practitioners and a police representative should, as a minimum, be involved in the strategy discussion. Other relevant practitioners will depend on the nature of the individual case.

Communications pathways were also strengthened so that social workers could more easily identify and engage with appropriate police representatives when concerns involving children already open to children's social care emerged. Back up arrangements were also introduced for when front-line police officers are not available for strategy discussions.

Business information systems have also been improved so that performance management measures can now be easily monitored. This has enabled areas of practice to be targeted for further work.

Impact on outcomes -*Timely strategy discussion with the right people involved secures disclosure, leading to the conviction of the perpetrator and protection of children –*

A 12-year-old girl disclosed sexual abuse from an extended family member whilst in school. The child was clear that she wished to make a statement to the Police. An urgent strategy meeting involving children's social care, police and health took place to coordinate agency responses and consider whether a medical assessment was appropriate. A joint visit was made to see the child in school, she made a clear disclosure which resulted in a conviction. Had there not been a swift and joint approach to this case then the child may have retracted her statement due to having second thoughts, being persuaded by family members to withdraw or in the belief that the disclosure was not being taken seriously.

An information leaflet has also been developed for parents/carers of children who may be asked to undergo a medical assessment. The leaflet explains why a referral for a child protection medical assessment is made, the rights of children/parents and carers, what the medical assessment involves, and what happens next.

Multi-agency training needs were analysed in relation to Strategy Discussions/ joint investigations/ Child Protection medicals and a training package has now been developed. Initially, three events have been planned targeted at those most likely to be involved in strategy discussions. The Child Protection Enquiries chapter of the interagency procedures has been updated to provide further guidance and clarity around strategy discussions.

As a spin off from this work Partnership Liaison Meetings have now been introduced. These help facilitate discussions and problem solving between operational staff from the police, social care, and health organisations, to tackle any difficulties they may be experiencing in partnership work.

The work to improve the effectiveness of strategy discussions has highlighted the benefit of gaining a full understanding of the issues impacting on practice by engaging with frontline professionals and gathering detailed data to inform analysis. The Partnership will use this learning to tackle other difficult safeguarding practice issues.

Key actions to take forward

- The development of a communications sheet/pathway to help District and other Children's Social Care teams engage with appropriate health representatives when the need for a strategy discussion is identified outside the MASH i.e. concerns emerge about children already open to children's social care or where cases have not been flagged within the MASH.
- Implementation of the multi-agency training programme.
- Further exploration of decision making around joint and single agency investigations

Priority 4 - Contextual safeguarding

Contextual safeguarding is a complex area of safeguarding relating to risks from outside the home which may overlap. To help develop its approach to protecting children from those risks the NSCP submitted a joint bid with Nottingham City and the Violence Reduction Unit to the Tackling Child Exploitation Programme. The bid was successful and the Partnership has worked with the Tackling Child Exploitation Programme[1] which supported the partnership through facilitated sessions which focus upon exploration of local partners experiences of current child exploitation and extra familial harm pathways and processes, geographically aligned governance arrangements and partnership working across the city and county landscape. The Project Learning Report can be found here: TCE-Project-Learning-Report-Nottingham-_FINAL.pdf (researchinpractice.org.uk)

A Cross Partnership Contextual Safeguarding Strategic Management Group has been formed and will take forward the learning from the Bespoke Support Project. The priority for the group is to develop a roadmap towards the integration of the response to child exploitation and extra-familial harm. The group has also been given responsibility for taking forward the learning from the National Child Safeguarding Practice Review Panel Report – 'It's hard to escape'. The learning from this review also featured in a joint Partnership Forum in which John Drew, author of a Serious Case Review for Waltham Forest, provided a thought-provoking presentation on his findings which the Partnership has been able to use in a number of seminars.

