Nottinghamshire Safeguarding Children Partnership

Annual Report 2018/19

SAFEGUARDING CHILDREN ARRANGEMENTS FOR NOTTINGHAMSHIRE

Version 1.0

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Essential information

This report has been compiled on behalf of the Nottinghamshire Safeguarding Children Board (NSCB) and Nottinghamshire Safeguarding Children Partnership (NSCP) by Steve Baumber, Service Manager, Partnerships and Planning. It has been produced in consultation with members of the Safeguarding Assurance & Improvement Group and approved by the Strategic Leadership Group. The content is drawn from the work of the NSCB & NSCP and their supporting groups including; reports presented to those groups; records of meetings; multi-agency audit findings; s.11 self-assessments; and the findings from serious care reviews and other forms of case review.

The report will be published in October 2019 and will be a public document.

For further information about the content of this report or the work of the NSCP please contact the NSCP office on 0115 9773935 or by email info.nscp@nottscc.gov.uk or visit the website at https://www.nottinghamshire.gov.uk/nscp

Introduction by the Independent Chair of the NSCB

Welcome to the 2018/19 Annual Report for the safeguarding children arrangements in Nottinghamshire.

The past year has seen significant developments in the way that safeguarding children work is coordinated in Nottinghamshire. In June 2018 statutory guidance[1] was introduced which required the implementation of new safeguarding arrangements, jointly led by Local Authorities, Clinical Commissioning Groups and Police, to replace Local Safeguarding Children Boards (LSCBs). Work had already commenced in Nottinghamshire to develop a new approach for agencies to work together under a 'Partnership' and we were well placed to respond to these requirements. In doing so we followed a principle that the strengths of current arrangements should be maintained, whilst using the flexibility of the new guidance to address the challenges of coordinating safeguarding in a large county and, in particular, from an increasing range of threats facing children in their social environment.

Nottinghamshire began the transition to the new arrangements at the beginning January 2019. This was completed in March 2019 and the Nottinghamshire Safeguarding Children Board (NSCB) was disestablished, having completed all its work in relation to the Serious Case Reviews it had commissioned.

This report details the work of the NSCB over the past year, the development and implementation of the new safeguarding arrangements and a summary of the activities undertaken by the Nottinghamshire Safeguarding Children Partnership since its formation. In doing so it fulfils the requirements for me to provide an Annual Report as Independent Chair of the NSCB and for the Safeguarding Partners to provide a Yearly Report.

Revised statutory guidance in relation to child death reviews was also published during the year. This passed responsibility for the review of child deaths from the Independent Chair of the LSCB to the 'Child Death Review Partners[2]'. A joint Nottinghamshire/Nottingham City Child Death Overview Panel (CDOP) was formed in response to the new guidance. The annual report of the CDOP (in relation to Nottinghamshire reviews) has been incorporated into this report whilst further work around the governance arrangements is progressed.

In addition to preparing for the new arrangements, the last year has seen a wide range of work undertaken to promote continual improvement in the safeguarding children arrangements for Nottinghamshire. As we strive for excellence there will always be more to do but I am satisfied that organisations are overall working effectively to keep the children and young people of Nottinghamshire safe.

The disestablishment of the NSCB could be seen as the end of an era, and there will certainly be occasions some of us will fondly look backwards whilst grappling with new challenges. But it also presents us, wherever we figure in the new arrangements, with an opportunity to refresh our thinking, and our commitment to ensuring that Nottinghamshire children remain as well safeguarded as possible. In this regard I am pleased that the safeguarding partner organisations have taken this opportunity, demonstrating real commitment to the new safeguarding arrangements and providing effective joint leadership of these through and beyond the implementation period.

[1] Working Together to Safeguard Children 2018

[2] Clinical Commissioning Groups and the Local Authority

Direct involvement of a wider range of agencies in the new arrangements has also been welcomed across the partnership and early indications are that this will increase the effectiveness of partnership working, and the services which the agencies deliver.

Finally, as this will be my last report as Independent Chair of the NSCB, I would like to thank all of the many people who contributed to Board's work over the last 12 years and to wish you all the best for the future.

Chris Few

Independent Chair/Independent Scrutineer

Nottinghamshire Safeguarding Children Partnership

Vision and values

In developing the new safeguarding arrangements, 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.

Safeguarding partners

The safeguarding partners that took over responsibility for the safeguarding arrangements in Nottinghamshire from 1st January 2019 are:

- Nottingham and Nottinghamshire Clinical Commissioning Groups
    - NHS Nottingham North & East CCG
    - NHS Nottingham West CCG
    - NHS Rushcliffe CCG
    - NHS Mansfield and Ashfield CCG
    - NHS Newark and Sherwood CCG
- NHS Bassetlaw Clinical Commissioning Group
- Nottinghamshire County Council
- Nottinghamshire Police

Development of the new arrangements

The Children and Social Work Act 2017 introduced a new duty on three agencies, namely the local authority, the chief officer of police and clinical commissioning group (together referred to as the 'safeguarding partners'), to make arrangements for safeguarding and promoting the welfare of children in the area.

Senior representatives from the 'safeguarding partners' for Nottinghamshire and the NSCB Independent Chair, first met in November 2017 to start planning for the development of new safeguarding arrangements. It was agreed that options for the new arrangements should be developed and the NSCB was updated in December 2017 of the proposed plan. In February 2018 the

safeguarding arrangements options were presented to the 'safeguarding partners' and NSCB Independent Chair. The options report included: -

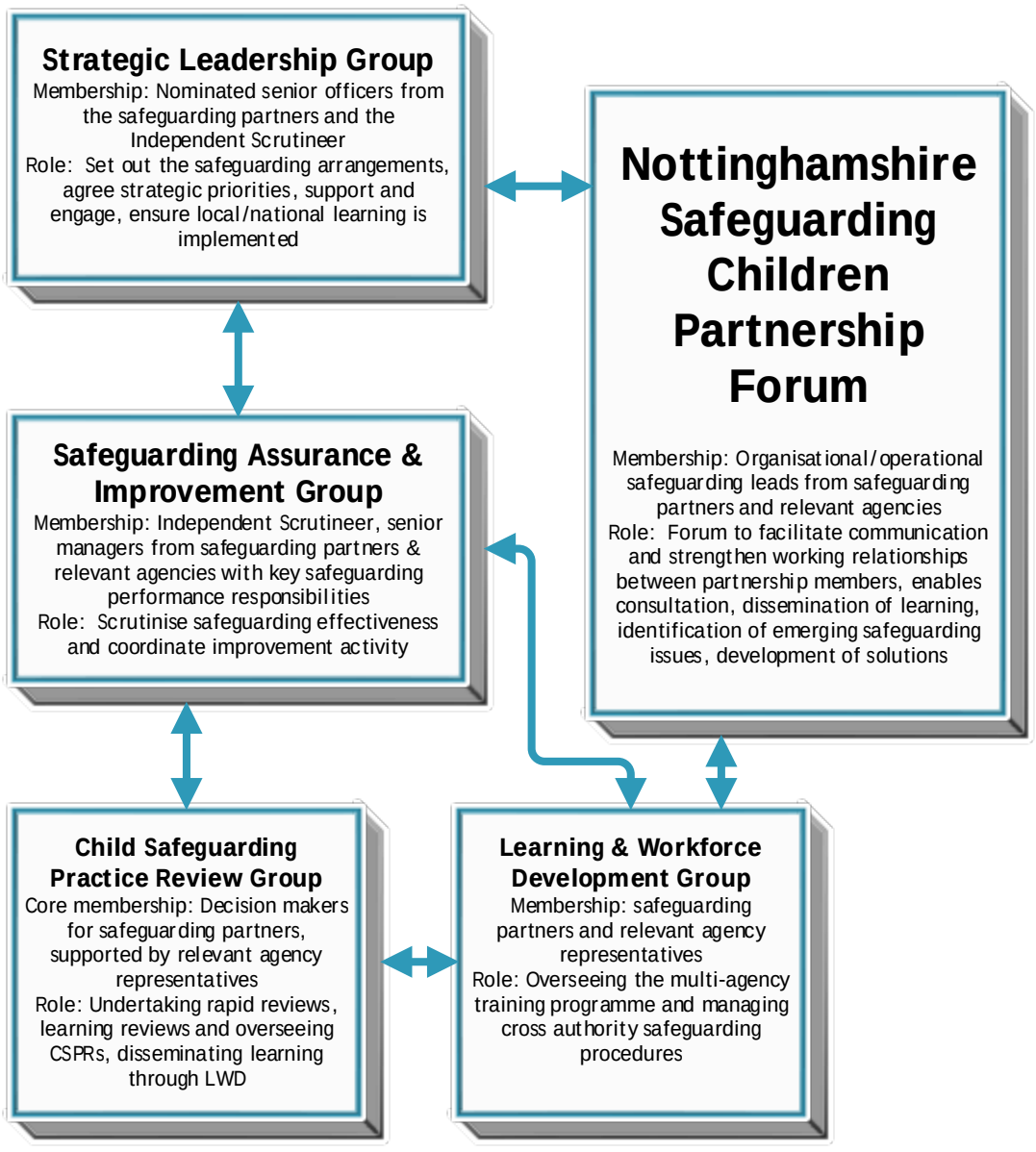
- A comparison of LSCB functions against the new safeguarding arrangements
- An assessment of the strengths and weaknesses of the NSCB – including consideration of the more general findings of the Wood Review
- Consideration of the 'Early Adopters' proposals outlined on the Association of Independent LSCB Chairs website
- Four potential models including variants in relation to geographic footprint and scrutiny arrangements

The group selected a preferred option for further development and this was consulted on with the NSCB through a workshop session in March 2018. The feedback received was then used to develop greater detail around the preferred option. Working Together to Safeguard Children 2018 and accompanying transitional statutory guidance was published in June 2018 and this set out the requirements for the new safeguarding arrangements and the timetable for implementation. Further consultation took place with the NSCB Executive and in September 2018 the proposed safeguarding arrangements were presented to the NSCB to consider how best organisations could contribute and be part of them.