Key action to take forward

- Complete work required to enable an alignment of responses to child exploitation and extra familial harm across the two children's safeguarding partnerships and further explore opportunities for integration of current pathways for child criminal exploitation and extra familial harm

Harmful Sexual Behaviour

An area of contextual safeguarding that has been a focus for improvement work for the NSCP is the response to concerns about Harmful Sexual Behaviour (HSB). The multi-agency HSB Steering Group has been leading this work and undertook an audit of cases to assess progress since the previous audit in 2018. Good and outstanding practice was identified with improved practice and progression in the quality of practice. Identification of HSB from a range of professionals from different backgrounds had improved with prompt referrals being made. In some cases, very good relationships were established with the young person and these had a positive effect on the outcome. There was also evidence of the HSB Panel making a positive contribution towards the management of risk and improving outcomes for young people.

Providing therapeutic support and preventing further harm - A 14-year-old boy was convicted of harmful sexual behaviour against a child within the family and sentenced to a 12-month community order. The case was jointly assessed by the Youth Justice Service and Children's Social Care and presented at the HSB panel where roles and responsibilities were agreed. The case was held by Youth Justice Service and joined by Head2Head (CAMHS) to complete an additional assessment as well as specialist therapeutic work around HSB. Intervention was delivered over the course of 12 months where support was offered to the family as well as direct work with the young person. The young person returned to the family home, returned to school, there were no further instances of HSB and the case was closed to all services.

[1] The TCE Programme is a joint initiative by the University of Bedfordshire, Research in Practice and The Children's Society

Harmful Sexual Behaviour Panel – effective interventions –

A review of the 24 HSB cases that have been referred to Head2Head (CAMHS) within the past 2 years (since the introduction of HSB panels) revealed that there have been no cases where there has been a new offence or proved allegation of HSB. In one case an historic allegation has come to light which is being investigated be police and, in another case, there are continued concerns around HSB and risk to the public which are being managed.

This is in line with the national picture and what research suggests where it is thought that the recidivism rate is less than 5% where intervention is delivered.

Areas for improvement included consistency in the use of the appropriate pathway once HSB concerns are identified, accessing expert advice at the right time and use of specialist assessments. Whilst multi-agency work was on the whole good greater engagement with health colleagues was needed in some cases.

HSB procedures have been updated with expanded guidance on the continuum of sexual behaviours, aligned to NSPCC resources, and greater clarity on pathways to follow.

Key actions to take forward

- HSB Steering Group to continue to practice development work and undertake a follow up organisational audit

Missing children

Children missing from home or care may be vulnerable to a range of extra familial risks. Local case reviews have indicated good multi-agency practice in this area of work with robust systems for information exchange and follow up Return Interviews. The SAIG agreed to strengthen practice further by adopting the Philomena Protocol which ensures that information is captured about children at risk of going missing when they came into a residential setting. Whilst current practice is good at collating information to assist finding a missing child adopting the protocol will lead to more consistent recording across the country which will assist if a child moves areas.

Key action to take forward

- Implementation of the protocol with foster care providers and other residential settings