A small working group was then formed to draft the safeguarding arrangements document which was agreed and published on 27th December 2018. The arrangements are set out in a document which can be found at https://www.nottinghamshire.gov.uk/nscp/about-the-partnership

Structure of the new arrangements

Nottinghamshire Safeguarding Children Partnership



Key features of the new arrangements: -

- For the first time three agencies (CCGs, police and the local authority) have joint and equal accountability for safeguarding children in Nottinghamshire
- The Safeguarding Partners, through the Strategic Leadership Group (SLG), are central to the arrangements
- The new arrangements provide a rationalised model under which partners can work together to improve safeguarding
    - The Partnership Forum – provides a means of communication, consultation, coordination and networking with a wider range of organisations and greater connectivity with operational managers
    - The Safeguarding Assurance and Improvement Group (SAIG) – responsible for scrutiny and the coordination of improvement activity with senior representatives from the safeguarding partners and relevant agencies
    - Child Safeguarding Practice Review Group – undertakes 'Rapid Reviews', makes decisions on the need for Child Safeguarding Practice Reviews and oversees any that are undertaken, has flexible meeting arrangements to meet the timescales for reviews
    - Learning & Workforce Development – overseeing the multi-agency training programme and cross authority interagency procedures and ensuring connectivity between the two
- An Independent Scrutineer ensures that the SAIG fulfils its functions effectively and with integrity, acts as a critical friend to the SLG, is an advisor to the safeguarding partners in relation to case reviews and provides an annual assessment of the safeguarding partners leadership of the arrangements
- Greater engagement with schools with five Designated Safeguarding Leads from schools and the Safeguarding Children in Education Officer, attending the Partnership Forum
- Representatives from the Safeguarding Partners lead each group and the SLG member is responsible for linking in with them

Implementation of the new arrangements

The implementation period for the Nottinghamshire Safeguarding Children Partnership began on 1st January 2019. The Department for Education confirmed that the arrangements were compliant with statutory guidance and legislation on 9th January 2019. The SLG met on 16th January 2019 and formally agreed to take over responsibility for case review decisions. The last remaining serious case review (KN15) under the NSCB was published on 19th March 2019 and accordingly the NSCB was disestablished in line with the Working Together Transitional Guidance.

All the groups under the new structure are now active and have taken on their new responsibilities. The arrangements will be reviewed to ensure that the new processes are embedded and working effectively and to respond to learning from the Early Adopter Programme which is being supported by the National Children's Bureau https://www.ncb.org.uk/what-we-do/our-priorities/vulnerable-children/projects-and-programmes/safeguarding-early-adopters.

Finance

The work of the NSCB/NSCP during 2018/19 was funded by:

- contributions from partner agencies
- income generated through training and safeguarding checks
- direct funding of specific posts by Nottinghamshire County Council and the Nottinghamshire County Clinical Commissioning Groups

Partner Contributions		
Nottinghamshire County Council*		£151,848
National Probation Service		£1,647
DLNR CRC Ltd		£1,765
Police		£17,612
CAFCASS		£550
NHS Bassetlaw CCG		£19,253
NHS Nottinghamshire County CCGs:		£64,404
*Includes £7,000 from Education and Inclusion on behalf of schools and £2,000 from Early Years on behalf of childminders		**£257,079**

NB. The contributions have remained the same for the past ten years or reduced in some cases

Income generated	
Training Fees	£3,540
Training non-attendance charges	£5,890
Safeguarding Information Management Team (SCIMT) safeguarding checks	£8,295
	£17,725

Charges for training and safeguarding checks relate to non-partner agencies. Non-attendance at multi-agency training events without notice incurs a charge.

The following table sets outs expenditure in relation to the safeguarding work undertaken by the NSCB/NSCP:

NSCB/NSCP Budget Expenditure			
Support costs	Administration & Independent Chair	£43,411	
	Meeting venues	£590	
	Stationery/provisions	£396	
	Interagency procedures	£3,250	
	Communications	£4,200	
	Home Start	£2,400	
	Association of Independent LSCB Chairs	£1,500	
			£55,747
Training provision	Staff costs	£78,074	
	Venues	£9,442	
	e-learning	£4,403	
	Specialist Providers	£7,700	
	Photocopy & Printing	£708	
			£100,327
Serious Case Reviews	Lead Reviewer & room hire		£6,982
Safeguarding Children Information Management Team	Staff costs		£66,709
Sub total			**£229,765**
Child death review and case review support**	NSCB Development Manager & Child Death Administrator		£81,769
	Child death development work		£4,200
Partnership support***	Service Manager Partnerships and Planning		£64,365
Total			**£380,099**
****funded by NCC** *****funded by NCC/Notts County CCGs**			

Summary of partnership activities

Contextual safeguarding

Working Together to Safeguard Children 2018 refers to threats to children and young people from outside the family home under the term 'contextual safeguarding', reflecting the work undertaken by the University of Bedford, and others, in this area of practice. Contextual safeguarding covers a broad range of extra familial threats which may overlap including; exploitation by criminal gangs and organised crime groups such as county lines; trafficking; online abuse; sexual exploitation and the influences of extremism leading to radicalisation. Some of these issues have previously been the focus for practice development in Nottinghamshire with oversight by the NSCB (e.g. child sexual exploitation) however the inclusion within Working Together 2018 has prompted further attention by the partnership on wider environmental risk factors.

In September 2018 an overview of contextual safeguarding was provided to the NSCB with a summary of the key issues for consideration. A review was subsequently undertaken of the arrangements in place to respond to extra familial threats to identify potential gaps or areas for improvement. At the same time existing workstreams were progressing and these were drawn together and presented as an update to the SAIG (March 2019) and Partnership Forum (June 2019). A recent initiative that has been included within this workstream is the creation of a Youth Violence and Child Exploitation Panel which started as a pilot in January 2019 and has now been evaluated and established permanently. The panel meets monthly to consider complex cases requiring more intensive intervention. The operation of the panel is developing and a multi-agency steering group has been formed to oversee this work.

The Learning and Workforce Development Group has undertaken an assessment of the multi-agency and single agency training available in relation to contextual safeguarding issues. The NSCP training programme for 2019/20 will respond to any training needs identified in relation to extra familial risks.

The Partnership has also supported the work led by the Police and Crime Commissioner and the development of a Knife Crime Strategy.

It should be noted that Nottinghamshire agencies are contributing to a serious case review led by Waltham Forest LSCB which in turn will feed into the first national child safeguarding practice review that is examining the theme of adolescents in need of state protection from criminal exploitation.

Child Sexual Exploitation (CSE)

The Cross Authority CSE Group (CSECAG), chaired on behalf of the partnership by the Detective Chief Inspector, Public Protection Lead for Children, has continued to lead on developing and improving the response to child sexual exploitation. The group is well established, and practice has been developed over several years. A Multi-Agency Sexual Exploitation panel is operating which provides enhanced case management for more complex cases and a system for gathering intelligence (Operation Striver) is in place which supports the early identification of potential sexual exploitation risks in the community.

In October 2018, Nottinghamshire Police completed a CSE Problem Profile and Threat Assessment following on from the strategic overview produced in September 2017. The profile and assessment used a variety of data sources to identify the threats and vulnerabilities in relation to CSE in Nottinghamshire with the purpose of guiding police and partner agencies direction of resources, investigations and decision making. Specific areas of activity were detailed including the methods employed to tackle CSE, such as the police CSE Disruption Team which had proved to be a successful tactic. Gaps in intelligence were also identified and where possible further information will be sought. The key inferences drawn in the Threat Assessment were that in future years the majority of offences will be online or cyber enabled with offence totals increasing.