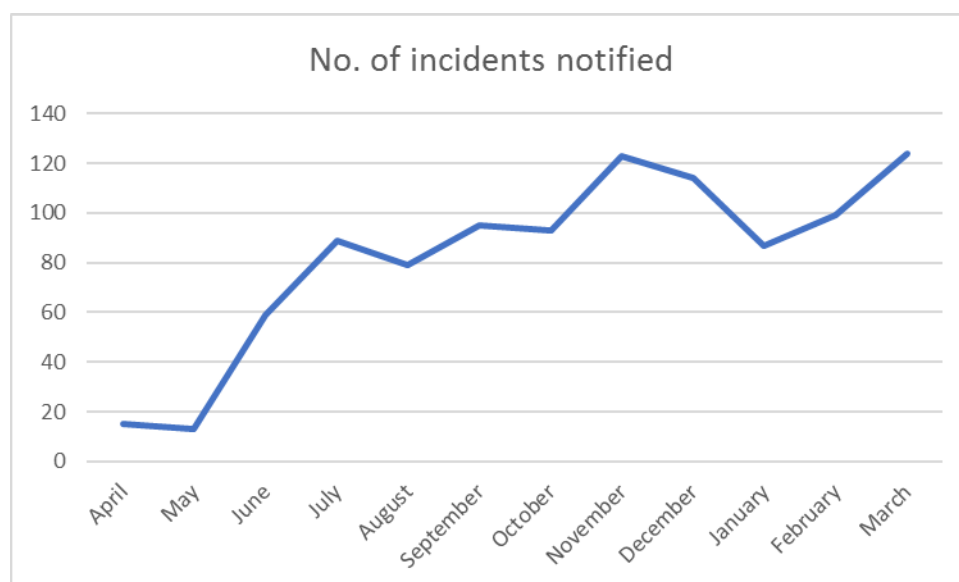
Priority 5 - Information sharing

Enabling information sharing between partners

Child Protection Plan – children's social care/police information sharing

Details of children on a child protection plan are provided to the police so that if they attend an address where a child lives who is on a plan, they can be alert to anything that may increase concerns. If the police attend an address where a child protection 'flag' exists an automatic notification is sent to children's social care with brief circumstances of the incident. This does not replace the need for the police to make appropriate safeguarding referrals but provides the social worker with an up to date knowledge of potentially relevant incidents which they can then use to inform their overall assessment of the child's safety and wellbeing.

Notifications received by children's social care about incidents attended by the police



On average **over 80** incidents per month are attended by the police at addresses where children are living subject to a child protection plan. Through a semi-automated system these are notified to the social worker who is working with the family who can decide if they need to take any further action. An examination of a sample of cases revealed that often the social worker for the child would make contact or visit the child after a notification to check on the child's welfare. Sometimes this included offering support where the family had been subjected to threats or abuse. On other occasions it prompted the social worker to find out more information from the police about the incident.

'Without the information (provided through the incident notification) we would have no understanding of the true circumstances G (2 yr. old girl) was living in' Social worker who received a notification of anti-social behaviour reported at an address where a 2 year old girl on a child protection plan was living.

A combination of technical issues and the first lockdown impacted on the number of notifications in the first quarter.

Key actions to take forward

- Develop technical solution for providing child protection plan data to the police which increases the frequency and timeliness of the data being provided
- Identify what information sharing systems that need to be in place to support a multi-agency approach to child criminal exploitation

Priority 6 - Developing how the Partnership engages, listens, and responds to the views of children and families

Strengths-based practice

The Partnership has supported the implementation of a strengths-based approach to practice initiated by Nottinghamshire County Council Children and Families Department. Child protection conferences were identified as a priority area for embedding strengths-based practice and a phased roll out of the new approach began in late 2020. By adopting a restorative and relational strengths-based practice framework to conferences, the aim is to:

- move away from a deficit and compliance culture towards practice underpinned by high challenge and high support
- identify strengths and resilience as well as needs and risks.
- build meaningful relationships
- hear the voice of the child and let that voice have an influence

A new agenda was introduced for conferences with a greater focus on participation and building on the child, family, and community strengths to promote positive and sustained change. Increased use of advocates and strengthening engagement with parents prior to conferences ensuring information was available to them ahead of the conference and creating opportunities to discuss issues with them.

Key actions to take forward

- ➢ Further roll out of strengths-based practice across the Partnership

Re-imagining services based on need rather than thresholds

The SAIG and Partnership Forum have started to take forward discussions around how to coordinate access to all partner services differently and this has included exploring Relational Practice models that would potentially support strengths-based approaches.

The Pathway to Provision has been in existence for 11-12 years and the use of risk-based thresholds had meant a lot of onward referral or going back and signposting people.

Some other authorities were working on the idea of multi-agency front-door action based on need rather than risk thresholds and the SAIG held an initial workshop to explore what that would look like and how it would differ from what was being done currently and what that might mean for organisations.

A workshop session at the Partnership Forum included an input from Steve Walker, Director Strengthening Families Protecting Children Programme at Leeds City Council and this was followed up by a session at the SAIG which explored different organisations' perspectives.

Key actions to take forward

- ➢ Roll out of strengths-based approaches in child protection conferences and expansion of strengths-based practice to other areas of partnership work
- ➢ Further exploration of needs-led access to services

Priority 7 - Providing inclusive and accessible services to safeguard and promote the welfare of children

A review has been undertaken be undertaken of the Partnerships response to Female Genital Mutilation(FGM), so called honour-based violence, forced marriage, children, and families from abroad, ritual abuse and racist bullying.

The review included an appraisal of the current procedures and guidance, consultation with training leads from across the Partnership and discussions with representatives from the local authority and health organisations that had lead roles in relation to these issues.

With the exception of two areas of practice the current guidance and procedures appropriately addressed the issues concerned. Further work is underway to consider guidance on responding to ritual abuse and to consider whether further, more specific, guidance is needed in relation to racist bullying. Operational work in relation to FGM and so-called honour-based violence was well supported through the appointment of designated leads in a number of partner organisations.

Research undertaken through the Learning and Workforce Development Group and by the NSCP Training Coordinator has identified a number of potential options for strengthening the Partnership's training in relation to diversity and race. These include understanding and supporting diversity in safeguarding work with children and families, working with Black, Asian and minority ethnic children and families and unconscious bias training.

Key action to take forward

- NSCP Training Programme to be strengthened in relation to diversity and race

Review of the use of restraint within Clayfields

Clayfields House provides secure accommodation for up to 20 children and young people of either gender between the ages of 10 and 17 years of age. It is licenced by the Department of Education and inspected by Ofsted. The contract for the provision of services is reviewed through HM Prison and Probation Service and the Youth Custody Service. The NSCP is required to review the use of restraint at Clayfields House and include the outcome within its yearly report.

A comprehensive report and presentation have been provided to the Partnership by the Centre Manager and Independent Monitor providing details of the legal framework for Restrictive Physical Interventions, Data on the use of restraint, quality assurance governance and staff support. The SAIG agreed with the conclusions that:

- Staff are trained to a high standard using the Management of Actual or Potential Aggression (MAPA) form of physical intervention from the Crisis Prevention Institute.
- Internal and external monitoring of physical interventions are thorough, and the internal quality assurance regime is robust.

It should also be recognised that in the most recent Ofsted Inspection Clayfields House was judged overall as being good – including their health and protection arrangements.

Case reviews

There is a statutory requirement on safeguarding partners to conduct a 'Rapid Review' when serious child safeguarding cases are identified. The reviews should be completed within 15 working days and a report provided to the National Child Safeguarding Practice Review Panel (NCSPRP).

Nottinghamshire Rapid Reviews have continued to be subject of positive feedback from the NCSPRP. This is a reflection on the quality and timeliness of information provided for the review by all partners and organisations involved in the process and the support provided through the NSCP Business Unit.

"We thought that your rapid review was thorough with good practice identified and a number of single agency and partnership actions to take forward." (National CSPR Panel feedback)

Nottinghamshire is committed to learning as much as possible through Rapid Reviews. Only where it is necessary will a Child Safeguarding Practice Review be commissioned with the aim of further developing the findings from the Rapid Review. In their '*Annual review of LCSPRs and rapid reviews*' the NCSPRP used a Nottinghamshire Rapid Review and CSPR as a case example of good practice in relation to progression from Rapid Review to LSCPR.

What have we learned through Rapid Reviews?

The added vulnerability of children whose first language is not English and who are subject to abuse or neglect was highlighted by two reviews. The importance of effective communication with children and families and the use of language line and interpreters was recognised and actions in relation to this have been completed.

Sudden Unexpected Death in Infancy (SUDI) featured in two reviews. The findings from those reviews correlated with those in the National CSPR. In particular the added risk of SUDI for babies born to families with children already considered to be at risk of significant harm and the risk of co-sleeping when under the influence of drink or drugs. The work of the Safer Sleeping Group in relation to the national review 'Out of Routine' is described later.

Strong multi-agency working involving key partners including the Youth Service, Police Schools Liaison Officers and Safer Neighbourhood Teams in cases of children at risk of criminal exploitation (CCE) was recognised in two reviews. The value of targeted interventions on a geographical basis in areas with high levels of gang related violence/knife crime etc. in the form of Police led Neighbourhood Safeguarding

CASE REVIEW DECISIONS

A total of 8 Rapid Reviews undertaken

- 5 - no further review needed
- 3 – Child Safeguarding Practice Reviews (CSPR) commissioned

NSCPR agreed with the decisions of all 8 of the Rapid Reviews (100%) compared with 69% nationally

7 out of the 8 Rapid Reviews were completed within 15 days (87.5%) compared with 21% nationally

The quality of NSCP Rapid Reviews have continued to be subject of positive feedback from the NCSPRP

Learning from reviews is embedded in the NSCP Learning & Improvement Framework

Positive engagement with family members during CSPRs

1 CSPR (RN19) published following the completion of other parallel processes

Disruption meetings. Learning from those reviews was shared with the strategic contextual safeguarding group to build on good practice.