Harmful Sexual Behaviour (HSB)

Following on from the HSB audit in January 2018 work has continued to develop and improve practice when responding to concerns about children and young people sexually harming others. Specialist training has been commissioned and attended by relevant practitioners from Social Work Teams, Family Service and Youth Offending Team. In addition, multi-agency training events have been delivered and guidance for practitioners was revised and improved. A multi-agency HSB Steering Group was established to develop a Harmful Sexual Behaviour Panel where cases of children with sexually abusive behaviour are presented and consistency of assessment and intervention is assured. The number of cases assessed doubled (30) in the first six months of the panel operating compared to the previous six months (14) indicating that awareness had been raised and more cases where there is harmful sexual behaviour are being identified and assessed.

HSB interventions have improved because of training that has enabled staff to better identify needs, build interventions and sequence delivery with young people who have carried out HSB. The CAMHS 'Head 2 Head' Service has been re-commissioned to undertake direct work with young people who have carried out HSB with a fast and robust referral route directly from the HSB Panel.

A review of the panel was undertaken in September 2018 which identified some administrative improvements that would improve the operation of the panel. In November 2018 an audit of 10 cases that had been presented to the panel took place. The audit noted that delays in the presentation of some cases to the panel were due to uncertainty around the panel process. Representation on the panel by partner organisations was good with standing panel membership. Excellent assessments with appropriate use of specialist HSB tools were evident. Clear recommendations regarding future interventions were documented in the panel meeting minutes for all the cases. Overall the auditors noted practice improving over the period covered by the audit with more consistent assessments and plans for intervention being developed in the later cases. Recommendations to further improve practice were identified and will be monitored by the HSB Steering Group.

Youth violence

The Partnership recognised that violent and weapon enabled crime is a complex and emerging issue requiring a multi-agency response. An audit learning event was commissioned through the Multi-Agency Audit subgroup of the NSCB to consider how well partners are working together to identify, prevent and manage risks.

A sample of 13 cases were selected for audit including young people that had been named as either the aggrieved party or the suspect in a knife related incident reported to the police. The Learning Audit identified several areas for development including; training and awareness raising which should include the identification and assessment of risk, intervention toolkits and pathways. The findings from the Learning Audit were presented to the Safeguarding Assurance and Improvement Group in March 2019 and the multi-agency Youth Violence and Criminal Exploitation steering group is taking forward the recommendations from the audit.

Historical and non-recent abuse, Operation Equinox, and the Independent Inquiry into Child Sexual Abuse (IICSA)

Nottinghamshire County Council and Nottinghamshire Police have been working together to respond to concerns and disclosures of non-recent abuse made by previously Looked After Children. A dedicated police team was established to investigate allegations of abuse, primarily in children's homes, under the operational name of 'Equinox' and social workers have worked closely with them to coordinate their responses. This work is overseen by a Strategic Management Group (SMG) on behalf of the NSCB and Nottingham City Safeguarding Children Board.

The Independent Inquiry into Child Sexual Abuse (IICSA) included 'Nottinghamshire Councils' as one of its line of investigations to consider the experience of victims and survivors and examine the scale and nature of the abuse that may have taken place under the care of the relevant authorities. The Inquiry is exploring how public authorities responded to allegations that children were being sexually abused and is seeking to identify any common themes and failings. Partner organisations in Nottinghamshire have been supporting the Inquiry through the provision of information and statements. The NSCB has received regular updates through the SMG on both Operation Equinox and IICSA.

The NSCB Chair's decision to undertake an independent review in to abuse within Nottingham and Nottinghamshire children's homes was pended following the announcement by IICSA of the inclusion of the issue within the scope of that inquiry. This decision will be reviewed when IICSA has reported its findings in full.

Following publication, the wider interim report by IICSA was considered by the NSCB in June 2018. The four recommendations within the report were reviewed to ensure that any necessary local response was in place.

The IICSA Public Hearing in respect of the 'Nottinghamshire Councils' investigation started on the 1st October 2018 and ended on 26th October 2018. The NSCB Independent Chair and senior representatives from partnership organisations provided evidence to the Inquiry. IICSA published the report their findings on 31st July 2019 and the partnership is overseeing the response of organisations and ensuring that the learning from the review is disseminated.

Nottingham City Council, Nottinghamshire County Council and Nottinghamshire Police are reviewing their own learning from the preparation and participation in the Inquiry. The views of the survivors as represented to the Public Hearing were collated and brought to the attention of NSCB members, in particular: -

- the importance of being believed,
- access to therapy,
- access to justice,
- the lifelong impact on the survivors and
- the importance of apologies and contrition from the relevant organisations

The County Council, the police and health colleagues have been committed to supporting the local support group for victims and survivors. Multi-agency funding has been provided to establish discrete posts to provide improved support for victims and survivors and work is ongoing to strengthen services to victims and survivors of childhood sexual abuse.

The County Council has reviewed its approach to responding to civil claims where the nature of the claim relates to childhood abuse. A review has been undertaken of the 'Rota Visit' system that was in place for Elected Members to assure themselves of the safety and quality of provision of residential care for looked after Children. As a result, the system has been withdrawn and Rota Visits have ceased. In its place a Governance Board has been established led by Elected Members and with cross-party representation alongside senior professionals from multi-disciplinary backgrounds. The Board strengthens the input/oversight of members and is responsible for ensuring that the six children's homes operated by the local authority have a clear sense of purpose, a vision for the future and are safe places for children to live. The Board is also responsible for ensuring that the views of children and young people receiving care are considered in the development of services.

The process for notifying the Lead Member for Children's Services and other Elected Members of relevant incidents was strengthened by the adoption of a formal protocol. The protocol includes the criteria for incidents to be notified and sets out the notification and dissemination process.

In April 2019, a decision was made by Nottinghamshire Police to formalise Operation Equinox into a permanent team.

This team has a wider 'terms of reference', but in general, is an historic abuse team where the perpetrator is in a position of trust.

The new terms of reference (TOR) for Equinox is to capture all non-recent abuse allegations where:

- Offender is in a Position of Trust (does not include familial abuse)
- Offences reported by a complainant aged 18 years and above
- Allegations are reported over a year since the occurrence
- Offences fall within the Sexual Offences Act or are historic physical abuse.

Looked After Children (LAC)

Nottinghamshire County Looked After Children and Care Leavers Partnership Strategy

This strategic partnership is led by the County Council and sets out a shared vision and ambitions for how we care and provide support for LAC and care leavers.

Nottinghamshire Children in Care (CIC) Service Improvement Forum (SIF)

The Nottinghamshire CIC Service Improvement Forum was established in December 2016 to implement/continue the CIC health pathway review work/suggestions. The objective of the Service Improvement Forum is to be a system where partners hold themselves to account through an outcomes framework delivering care and meeting health needs of CIC. This forum continues to meet quarterly. A working action plan is overseen by the CIC health Commissioners and designated CIC professionals. This is a County wide forum with agreement to commitment from both the City and County Local Authorities, CCGs and health providers. Working groups have been established to help support the actions in the plan.

Key work streams identified from the SIF include;

1. Out of area pathway to be embedded and reviewed and the CAMHS element to be included
2. Other local authority children pathway to be embedded and reviewed and the CAMHS element to be included
3. Agreement and implementation of the "Decliner pathway" for those young people refusing a statutory health assessment
4. Further work to be undertaken to consider "hard to reach groups" such as those young people who do not engage, UASC and those in secure accommodation
5. Further work to be undertaken to review process for those children and young people categorised as CIC due to the time needed for respite/short breaks
6. Further work to be undertaken to review process for those children and young people categorised as CIC due to being on remand; linking with specialist nurse for the Youth Offending Team

Emotional Health

A year-long 'Integrated Personal Commissioning' pilot for Looked After Children and care leavers (0-25) with mental health needs was launched operationally within Nottinghamshire in April 2018. A Memorandum of Understanding is in place with NHS England, who have provided funding and oversee progress of the pilot.

Nottinghamshire is one of seven sites nationally piloting this model, which aims to further health and social care integration, promote person-centred planning, and identify effective support measures for children and young people with mental and emotional wellbeing needs (outside of CAMHS), via the use of personal health budgets.

A working group has been established from the SIF to work on actions that will further support the emotional health of looked after children. These actions include reviewing process for managing those children and young people placed out of area.

Unaccompanied Asylum-Seeking Children (UASC)

Since the implementation of the National Transfer scheme in July 2016, revised practice guidance, documentation and pathways have been implemented.

The majority of these young people are aged over 17 years and only receive an Initial health assessment before leaving care. They then receive health services as would any other adult. Many are placed in Nottinghamshire by other local authorities. Further discussion is required to understand the support that these young people receive, particularly on leaving care.

Care Leavers

All actions from a CCG led workshop held in July 2017 to review services commissioned, identify gaps and/or consider alternative ways of improving support around health for care leavers have now been fed into the Service Improvement Forum action plan. A further working group is being established from the SIF to take additional actions forward and consider transition to adulthood.