Abuse of children who are looked after was an issue in two reviews highlighting the need to ensure that good safeguarding practice continues beyond the point at which children are placed in care.

Whilst good practice in relation to strategy discussions was identified in some case there continues to be issues with the effectiveness of strategy discussions where a child is already open to children's social care. The work described earlier in this report is now focussing on this area of practice.

Actions taken as a result of Rapid Reviews

- A Local Authority Commissioning Officer now acts as a single point of contact for the Clinical Commissioning Groups in relation to children discharged from detention under the Mental Health Act. Joint working arrangements have been developed involving the LA and CCGs in respect of a review of Continuing Care for Children, particularly in relation to the assessment and response to "challenging behaviour."

- A standard approach and terms of reference for Primary Care Liaison Meetings has been agreed through work by Named GP, CityCare and NHCT 0-19 services. These meetings consider the needs of families where safeguarding concerns have been identified (commonly referred to as 'think family' or 'red card' meetings). These have been circulated to GPs and reinforced at GP safeguarding Lead workshops.

- Multi-agency Neighbourhood Safeguarding Disruption Meetings have been developed, led by Police Neighbourhood Policing Teams in geographical areas identified at high risk of youth violence associated with gangs.

- Communication aids when dealing with families whose first language is not English have been promoted with health practitioners.

- Learning from reviews has been fed into the strategy discussion workstream described earlier and this has included the introduction of a 'prompt' to ensure the Youth Justice Service is involved in strategy discussions when appropriate. Revised guidance and training to Police and CSC staff in relation to single and joint Section 47 enquiries leading to better decision making and more effective investigations.

- A new process has been introduced by NCC Education Department for monitoring and intervening when young people in the care of the Local Authority are at high risk of becoming Not in Education, Employment, or Training (NEET) with the aim of reducing such occurrences.

Actions taken in response to National Child Safeguarding Practice Reviews

1. It was hard to escape: Safeguarding children at risk from criminal exploitation

Work within NSCP to consider the recommendations of this review has been remitted to the Cross Partnership Contextual Safeguarding Strategic Management Group – further details of the work in relation to contextual safeguarding is included within the Partnership Priorities section.

2. Out of routine: A review of sudden unexpected death in infancy (SUDI) in families where the children are considered at risk of significant harm

The SAIG considered the learning from this review and agreed that work to develop the "prevent and protect" model for SUDI would be carried forward by the existing cross partnership "Safer Sleep Working Group".

The work is ongoing however early progress has been made. A benchmarking exercise against the review has been completed. The NSCP Pathway to Provision, thresholds document has been updated to reflect risk of SUDI at all levels. The NSCP/NCSCP Interagency procedures have been updated to include guidance related to the risks of unsafe sleeping. Child Protection Chairs have been briefed to include safer sleep as part of the Child Protection Plan for any unborn and infant under 1 year.

A 3-tier training plan is in development in line with the "continuum of risk" as outlined in the national review. The learning from review is also being disseminated across midwifery and Healthy Family Teams.

A mapping exercise has been completed to identify all current contacts where safer sleep advice is routinely provided in order to identify and fill any gaps. A Multi-Agency Risk Assessment tool for safer sleep is available via the interagency procedures and was highlighted as best practice in the national review.

Impact on outcomes –

Raising awareness that everyone can play a role in preventing sudden infant deaths – A Children's Social Care Worker used the knowledge gained via the training to successfully get a young mother and her baby re-housed. The tiny flat they were living in was not big enough to get her bed and the babies cot in the same bedroom and this indirectly encouraged "unsafe sleeping" practices. The Social Worker had learnt during the training that '*The safest place for your baby to sleep is a separate cot or Moses basket in the same room as you for the first 6 months, even during the day*'. This was not possible in the small flat and so the proactive action in getting the family re-housed allowed for mother and baby to sleep in the same room so reducing the risk of SUDI.