A distribution of "important health information" pathway has been written by designated CIC professionals and agreed by health providers and Nottinghamshire and Nottingham City Councils in 2018. This pathway was implemented on 1st October 2018. It is currently being audited. Quality assurance of the "important health information" has been included within the health provider and CCG audit programmes.

Raising awareness around the needs of care leavers has been undertaken over the past 12 months by including information in health provider safeguarding children training slides, GP training events, CCG newsletters and liaison with the Nottinghamshire Safeguarding Adults Board.

The Local Offer for Care Leavers was published on 1st April 2019. The offer, produced by Nottinghamshire County Council and the District and Borough Councils, sets out the services and support that are available when a young person is leaving care. Designated health professionals have also contributed to the health element of the offer. www.nottshelpyourself.org.uk/careleaverslo,

Child sexual abuse and listening to children

The NSCB used one of its development sessions to look at how to interpret behaviour and responses of children who may have been sexually abused, this followed up learning from a previous case review and emerging findings from IICSA. An input was provided by a survivor of sexual abuse who described opportunities in her childhood when practitioners may have been able to pick up indicators of abuse and respond differently. Specialist services provided a reminder of theoretical frameworks for sexual abuse and highlighted the impact on children of abuse. Details were provided of the counselling and support services that can now be accessed directly through the East Midlands Children and Young People's Sexual Assault Service at the Queens Medical Centre, Nottingham.

CP-IS go-live

In June 2018, Nottinghamshire went live with the Child Protection – Information System (CP-IS) following a significant amount of work by representatives from Nottinghamshire County Council and health partners under the Nottinghamshire CP-IS Project Board. CP-IS is an NHS England sponsored programme aimed at improving the availability of information for health practitioners about children at risk or in care of the local authority. The NSCB supported the local implementation project which has coordinated the extraction of child protection information from the local authority system and

then data matching with NHS records. The CP-IS system enables health practitioners in unscheduled care settings to identify if a child visiting their service is looked after or has been on a child protection plan in Nottinghamshire within the preceding 12 months. Positive checks are automatically notified to children's social care and if the case is open the social worker for the child is made aware that the child has visited an NHS service.

This new system enhances information sharing across the partnership and the expected positive benefits will be monitored under the new safeguarding arrangements.

Young people detained under s.136 Mental Health Act

A working group involving Nottinghamshire police, NHS Nottingham City CCG, the Integrated Commissioning Hub, Children's Services, the Approved Mental Health Professionals (AMHPs) team and Nottinghamshire Healthcare NHS Foundation Trust have driven forward actions to address recommendations arising from an NSCB audit. The audit looked at the experience of young people detained under s.136 Mental Health Act.

Arrangements have been put in place for each s.136 incident to be reviewed by a Local Authority Service/Assistant Director to ensure that a lead professional is in place to coordinate support and care and to ensure that there is an understanding of the issues that led to s.136 and how recurrence can be prevented. The Service Director also took responsibility for communicating with other local authorities who place a young person in this area the need to undertake actions as part of the discharge planning process. A programme of training, 'REACH', was commissioned to train staff across the partnership on responding to young people who have experienced Adverse Childhood Experiences (ACEs). Arrangements have also been put in place for the AMHPs assessment/report to be shared with the Service Director and Child and Adolescent Mental Health Services (CAMHS).

The new Hopewood Unit opened providing the first dedicated specialist eating disorder inpatient service and first Psychiatric Intensive Care Unit (PICU) for young people in the East Midlands. There is an ongoing challenge in relation to young people requiring more specialised beds types, for example secure hospital beds and this is being raised through regional commissioning.

Arrangements for a Locum Consultant Psychiatrist for the Crisis Team (CAMHS) were put in place to cover all MHA assessments during working hours with out of hours assessments continuing to be allocated to the on-call Psychiatrist.

Multi-Agency Safeguarding Hub (MASH)

The MASH is the single point of contact for all professionals to report safeguarding concerns to children's/adult's social care. Demand on the resources in the MASH has risen significantly since its inception and this was highlighted to the NSCB in March 2018 when the level of contacts resulting in no further action was raised as a concern. This prompted a multi-agency audit to develop a better understanding of the nature of enquiries which result in no further action with a view to recommending actions to address any issues.

There were an average of 2227 MASH enquiries per month (September 2017 – September 2018). The audit looked at 100 cases that had been closed with an outcome of no further action and excluded enquiries that had been passed on to other agencies or where advice and guidance were provided. The sample included a range of enquiries from different organisations.

Of the 100 MASH enquiries which resulted in no further action, 66% of cases merited contact at level 4[3] which demonstrated a good level of understanding of thresholds. Auditors agreed with 95% of MASH decision making and clarification was needed in 5% of cases.

The 34% of cases which did not appear to require contact at level 4 still included complex issues requiring fine professional judgements which benefit from multi-agency information sharing and decision making. The following themes emerged within this category of cases: -

- Self-harm and mental health and wellbeing of children and young people – despite all relevant protective factors being in place.
- Parent/carer overdose – a difference in referring behaviour between the acute health trusts to this issue with protective factors not always being clear/difficult to evidence prior to discharge.
- Harmful sexual behaviour – use of the Brook Traffic Light Tool and confidence in applying the recommendations
- Domestic abuse – the most common reason for enquiries from several organisations; with the Nottinghamshire Police policy being to refer all cases of domestic abuse where there are children to children's social care.

A detailed action plan was developed to provide further assistance to practitioners dealing with the above issues. The audit identified steps that organisations could take in some circumstances before contacting the MASH including; further discussion with relevant family members, considering which agencies are already involved which would mean relevant support is already in place (this can be difficult to establish) and thinking about the role and impact a social worker would have on the case. The audit also identified process issues in the MASH which could assist in managing the number of enquiries including recording and the timeliness of outcome letters being sent to partners.

Safeguarding pre-mobile babies

The partnership has worked together to support practitioners to respond appropriately to bruises or suspicious marks on pre-mobile babies. This work was prompted by learning from case reviews, and feedback from Designated Safeguarding professionals, that found sometimes there is uncertainty as to whether to make a referral to children's social care, or delays in referring, and that practitioners were not always clear about the process to follow. The 'bruising in babies' pathway', developed in 2015, already provided guidance to practitioners but this was revised in 2018 to provide further clarity and it was recognised that there was a need to raise awareness of the pathway. The 'Was Not Brought' video, developed by colleagues in Nottingham City had proved very successful and therefore the NSCB agreed to commission a video animation to promote the pathway and highlight the risks to pre-mobile babies. The Designated Doctor for Safeguarding (North Nottinghamshire) led a multi-agency working group that collaborated with a specialist company to develop the animation which was launched in March 2019 https://www.nottinghamshire.gov.uk/nscp/news/babies-that-don-t-cruise-rarely-bruise.

Since its release an evaluation of the impact of the video animation has been undertaken with very encouraging results. Practitioners were asked how likely it would have been for them to refer a non-mobile baby with a bruise to children's social care prior to seeing the video, 64% said it would have been likely or very likely whereas after viewing the video this rose to 95%. Awareness of the 'bruising in babies' pathway' increased from 33% to 100% as a result of viewing the video. Practitioners were also asked to summarise the key messages from the animation and it was clear from the responses

[3] Defined in the Pathway to Provision thresholds document

that they understood that; bruising to pre-mobile babies is extremely rare, that if a baby has a bruise you must challenge to find out what has happened and that if there is any doubt a referral should be made to children's social care.

Learning review – injuries to pre-mobile babies

On 8th June 2018 the NSCB Independent Chair commissioned a multi-agency Learning Review following six cases of injuries to pre-mobile babies. All children subject of the review were aged between 6 and 11 weeks at the time of the incident leading to injury. There were 5 males and 1 female. Previous injuries or concerns had been raised in relation to the subject child in two cases and in four cases in relation to their older siblings. Two of the children were previously known to Nottinghamshire Children's Social Care and one of these was subject of a Child in Need Plan at the time of the incident. The cases were spread across the County with four children being treated for their injuries at Kings Mill Hospital, one at Queens Medical Centre and one at Bassetlaw Hospital.

An assessment of the safeguarding practice in each case was undertaken. The review concluded that:

- None of the cases met the criteria for Serious Case Review (SCR). Case six did lead to a rapid review being submitted to the national panel under the new arrangements and the panel agreed with the conclusion that an SCR was not required.
- This review has not revealed any significant failures by agencies that could have prevented injuries to any of the children.
- No systemic issues have been identified leading to pre-mobile babies being unsafe in Nottinghamshire
- Investigations are ongoing in all of the cases but analysis of the cases to date has not indicated that events leading to injuries could have been predicted

A variety of practice issues were identified and explored through the review:

- Effectiveness of strategy discussions
- Repeat skeletal surveys
- Pathway for non-mobile baby with bruising or a suspicious mark
- Lack of clarity within MASH regarding responsibility for arranging child protection medical.
- Quality of decision making and requirement for pre-birth ICPC
- The challenge of dealing with "Hidden males".
- "Routine enquiry" by midwifes in relation to domestic abuse.

Following the review, the 'bruising in non-mobile babies' pathway' was reviewed and an animation film developed to raise awareness (referred to earlier in this report).

Learning from the review was disseminated through the NSCP Training Programme. Follow up actions were identified; to seek assurance that the pathway is effective, to incorporate the learning into the strategy discussions improvement work and to follow up the action taken by one of the acute trusts in relation to their agency specific findings.

S.11 Safeguarding Self-Assessment

The biennial s.11 safeguarding self-assessment was undertaken in May 2018 and subsequently reported to the Multi-Agency Audit sub group and NSCB Executive. The self-assessment was carried out in conjunction with colleagues in Nottingham City Safeguarding Children Board and required organisations to assess their compliance with a series of standards based on the duties set out under s.11 Children Act 2004.

- leadership and organisational accountability
- serious case reviews
- safer working practices
- training
- supervision
- policies and procedures
- whole family/think family approach
- voice of children
- environment

The assessment also included local standards which focussed on specific areas of practice including; whistle blowing, understanding and use of the Pathway to Provision, recording standards, involvement in multi-agency meetings, monitoring of Children in Need and policies in relation to parents/carers who disengage.

Eighteen organisations completed the NSCB self-assessment tool, in addition a further seven organisations completed their own self-assessment tool and submitted it for information.

Compliance with the standards was generally high with organisations reporting on areas of difficulty that tended to be specific to them. A common area requiring development for nearly half of the organisations completing the assessment was safeguarding training and evidencing compliance with organisational training requirements. Several organisations were reviewing their induction processes for new starters and/or their training provision and this prevented them from reporting full compliance. The NSCB Learning and Development sub group took responsibility for working with those organisations to support them with their improvement work.

Whilst wishing to avoid duplication for organisations that are required to submit other forms of self-assessment, analysing and reporting on the submissions made using non NSCB self-assessment tools was recognised as problematic. It was agreed that the process for s.11 self-assessments will be reviewed under the new arrangements.

Monitoring the use of restraint in Clayfields Secure Unit

The NSCP has carried out its responsibilities in relation to monitoring the use of restraint within secure children's units in the area. The Centre Manager for Clayfields House Secure Children's Home and the Physical Intervention Monitor/Teacher attended the Safeguarding Assurance and Improvement Group and presented their annual report. The report provided assurance to the NSCP about the use of restraint and the steps taken to minimise the use of force within Clayfields. Details were given regarding the Restrictive Physical Intervention (RPI) methods used[4], when they are applied, by whom and what steps are taken prior to RPI to minimise its use.

This year, following feedback provided by the NSCB, the report included comments from young people that had been noted in the RPI debrief and key work sessions following restraints. This further information provided an extremely valuable insight into the experience of young people involved in restraints and their views on how future incidents could be avoided. The Centre Manager reported a

[4] MAPA – Management of Actual and Potential Aggression

marked improvement in the quality and quantity of debriefings as a result of the work of the Physical Intervention Monitor and an increase in the number of MAPA trainers. The young people resident at Clayfields also have access to an advocate from the Children's Society who undertakes weekly visits.

The level of use of restraint is closely monitored and each incident is reviewed by the Duty Manager, Independent RPI monitor, a MAPA trainer and the Head of Care and Safeguarding/Designated Safeguarding Officer. The number of incidents where restraint is used during the year can vary significantly with often a small number of residents accounting for a large proportion of incidents. This year incidents where restraint was used increased from 173 (2017/18) to 190 (2018/19) and this is attributed to a higher number of residents being involved in 10 or more incidents and accounting for 60% of the total number of incidents. It is reassuring however that the number of injuries to both young people and staff decreased during this period.

Clayfields has a 'referral criteria' for notifying the Local Authority Designated Officer of certain incidents and details of the five referrals were provided along with the outcomes of those enquiries.

Comparative data regarding the use of restraint in other secure units is not readily available however this is an area that Clayfields has identified as a priority for the year ahead and they are actively working on links with other establishments to share best practice, data, and training information.

Learning and Workforce Development

The Learning & Workforce Development (L&WD) group leads on the following areas:

- Promoting a culture of continuous learning and improvement across organisations that work together to safeguard and promote the welfare of children
- Monitoring and evaluating the effectiveness of learning and development activity, including multi-agency training for all professional's
- Contributing to the effective implementation of the Nottinghamshire Learning and Improvement Framework

Under the new safeguarding arrangements, the L&WD group also took over responsibility for the interagency safeguarding procedures and two of the six meetings per year are now held jointly with Nottingham City to specifically review and approve updates to the procedures.

Thanks to the Named Nurse Sherwood Forest Hospitals Foundation Trust and the Consultant Paediatrician and Designated Doctor for Safeguarding Children, Nottinghamshire County North who have chaired the group over the past year. The work of the L&WD group is supported by the NSCP Training Coordinator and NSCP Administrator.

Membership of the group has been good and was recently strengthened by the addition of operational representatives from the police who have taken responsibility for promoting the multi-agency training opportunities amongst Nottinghamshire Police Officers and Staff.

Annual Training Programme

The training programme is informed by the annual training needs analysis, learning from case reviews and audits. The programme is mostly delivered by representatives from partner organisations with the NSCP Training Coordinator organising and planning the events. A Training Pool of approximately 15 representatives from a range of organisations delivers the core training and subject matter experts are approached to contribute to specialist events. The use of outside training providers is limited to a few courses where local resources are not available. We are very grateful to all those practitioners who have given their time to contribute to the training events over the year.

This year a new course 'Meeting the Needs of Looked After Children- a Multi-Agency Approach' was developed. This course benefitted from a fantastic input provided by a young person who was looked after. The young person's perspective was extremely valuable and very well received.

2018/19 Multi-Agency Safeguarding Training Events

- **45** face to face training events took place this year including core safeguarding training, specialist subject events and seminars.
- The provision of courses has been responsive to need with additional events being planned according to demand (i.e. additional Child Sexual Abuse and Harmful Sexual Behaviour training events were added to the programme).
- Attendance at our face to face training has increased in comparison to last year, with **2,197** practitioners accessing events in 2018-19 (compared to 1,982 the previous year).
- Take up of training opportunities by organisations remained similar to the previous year's however there has been a noticeable increase in attendance by Childrens Social Care and Schools & Colleges staff (both with over 100 more course places being accessed).

E Learning

This year a new E learning provider was commissioned to provide safeguarding E Learning modules across the partnership. This was driven by financial considerations plus the added advantages of being able to develop our own modules and link to Nottinghamshire County Council's platform for accessing courses. L&WD group members were instrumental in cascading the new process for accessing modules to their organisations. Organisations have quickly got used to the new system as this is evident in take up. The introductory E learning modules are often used by partner organisations as part of their induction processes for new staff and provide a good grounding of safeguarding.

E Learning

- **20** courses are now available for use by partner organisations. All the courses have been peer reviewed to ensure that the course content is appropriate, up to date, and in line with our local procedures.
- Since moving to the new provider, we have authored **2** new bespoke modules; **Safer Sleeping for Babies (SIDS)** and **Trauma, Toxic Stress and Adverse Childhood Experiences (ACEs).** Both courses have proved popular, for example 107 people completed the Aces course within the first 2 weeks of going live.
- Despite the changes this year we are pleased to see that we have had **5518** course completions – and whilst this represents a fall on the number completed last year (6,300) this should be seen in the context of the average annual course completions in recent years being circa. 4000 and the unusually high number of course completions in 2017/18.

Evaluation of training

A robust system of course evaluation is in place and the L&WD group monitor feedback and evaluations regularly.

In relation to our core course: Working Together to Safeguard Children we continue to receive very positive feedback. Fifteen courses were delivered and when asked to rate delegates overall satisfaction with the course 92% (89% - 2017-18) rated their satisfaction levels as good or very good. Confidence levels in contributing towards multi-agency child protection work were also reported to have increased – prior to the course 47% rated themselves as having good/very good confidence, which then improved to 87.5% after completing the course. This clearly is a positive measurement of the impact of the course, but we have also received very positive comments from delegates who have attended a range of our courses:

"This was some of the best training I have ever been on in terms of safeguarding. I learnt so much. Thank you" (Working Together)

"Very good training day made a very complicated subject very clear and helpful" (Working Together)

"Excellent course. Delivery, interaction between all content could not be faulted. An enjoyable day" Working Together)

"Excellent training as always from NSCB, trainer was very engaging and kept our attention throughout the day" (Neglect Course)

"This is one of the best courses I have been on for a while. Not only in the specific subject matter but also in discussing many related issues! (Hidden Men course).