Key actions to take forward

- Three Child Safeguarding Practice Reviews commissioned during the year are ongoing and require completing
- Since the requirement to undertake Rapid Reviews was introduced (1st July 2018) Nottinghamshire has completed 23 reviews (as at 21/6/21) and a thematic review of those reviews is now planned for Autumn 2021 to support the dissemination of learning and inform future safeguarding improvement work
- Completion of the Safer Sleeping Working Group action plan

Multi-agency training, guidance, and procedures

Providing high-quality multi-agency training, linked to learning and improvement objectives.

Following the introduction of lockdown and social distancing measures due to the COVID 19 pandemic all training courses provided by the Partnership were redesigned and adapted to be delivered virtually. The first updated events started to be delivered in June 2020. Participation in training has increased with **2,840** practitioners attending virtual events this year compared with **2,346** attending face to face events in 2019/20. Completion of E learning modules has also increased significantly with **13,625** completions this year compared to **8,060** the previous year. New E learning modules were developed including:

- Child Criminal Exploitation and County Lines,
- Children Missing from Home and Care and
- What Makes a Good Quality MASH Referral?

Training provided through the partnership is directly related to the learning from case reviews, audits, inspections, and inquiries. The following provides some examples from the training programme delivered during 2020/21 along with impact evaluations

Harmful Sexual Behaviour training through virtual events has been provided to **197** practitioners. The training disseminated the learning from the Independent Inquiry into Child Sexual Abuse (IICSA), the findings from a local case review and areas for practice improvement from audits. The course content has been adapted to reflect the changes in availability of the Brook Traffic Light Tool with alternative resources signposted. Interagency guidance and procedures have been reviewed and updated to provide clarity on the continuum of sexual behaviours and appropriate responses. Prior to attending the course only **19%** of delegates described themselves as having good or very good knowledge of how to identify and respond to concerns of harmful sexual behaviour and this rose to **90%** after completing the course.

Training to raise awareness of child criminal exploitation (CCE), how to identify and respond to it, has been developed and delivered to **425** practitioners. The training incorporates the learning from; a national thematic review, a case review involving a Nottinghamshire child who died in another area and two Rapid Reviews (RR1/21, RR2/21). A local e learning module was also developed with **541** course completions during the year. Prior to attending the courses only **32%** of delegates described themselves as having good or very good knowledge of CCE and this rose to **87%** after completing the course.

NSCP TRAINING 2020/21

13,625 E learning courses completed

2,840 practitioners attended virtual training events

Courses redesigned and adapted to be delivered virtually from June 2020

Responsive to the current concerns about safeguarding children

Impact of lockdown on children incorporated into courses

Harmful Sexual Behaviour Training adapted

Child Criminal Exploitation training introduced both virtual events and a new e learning module

Course evaluations demonstrate significant increases in knowledge and confidence in dealing with issues as a result of attendance

Virtual seminars on learning from case reviews

Cross partnership support for the delivery of training with 35 colleagues delivering events

Neglect training has been provided through virtual events to **207** participants. Neglect continues to be the primary reason for children in Nottinghamshire being on a child protection plan. An external expert is commissioned to deliver this training which will be further developed as part of the Partnerships new Child Neglect Strategy. Prior to attending the courses only **38%** of delegates described themselves as having good or very good knowledge of neglect and this rose to **97%** after completing the course. E learning related to awareness of abuse and neglect has **2,253** module completions with a further **642** completions of the more in-depth module.

Working Together to Safeguard Children is the core training course to develop multi-agency safeguarding work. Delegates on the 12 courses that were held during the year were asked about their levels of knowledge & skills relating to working together effectively – prior to the course **33.7%** rated themselves as good/very good, which then improved to **93.3 %** after completing the course.