"I just wanted to say a big thank you for the very high-quality training event yesterday. So much ground to cover and yet, with the variety of presenters it felt fast paced but not overwhelming" (delegate who attended our What's New Seminar).

Training developments

Having successfully implemented a new system for accessing and recording the use of E learning we are now introducing the same Learning Management System for practitioners from partner agencies to book onto our face to face events. Whilst this presents some possible risks in relation to reduced take up this will be monitored. The benefits that we are seeking to realize include;

- Enabling practitioners to directly book onto courses and cancel if unable to attend, complete online evaluation forms and print off certificates
- Make available personal safeguarding training records which include E learning and face to face training completed
- Reduce costs by closing the standalone training record system
- Reduce bureaucracy and free up resources to support increased training provision.
- Implement a new reporting system for all organisations, where they will receive regularly throughout the year, data on which courses, including E Learning, their staff have accessed. This will help partners to review and monitor their staff's attendance and take up of safeguarding training.

Guidance and procedures

Thresholds guidance

Having a common understanding between partner agencies around thresholds for services is an important element of an effective safeguarding system and the NSCB, and now the safeguarding partners, are responsible for setting out those thresholds. The Pathway to Provision (P2P) is Nottinghamshire's guidance that supports practitioners to identify an individual child's, young person's and/or family's level of need and to enable the most appropriate referrals to access provision.

The Safeguarding Survey undertaken in April/May 2018 included questions on awareness of the Pathway to Provision and the usefulness of the guidance it provides. Over 80% of respondents said they were aware of the P2P guidance, 64% said they had used the P2P and 84% of those that had used it said it was either helpful or very helpful. Respondents also had the opportunity to provide comments on how the guidance could be improved - most of the feedback provided concerned differing interpretations between the agencies of the thresholds and suggested further training would be useful. The Learning and Workforce Development Group are therefore following this up. A few comments were also made about the layout/length of the guidance and these were taken forward into the review of the document.

In July 2018 a consultation workshop was held involving representatives from a wide range of partner organisations and services. The workshop used case studies to test out the guidance and suggest areas for revision.

An updated version of the Pathway to Provision responding to the feedback in the survey and the learning from the consultation workshop was subsequently produced. Following approval by the NSCB the revised guidance was published in December 2018.

P2P Revisions

- Additional content to cover contextual safeguarding
- Short description of each service added
- Further guidance regarding self- harm, bruising in babies, home education, homelessness and FGM
- Some streamlining and re-ordering of content

Interagency Safeguarding Children Procedures

Cross authority safeguarding procedures are maintained by the partnership to guide safeguarding practice. The content of the procedures is reviewed twice a year and proposed updates and amendments are considered and approved by the cross-authority procedures sub group.

Interagency safeguarding procedures updates

July 2018

- Child Protection Conferences – timescales for ICPCs on unborn babies
- Harmful Sexual Behaviour – introduction of the HSB Panel
- Trafficked Children – links to updated statutory guidance

January 2019

- Responding to abuse and neglect – additional information about Early Help, Contextual Safeguarding and Domestic Abuse
- Assessment, Child Protection Enquiries – revisions to reflect Working Together 2018
- Child Protection Conferences, Information Sharing – reference to General Data Protection Regulations (GDPR) and Data Protection Act 2018
- Allegations Against Staff or Volunteers – amendments to reflect revised statutory guidance and local safeguarding arrangements
- Safe Recruitment – criminal records checks for someone from overseas
- Combined guidance on children from abroad, victims of modern slavery, trafficking and exploitation replacing previous separate chapters
- Harmful Sexual Behaviour – reference to technology-assisted harmful sexual behaviour
- Child Safeguarding Practice Reviews – new chapter to reflect Working Together 2018
- Child Death Reviews – new chapter following revised statutory guidance
- Children visiting prisons – new chapter providing best practice guidance
- Plus, various updates to links to external websites and guidance

Case reviews

Identifying and reviewing serious child safeguarding cases is an important part of multi-agency safeguarding work. The purpose of such reviews is to ensure that we identify improvements to be made to safeguard and promote the welfare of children.

Working Together to Safeguard Children 2018 (published 29th June 2018) introduced revised requirements in relation to the case review process summarised as follows:

- Safeguarding Partners to identify serious child safeguarding cases[5] which raise issues of importance in relation to the area
- Local authorities to notify incidents to a new National Child Safeguarding Practice Review Panel within five working days
- Safeguarding Partners to undertake a 'rapid review' within 15 days of a serious child safeguarding case being identified
- Safeguarding partners to consider whether a 'child safeguarding practice review' should be commissioned (this replaced 'serious case reviews' commissioned by the LSCB Independent Chair)

The National Child Safeguarding Practice Review Panel (NCSPRP) was introduced with responsibility for identifying and overseeing the review of serious child safeguarding cases which it considers raise issues that are complex or of national importance.

Transitional guidance[6], published alongside the revised Working Together to Safeguard Children 2018, provided guidance for the local implementation of the new requirements. In line with the transitional guidance the requirement to undertake Rapid Reviews and notify the NCSPRP of incidents was implemented immediately.

The local authority already had a process for service managers to notify serious incidents to Ofsted and inform the NSCB office. This process was reviewed and revised to incorporate a trigger for a Rapid Review to be undertaken. A method was quickly developed to carry out a Rapid Review within the 15-day period which included a decision point by the Independent Chair on whether a Serious Case Review should be commissioned. The new process was subsequently refined, and a cross authority rapid review process was agreed with Nottingham City.

Following confirmation by the Nottinghamshire Strategic Leadership Group of the implementation of the new safeguarding arrangements on 16th January 2019 the safeguarding partners took over responsibility for decision making regarding case reviews and the new criteria for child safeguarding practice reviews were adopted.

The Serious Incident Review Group (SIR), under the Nottinghamshire Safeguarding Children Board, was previously responsible for making recommendations about whether to undertake a serious case review with the final decision resting with the Independent Chair. The SIR Group then monitored improvement working arising from reviews. With the introduction of the new safeguarding arrangements the SIR Group was replaced by the Child Safeguarding Practice Review (CSPR) group which took on responsibility for rapid reviews and decisions around whether to undertake a Child Safeguarding Practice Review. The new group meets to undertake Rapid Reviews when required and in addition four set meetings are scheduled to enable the group to carry out its other functions.

[5] Serious child safeguarding cases are those in which:
- abuse or neglect of a child is known or suspected and
- the child has died or been seriously harmed

[6] Working Together: transitional guidance HM Government

Thanks to the Home Start Manager who chaired the SIR subgroup and to the DCI Public Protection Quality and Compliance who now chairs the CSPR Group. The CSPR Group and the equivalent group in Nottingham City are now both chaired by the same person and this will therefore assist with the continued alignment of Rapid Review procedures and consistency in decision making across the two areas. The work of the CSPR Group is supported by the NSCP Development Manager and a member of Business Support.

SIR/CSPR Group activity

- The subgroup met on 5 occasions throughout the year.
- In addition, a 'rapid review' was undertaken in relation to 6 cases which were subject of serious incident notifications post 29th June 2018.
    - In all 6 cases a recommendation was made that the criteria for SCR was not met. The NSCB independent chair agreed with the recommendations and summaries of the cases were submitted to the National Child Safeguarding Practice Review Panel (NCSPRP) for their consideration. The NCSPRP endorsed the decision of the chair on each occasion.
- During the reporting period NSCB finalised 3 serious case reviews[7],
    - **SCR KN15** which was signed off by NSCB on 7th June 2017 and published on 19th March 2019 following the completion of the Coroner's inquest
    - **SCR PN16** which was signed off by NSCB on 15th May 2017 and published on 22nd November 2018. Publication of this review was delayed due to issues involving other processes.
    - **SCR QN17** which was signed off by NSCB 16TH July 2018 and published 2nd November 2018 following the completion of the Coroner's inquest.
- There are no current ongoing Serious Case Reviews or Child Safeguarding Practice Reviews

Every three months the group has actively monitored the action being taken in relation to completed reviews. Updates are requested from each agency that has any ongoing work in relation to a review and their actions are reviewed and signed off as appropriate.

During the reporting period the sub group monitored the completion of 33 out of 40 outstanding actions from Serious Case Reviews. The outstanding actions are being progressed and are mainly more complex actions which require a longer-term piece of work such as policy and procedure updates.

Dissemination of learning

The learning from case reviews has been presented at the 'What's New in Safeguarding (WNIS)' half day seminars – five of which took place during the year with over 500 participants. In addition, a more in-depth workshop, 'Learning from Serious Case Reviews', took place on 7th March 2019. This half day event provided an opportunity to explore the issues raised through the ON16 and QN17 serious case reviews.

At the end of each SCR, following publication of the overview report, a learning and improvement bulletin has been published to provide a concise method of cascading the learning from the review to as wide an audience as possible.

[7] Case reviews are given an anonymised alpha numeric code which consists of a consecutive letter and the year the review was commissioned.

Serious Case Review KN15

This review related to a 13-year-old girl who sadly died whilst missing from home after a family argument. During her early childhood she had witnessed domestic violence involving her birth father and mother. The family moved several times and mother remarried. Step-father self-reported mental health problems. Early Help support was provided when the child lived within a neighbouring local authority, but this ended before the family moved into Nottinghamshire. The child went "missing from home" on several occasions and not all the episodes were reported to the authorities. Information was shared between schools when the child moved to a new secondary school in Nottinghamshire. Two referrals were made to the MASH, but these were assessed as being below the threshold for Children's Social Care involvement and an Early Help Assessment was recommended.

KEY LEARNING:

1. Early intervention and support for families will be more effective, cohesive, and focused, when delivered with a written assessment and plan
2. Assessments, following the identification of emerging needs, should explore the wishes and feelings of the child to further understand the cause of a child's behaviour and possible underlying distress. The intervention should avoid only focusing on the behavioural change of the child.
3. Adults who present with mental health problems should be assessed in relation to the risk they may pose to children within the family
4. The potential consequences for the child should be considered by those involved before sharing concerns about possible emotional abuse with parents/carers.
5. When a child moves school, professionals should be aware of a child's history and alert to any gaps in that history.

PRACTICE IMPROVEMENT:

The Early Help Assessment Form (EHAF) was revised and improved.

Re-launch of the school's child protection and confidential file audit tool, which provides advice on recording and reporting concerns including advice on the use of the EHAF and the thresholds guidance 'Pathway to Provision'.

A Neglect Tool was developed for use by all agencies which prompts practitioners to consider the impact on children of parental mental health.

The Multi-Agency Safeguarding Hub (MASH) now keeps a record of all referrals irrespective of whether they are taken forward along with the rationale for advice/decisions made. A prompt has been included to consider the risk to a child of informing alleged perpetrator of disclosures. Further guidance has been provided to MASH staff around the issue of parental consent in the context of safeguarding and a review of the MASH system in relation to call handling and differences in the way telephone and written referrals are handled has been undertaken.

Serious Case Review PN16

This review related to a young person known as 'Madison' for the purposes of the review. Madison's birth father died when she was very young, and she lived with her mother, stepfather and half-siblings. From an early age professionals were concerned that she was being treated differently from her half-siblings. Madison had been labelled as problematic, with self-harming behaviours, failure to thrive and developmental delay which had not been considered in the context of abuse and neglect at the hands of the carers. Agencies responded to some reports of emotional and physical abuse but struggled to intervene in a way that brought about positive change in her life. There were also indicators of potential sexual abuse which were not recognised or responded to, and occasions when the views of the parents overshadowed the voice of Madison.

There is no single index incident or event that triggered the review. Madison made disclosures of abuse and asked to be looked after by the local authority in 2016, aged 16 years.

KEY LEARNING:

1. When working with cases over a number of years professionals need to use a chronology of information to provide context for enquiries and assessments;
2. We need to be aware of the danger of losing sight of the needs and views of the child and placing the interests or views of adults ahead of these;
3. Children will lose confidence when professionals are unable or unwilling to take sufficiently effective action in response to their concerns and this may affect their willingness to disclose future abuse;
4. Children of sufficient age and understanding want to be kept informed of the progress of enquiry and assessment and expect explanations about what decisions are being taken and why;
5. Professionals should reflect on how best to enable children to express their views and promote opportunities for the child's views, wishes and feelings to be heard and understood.

Serious Case Review PN16

PRACTICE IMPROVEMENT:

Guidance, 'Good Practice Supporting the Voice of the Child', has been included within the interagency procedures. Further assurances were sought from partner organisations about how they ensure young people contribute to the planning, delivery and evaluation of services.

NCC Education Services together with the Child and Adolescent Mental Health Service (CAMHS) have produced specific guidance 'Young People & Self-harm: Guidance for Schools'. This has been introduced at a launch event followed by seven workshops across the county for education professionals working in secondary schools. Interagency guidance on self-harm and suicidal behaviour was reviewed and a new E learning module was made available. The NSCB also jointly funded a new website 'Health for Teens'.

Multi-agency training workshops on recognising and responding to neglect have been held and a new Neglect Toolkit is available through the interagency procedures.

A flow chart for health professionals was developed to assist them when dealing with a young person presenting with genital symptoms. The circumstances of this case were also developed into a case study and circulated within the health community.

Policy and guidance – the Interagency Safeguarding Children Procedures contain a practice guidance document 'Guidance for Practitioners: Completing Chronologies and Genograms.' This guidance was updated in May 2016.

Nottinghamshire Schools have been provided with a sample 'Child Protection Confidential File' audit template which contains a question on use of chronologies. Schools have been provided with guidance on the use of chronologies and some secondary schools are investing in IT solutions which allow them to produce a chronology.

Serious Case Review QN17

This review related to a young person known as 'Peter' for the purposes of the review. 'Peter' was 16 years old when he tragically took his own life. His mother and father had split up early in his life and he lived with his mother and 4 siblings/half-siblings. There were some difficulties in the home environment and relationships between family members were on occasions strained. There was a history of suicide within the wider family. Around the age of 13 concerns began to emerge around self-harm, suicidal ideation and Peter's emotional well-being. As time progressed further issues became apparent including a possible eating disorder, OCD traits and Peter appeared to be struggling with his sexual identity. Support was provided to Peter by several services particularly the school, school nursing and the GP, there was also a referral to CAMHS services. He was making good progress academically and expected to achieve good results in his GCSE's. At the age of 16 Peter disclosed to a teacher that he was being sexually exploited and had been sexually abused in the past. A referral was made to Children's Social Care, a CSE assessment completed and a multi-agency CSE meeting held. Whilst his parents attended the meeting Peter choose not to and he took his own life shortly after.

At the inquest the Coroner concluded "I do not think that even those who knew him very well, particularly his parents, could have predicted what he would do- what is not predictable is not preventable."

KEY LEARNING:

1. There was a good working relationship between the School nurses, the school and the family GP, however, this work would have been strengthened through use of the Early Help Assessment Form (EHAF).
2. Earlier involvement of CAMHS may have been beneficial and professionals need to consider options to protect a child who disengages from services.
3. Police and Children's Social Care communicated well to coordinate their response to episodes of missing from home and followed the correct procedures.
4. Once an initial disclosure is made by a child any further interviews should be agreed as part of a strategy discussion with the agencies involved.
5. When making a verbal referral to the MASH the referrer should provide a summary of all the key concerns and any follow up information provided in writing should be fully considered.
6. Whilst concerns around CSE can sometimes be non-specific practitioners need to be aware that the threshold for significant harm may be met and ensure that Section 47 child protection enquiries are initiated where this is the case.
7. For CSE meetings to be effective it is important that all relevant agencies are appropriately engaged otherwise information exchange and action planning can become problematic.
8. Careful consideration should be given as to how the outcomes from multi-agency meetings are fed-back to the child including who is best placed to do this and what the potential impact of the meeting on the child is likely to be?

Serious Case Review QN17

PRACTICE IMPROVEMENT:

The Inter-agency practice guidance on Child Sexual Exploitation has been updated to reflect the learning from this review.

On the 16th October 2018 a new online MASH referral form was launched with the involvement of partner agencies. A review took place on the 15th November 18, feedback from partners was very positive finding it to be less cumbersome and straightforward to use adding value to the referral process.

NCC Educational Psychology Service has produced guidance for schools “Advice for school staff when listening to children disclose sensitive information”

The Nottinghamshire Early Help Assessment Form (EHAF) was subject of a multi-agency review. The use of the EHAF was promoted at several NSCB training events and a follow up survey found that 82% of the respondents had a good knowledge of the EHAF.

The learning from the serious case review has been shared widely at training events and 3 workshops have been held looking at this case in greater detail.

The learning from this review also contributed to the guidance ‘Young People & Self-harm: Guidance for Schools’ referred to earlier in the PN16 Serious Case Review practice improvement section.

Safeguarding partnership improvement priorities for 2019/20

Practice improvement

An important objective of the new arrangements is to coordinate improvement activity for the partnership so that there is a clear and shared understanding of which areas of practice are the focus for improvement work.