"I had knowledge of the pathway to provision and multiagency working but had gaps in my knowledge. This course definitely helped to fill these gaps in and made everything very clear" – delegate who attended a Working Together course

Whilst the amount of training provided has increased compared with the previous year the pandemic does appear to have adversely affected the availability of health staff to attend courses with a **50%** reduction which is unsurprising in view of the extraordinary demand on those services.

Key actions to take forward

- Plan for option to include some face to face events or blended events when circumstances allow
- Develop training options in relation to understanding and supporting diversity in safeguarding work with children and families, working with Black, Asian and minority ethnic children and families and unconscious bias training
- Further strengthen use of Rapid Reviews as a resource for disseminating learning

Strategic Priorities for 2021 -2023

Moving forward, the priorities for the NSCP have been reviewed and re-aligned to provide a more strategic focus:

Priority 1 Understanding and developing the role of the Safeguarding Partnership in evolving system arrangements

Nottingham and Nottinghamshire Integrated Care System (ICS) is a partnership between the organisations that meet health and care needs across our area and which now includes Bassetlaw. The ICS seeks to coordinate services and to plan in a way that improves population health and reduces inequalities between different groups. Nottinghamshire Safeguarding Children Partnership will seek to understand and develop its role within the context of the ICS to safeguard and promote the welfare of children.

Domestic abuse is a cross-cutting issue which has a significant impact on children at risk of harm. New legislation, the Domestic Abuse Act 2021, places statutory duties on agencies which will be overseen by Domestic Abuse Local Partnership Board and the NSCP will work with strategic partners to support work to protect those affected by domestic abuse.

Enablers

- Ensure safeguarding priorities are considered in the development of the Integrated Care Partnership and the strategic plan.
- Increased coordination and working with other strategic partnerships to maximise impact.
- Engagement with and representation on the Domestic Abuse Local Partnership Board

Priority 2 Preventing abuse and neglect

Child neglect has a lifelong impact on a person's wellbeing, and it is vitally important that as a Partnership we do all we can to prevent it. All partners should ensure that neglect and the impact of neglect on children is understood and identified. Good quality multi-agency support and intervention should be available and make a difference for children experiencing neglect.

We are committed to working together to ensure children, young people and families receive the right support at the right time. We know that timely support provided early in the life of the child, or soon after the emergence of a problem, prevents problems escalating and maximises opportunities for children to thrive. Early Help Services function as part of a complex system of universal, targeted and specialist support which works together with families and networks and we have set out priority areas to improve those services for children and families in Nottinghamshire.

Everyone has a responsibility to help prevent child abuse and neglect. We will work to broaden the reach, and increase the influence, of the safeguarding arrangements in faith groups, sports clubs, and the voluntary sector to support them to identify and respond to abuse and neglect.

The NSCP will develop restorative and relational strengths-based practice to work with children, young people and families. We will explore options for multi-agency front-door action based on need rather than risk thresholds and look at how multi-disciplinary/agency teams could better safeguard children and young people.

Enablers

- Nottingham & Nottinghamshire Child Neglect Strategy 2021-2024
- Nottinghamshire Early Help Strategy 2021-2025
- Development of strengths-based approaches

- Faith groups, sports clubs, and the voluntary sector action plan
- Alignment of responses to child exploitation and extra familial harm across the two children's safeguarding partnerships and further explore opportunities for integration of current pathways

Priority 3 Improving safeguarding practice

The Partnership will utilise its Performance Management Framework to identify areas of safeguarding practice to focus improvement activities. Having identified areas for development it will coordinate a partnership approach towards practice improvement and monitor the impact that work is having on outcomes for children and families. The NSCP Training Programme will be integral to this work, responding to the learning needs of the multi-agency workforce and supporting practitioners to work together effectively.

Enablers

- Rapid Review Thematic Analysis
- Developing understanding of diversity when working with Black, Asian and minority ethnic children and families in a safeguarding context
- Strategy Discussion Working Group Action Plan
- Child Protection Conference Participation Action Plan
- Safer Sleeping Working Group action plan
- Harmful Sexual Behaviour Steering Group

Rosa Waddingham (NSCP SLG Chair)

Colin Pettigrew

Nicola Ryan

Peter Quinn

Addendum to NSCP Annual Report.