The practice improvement workstreams for 2019/20 have been identified through several routes. The NSCB business plan for 2018/19 has been reviewed and areas requiring further attention have been taken forward. Action plans from recent case reviews, audits and inspections have been reviewed to identify common themes. National safeguarding issues have been considered and incorporated. The following Practice Improvement Workstreams are being monitored and supported by the SAIG during 2019/20:

Child Sexual Exploitation (CSE)

This remains an area of national focus and featured in a recent local serious case review (QN17). Whilst CSE falls under broader contextual safeguarding risks it was decided to maintain CSE as a distinct priority to ensure that attention is not lost on this area of work. A CSE Strategy has been agreed which seeks to: -

- Improve the voice of children and young people
- Develop an annual problem profile
- Improve data collation
- Reducing inequality by improving understanding of specific vulnerabilities for minority groups (LGBT+, children with disabilities, boys and those outside mainstream education)
- Supporting tactical/operational groups and improving parent/carer engagement

Contextual safeguarding

Following a review of the arrangements in place to deal with contextual safeguarding the following areas for attention were identified: -

- Raising awareness and developing a cultural shift
- Reinforcing existing pathways and frameworks
- Development of a pre-referral tool (for criminal exploitation)
- Briefings/training – development of E learning
- Further development of place-based intelligence sharing and interventions
- Ensuring exploitation work is connected

Strategy discussions/meetings

The partnership will work to improve the quality of strategy discussions and meetings to ensure that they are timely, involve all relevant partners and are well recorded. A full review will be undertaken to pull together known issues, understand the experience of frontline practitioners and develop an action plan to improve the effectiveness of strategy discussions/meetings through a multi-agency working group.

Injuries to pre-mobile babies

To improve the multi-agency response to safeguarding concerns about pre-mobile babies by seeking assurance that the revised 'bruising in babies' pathway is effective.

Information sharing

Support and develop information sharing across the partnership: -

- Introduce and embed a new system to ensure that police officers attending incidents are aware of any current child protection plans relating to children at the address. Children's social care in turn to be informed incidents reported at any address where a child resides who is subject of a child protection plan.
- Monitor the impact of the implementation of the CP-IS
- Review the basis for checks to be undertaken by the Safeguarding Children Information Management Team (SCIMT).

Multi-Agency Safeguarding Hub (MASH)

To support the MASH to function effectively and through the MASH steering group take forward the front door improvement plan: -

- Explore the possibility of children's emotional health and well-being practitioners being based within the MASH.
- A clear pathway is promoted within health and education regarding self-harm of young people and parental overdose.
- Support professionals to provide as much contextual information as possible when making a referral, particularly regarding parental overdose.
- Promote the use of the Brook Traffic Light Tool.
- Provide further support for schools and increase the confidence of staff responding to concerns about sexual behaviour.

s.136 Mental Health Act

Continue to monitor the work related to the safeguarding of children under s.136 of the Mental Health Act being taken forward by the Crisis Care Concordat. Specifically; issues regarding the implementation of the protocol on transporting children subject to s.136 to be explored and resolved; reporting of data related to children being taken to a place of safety and case recording regarding gender dysphoria from a multi-agency basis.

Safeguarding arrangements

The safeguarding arrangements will be reviewed to ensure that they are working effectively: -

- Learning from early adopter areas will be considered as part of plans to further improve the safeguarding arrangements.
- Develop engagement with children, young people and families
- The schedule of 'Relevant Agencies' will be considered with a view to expanding the partnership further.
- Arrangements for Independent Scrutiny will be further developed to support the role of the Independent Scrutineer
- Review the current funding of the partnership and agree the future arrangements

The Partnership will examine the findings of the Independent Inquiry into Child Sexual Assault following the publication of the report into the Nottinghamshire Councils line of inquiry to ensure that any issues not already responded to are fully addressed.

Child Death Review Annual Report

The Child Death Overview Panel is responsible for reviewing all child deaths to identify what could be done to prevent similar deaths in the future.

Between April and August 18 CDOP met monthly and was chaired by the Deputy Chief Nurse (Interim), NHS Bassetlaw Clinical Commissioning Group. CDOP members included Consultant Paediatricians, Specialist Nurses and Midwifery Services. Members also include representatives from Children, Families and Cultural Services of Nottinghamshire County Council, Nottinghamshire Police, the Voluntary Sector and Public Health.

In September 18 CDOP moved to a joint Nottinghamshire/Nottingham City CDOP but retained its individual reporting responsibilities in respect of child deaths. This commenced a transition period to an integrated joint CDOP commencing 1st April 2019. The new combined CDOP is chaired by the Consultant Public Health, Nottingham City. This is in line with good practice identified by the Child Death Review: Statutory and Operational Guidance (England). There is an agreement for the chair to rotate bi-annually between the Nottingham City and Nottinghamshire Local Authority Public Health representative

The lead NSCB officer for the group is Bob Ross, NSCB Development Manager (Child Deaths). The Panel was administered by Carol Fowler, NSCB Child Death Administrator.

Revised statutory guidance

The Children and Social Work Act 2017 moves responsibility for child death reviews away from safeguarding Children Boards and to the "child death review partners," that is, "the Local Authority" and "any clinical commissioning group for an area any part of which falls within the local authority area."

Nationally, on 1st April 2018 Government Department responsibility for child death review processes moved from the Department for Education (DfE) to the Department of Health (DH). Chapter 5 of Working Together 2018 provides a strategic overview of arrangements whilst DH has produced more detailed statutory guidance, 'Child Death Review: Statutory and Operational Guidance (England)'.

CDOP activity

- CDOP has met on 11 occasions during 2018/19. The first 5 meetings were County only. The next 6 meetings were jointly with Nottingham City.
- The table below gives a year to year comparison of the number of child deaths within Nottinghamshire and the number of child death reviews undertaken by the CDOP. In 2018/19 the number of child deaths was 47. This is below the average number of deaths since CDOP records began in 2008/9 which is 52

Year	No. of child deaths	No. of reviews by CDOP
2018/19	47	48
2017/18	53	46
2016/17	39	58
2015/16	50	35
2014/15	47	60
2013/14	59	43
2012/13	57	40
2011/12	45	40
2010/11	49	52
2009/10	48	43
2008/09	76	59
Total	570	524

- Of the 47 deaths which occurred in 2018/19, 30 were classified as **'expected'** deaths and 17 as **'unexpected'**[8] deaths.
- The proportion of unexpected to expected deaths is just over one third to two thirds which is in line with previous years.
- The number of child death reviews undertaken by CDOP in 2018/19 has remained stable with 2 additional reviews being completed this year compared with 17/18.
- Of the 48 deaths reviewed during 2018/19 11 were 'Unexpected' deaths and 37 were 'Expected' deaths. 'Unexpected' deaths are generally more complex than 'Expected' deaths and take on average longer to review.
- As part of its review of individual 'Unexpected' child deaths CDOP assesses the quality of the individual and multi-agency rapid response and where appropriate acts to address any shortcomings.
- Attendance by individual agencies at initial and final 'case discussion meetings' remains positive and allows for comprehensive information gathering, action planning and review.
- The child death review data collection has been prepared and submitted to the Department of Health to support national analysis work.

Key achievements

The formation of a joint Nottinghamshire/Nottingham City CDOP means that we now comply with the requirement of the new statutory guidance to have a geographical footprint which amounts to 60+ child deaths each year. To support the new CDOP the Terms of Reference and the interagency procedures have been revised to reflect the new arrangements and statutory guidance.

The joint Nottinghamshire/Nottingham City Safer Sleep Working Group continues to operate and work to reduce the incidence of child deaths where unsafe sleep conditions are a factor in the death. Workstreams include; workforce training, promotion of the 'safer sleep' risk assessment tool, ensuring parents and carers receive suitable resources to help them implement safer sleep environments and follow best practice advice, communications to ensure safer sleep messages are communicated broadly and regularly.

Joy Moran, Child Death Nurse (NUH), continues to chair the regional CDOP and is a member of the national CDOP working group.

Rapid response/Joint Agency Response training has been reviewed and revised to meet the requirements of the new operational guidance.

Nottinghamshire and Nottingham City Safeguarding Children Partnerships have jointly purchased 'e-CDOP' which is a secure, flexible and web-based solution to support the CDOP process and facilitate effective sharing of information between agencies. The system is in place from the start of the new CDOP arrangements for 2019/20 and will provide data directly to the National Child Mortality Database removing the need for annual data submissions.

Challenges/ Areas for development

Nationally, responsibility for the Child Death process has transferred from the Department of Health to the Department of Education which is an acknowledgement that the overwhelming majority of child deaths nationally (approx. 80%) have a medical cause. Working Together 2018 moves responsibility for Child Death Review arrangements away from Local Safeguarding Children Boards and to the 'Child Death Review Partners' i.e. the Local Authority and Clinical Commissioning Groups.

[8] An unexpected death is defined as the death of an infant or child which was not anticipated as a significant possibility for example, 24 hours before the death; or where there was an unexpected collapse or incident leading to or precipitating the events which led to the death' (Working Together 2015))

The Child Death Review Partners have agreed that reporting arrangements for the CDOP should be via the Strategic Leadership Group of the safeguarding partners.

The merging of Nottinghamshire and Nottingham City into a single CDOP brings opportunity for operational efficiencies, and further work is needed to develop these: -

- The management and administration of the CDOP process following the implementation of e-CDOP
- Attendance at meetings to be reviewed and rationalised
- Methods of operating at Panel meetings to be reviewed and streamlined providing greater opportunity for 'themed reviews.'