Independent Scrutineer Overview

I am very pleased to see that despite another year that has been greatly circumscribed by the pandemic, that safeguarding in Nottinghamshire continues to be consistently and safely delivered by the Partnership, as evidenced in this annual report.

From my independent perspective I can confirm that this report is a fair reflection of what I have seen directly over the past year, and would take this opportunity to thank officers at all levels and across the Partnership as a whole for their outstanding commitment and professionalism in unprecedented circumstances.

I will go on here to outline a small number of circumstances I have selected from a much wider pool, that I feel are especially indicative of the health of the Partnership in Nottinghamshire, that also represent positive developments over the course of the last year, before going on to look briefly at some of the issues that face us in the course of the next.

1. Completing Rapid Reviews (RR's) and Local Child Safeguarding Practice Reviews (LCSPR's) are both statutory responsibilities for the Partnership, and must be completed to strict deadlines, be of high quality and are the subject of national scrutiny. It is also essential that RR's and LCSPR's focus on learning and improvement, such that safeguarding practice in Nottinghamshire is both reflective and responsive, and the Partnership can grow and develop smartly.

   I have directly observed the rigor and sensitivity with which RR's and LCSPR's are taken forward in Nottinghamshire; deadlines are adhered to, a clear focus is evident on learning and feedback from the National body continues to be positive and complementary.

   But more than this I have seen willingness on the part of all involved to use these opportunities to think creatively, and keep the wellbeing of children and young people in the County at the centre of all our safeguarding activity. What is exceptional here, I would suggest, is that all this is done on the basis of a truly multi-agency perspective, without evident single agency agenda or defensiveness. A sign, I would argue, of a mature and engaged Safeguarding Partnership.

2. I talked, in the annual report last year, about the response to Covid 19 with respect to safeguarding in Nottinghamshire, so I will not repeat those observations here. Other than to note that, despite the length of the emergency and the understandable tiredness of staff; safeguarding continues to be a high priority, is being addressed through creative use of all available technology and new ways of working and has served to draw the Partnership together in an unprecedented way.

3. The Executive of the NSCP effectively drives the safeguarding agenda in Nottinghamshire; selecting priorities, signing off on RR's and LSCPR's and perhaps most importantly serving as a forum in which senior officers from the three agencies with statutory safeguarding responsibilities, can develop an overarching orientation to safeguarding that is the genesis of Partnership working.

   Chairing of the Executive has recently rotated to Health (with Rosa Waddingham taking over from Colin Pettigrew) and new Police representation is also now in place (Peter

Quinn), again these changes are indicative, I would suggest, of a mature and balanced Partnership

4. Over the past year I have negotiated with Police and Health Colleagues to extend the 'apprenticeship' scheme offered to Looked After Children (Our Children) to incorporate additional opportunities in the Police and Health, which opens up significant opportunity for this most disadvantaged of groups. I was most impressed with the positive and collaborative attitudes I encountered in this process, to the extent that it seemed I was 'pushing against an opening door'. This development, and shared sense of responsibility, speaks volumes about the health of the Nottinghamshire Partnership, and about a common commitment to 'do better' for Our Children.

Challenges for the Future

I will be looking at children placed in residential schools and unregulated children's homes (including semi-independent accommodation) over the next year. The impact of the pandemic has made it very difficult to progress this agenda remotely as I had wished, but it is my hope as restrictions ease, to progress this directly. I will liaise with my opposite number for the City of Nottingham (Liz Tinsley) to bring a joined-up approach to this matter if at all possible.

Secondly, as we emerge from the strictures of the pandemic, a delicate balance needs to be struck between maintaining much of the creative developments put in place (especially with regard to better use of technology) whilst also 'getting back' to direct contact and engagement with families and children.

I am also minded, to consider the possible impact of remote (home) working on opportunities for the sort of 'soft supervision' and professional reflection that working together in a shared office space permits.

It promises to be a busy year, and I look forward to meeting as many of the individuals involved in safeguarding across the County as possible.

Dr. Mark Peel

Independent Scrutineer NSCP

August 2021